WORK SAFE. FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

WCB Nova Scotia
Policy Manual

Nova Scotians – safe and secure from workplace injury

Table of Contents

User's Guide

What is in the Policy Manual?

This manual contains the following sections:

- an Introduction, which introduces the Manual to users, and provides some context for it;
- a Table of Contents, which lists the various parts of the Manual in the order in which they appear;
- the actual Policies. The Policies are divided into sections, numbered 1 to 11 (1 – entitlement, 2 – Health Care, etc) and each section is in turn subdivided into subsections. (see Table of Contents for details)
- a Glossary, which defines key terms used in the Manual.

Many users will most easily find what they are looking for by first consulting the Table of Contents or by a key word search by clicking Ctrl + F

Explanatory notes regarding the individual Policies in the Manual

Each Policy has a three-digit number in the top-right corner. The first digit is the Section number, the second digit is the Subsection number, and the third digit is the specific Policy number.

Take, for example, **Policy 3.2.1**:

First digit – 3 = Section 3 = 'Short-Term and Long-Term Benefits'

Second digit – 2 = Subsection 2 [of Section 3] = 'Temporary Earnings Replacement Benefit (TERB)'

Third digit – 1 = Topic 1 [of Subsection 3.2] = 'Calculation of Temporary Earnings Replacement Benefit'

Note: If a given Policy is revised, but not so extensively as to merit an entirely new Policy being issued, the original number of the Policy is retained and the letter 'R' (for Revised) is added.

On each Policy, the 'Effective Date' is stated: this means that the Policy applies to all decisions made on and after that date. In addition, each Policy contains a section entitled 'Application' that explains which decisions/claims the Policy applies to.

The 'Date Issued' is the date on which the policy was placed in the policy manual, and is indicated on each Policy.

Every Policy contains a 'Policy Statement' section. The Policy Statement is the formal Policy, as adopted by the Board of Directors. Some Policies also contain a 'Guidelines' section. Guidelines are intended to provide explanatory material to help readers understand the context and meaning of the Policy Statement. Material in the Guidelines section is often drawn from policy papers considered by the Board of Directors, but this material is not formal Board policy.

The 'References' portion of each Policy cites the section(s) of the Act from which the Policy draws its statutory authority. The 'References' portion sometimes also provides cross-references to related Policies.

Introduction

The Policies in this Manual set out the rules the Workers' Compensation Board (WCB) applies when interpreting *Workers' Compensation Act (the "Act")*. Policies are binding for Board staff, as well as the Workers' Compensation Appeal Tribunal (WCAT). The WCB Board of Directors consists of equal representation from both workers and employers, a neutral Chair and a Deputy Chair, who are granted policy-making authority by Section 183 of the Act.

For your convenience additional information on the WCB's Legislation, Policies and Policy Initiatives can be found online at https://wcb.ns.ca/About-Us/Policy.aspx

If you have any questions or comments about the Policy manual or would like general information about the WCB and its programs, please contact us at:

Email: policy@wcb.ns.ca

Mail: Partnerships and Policy
Workers' Compensation Board of Nova Scotia
PO Box 1150
Halifax, Nova Scotia B3J 2Y2

Telephone: (902) 491-8904 in Halifax; 1-800-870-3331 toll free

The WCB also offers two notification services, you can sign up below to receive notification by email of changes to WCB Policies or to receive information on upcoming WCB policy consultations.

Section 1 - Entitlement

Overview

Note: This Overview is intended to provide a general guide to Board policies and programs. It does not constitute official Board policy.

The policies contained in this section deal primarily with issues of determining when a worker is eligible for workers' compensation benefits, as opposed to the benefits payable after entitlement has been established—these are described in later sections.

Entitlement guidelines for both injuries and occupational diseases are covered in this section.

Subsection 1.1 – Injuries

- **Policy Number: 1.1.1R1 - Back Injuries**
- **Policy Number: 1.1.2 - Coverage Police/Firefighters Employed in Off-Duty Hours**
- **Policy Number: 1.1.3 - Claims Adjudication – Processing Continuing Claims**

Policy Number: 1.1.1R1

Topic: Back Injuries
Section: Entitlement
Subsection: Injuries

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. Traumatic back injury cases are adjudicated and processed in the normal general claims process. In cases with a history of traumatic back injury, subsequent recurrence due to the accident/injury is compensable, and claims can be reopened for recurrence.

2. Claims for back strains and/or sprains can be accepted if evidence indicates the problem arose from the job. There does not have to be trauma involved.

3. The general rule with regard to other than traumatic back cases is to consider reopening a claim if the further disability occurs within three to six months after the closing of the claim. Beyond this period, there must usually be a new incident or accident. However, it is not possible to establish complete criteria in respect to these cases and each has to be dealt with on its own merits.

4. In disc cases, recurrence after about one year is doubtful, insofar as compensability is concerned, unless there is a new compensable incident. Adjudication has to be, particularly in these cases, considered in the light of Section 10(5); i.e. the "aggravation factor". If a degenerative condition was present, then the claim would have been accepted on a limited liability basis in respect to the aggravation factor.

5. In the event of a permanent impairment case, further difficulty, particularly if disc surgery is involved, may warrant a reopening of the claim and further temporary earnings replacement considered on the basis of medical evidence.

6. In spondylolisthesis cases, the usual criterion for acceptance of a claim is that there must be trauma involved and such claims are, if accepted, usually accepted on a limited liability basis. If fusion is recommended, the opinion is that the spondylolisthesis is a developmental condition, and while responsibility may be accepted for surgery and compensation for a reasonable post-operative period, permanent impairment in such cases is not usually compensable. An exception is where there is a combined procedure for removal of a disc and fusion, in which case Permanent Medical Impairment for the disc can be considered.

Where subjective symptoms are present, depending on the case, a client may be referred to a Physiatrist.

Application

This Policy applies to all decisions made on or after October 27, 2016. It replaces Policy 1.1.1R issued on April 3, 1997 and effective May 2, 1997.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1)

Policy Number: 1.1.2

Topic: Coverage Police/Firefighters Employed in Off-Duty Hours
Section: Entitlement
Subsection: Injuries

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: Sept. 14, 1995

Policy Statement

1. The following sets out the policy for coverage of members of police or fire departments, assessed by the W.C.B., employed in their "off-duty" hours as special security, crowd control, etc.

    1.1. Where such police officers or fire fighters carry out similar off-duty employment and are assigned by and under the control of their respective departments, and in uniform, they are considered to be in the course of their employment, even though the remuneration is paid directly to the officers.

    1.2. Where such police officers or fire fighters accept similar off-duty employment and these duties are *not* assigned by, *nor* under the control of their department, they would not be considered to be in the course of their employment.

    1.3. In such instances, the police officers or fire fighters would be considered as employees of the firm using their services and would be covered by this firm should it be assessed.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 10

Policy Number: 1.1.3

Topic: Claims Adjudication – Processing Continuing Claims
Section: Entitlement
Subsection: Injuries

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. Regardless of the probable period of disability, claims will be referred to the Medical Officers at intervals not exceeding three months. A Form 10 will be forwarded as required. If it appears that further information is needed before additional payment may be made, then the file is to be returned to the Claims Adjudicator of record for appropriate action.

2. Medical reports will be referred to the Medical Officers as necessary and returned to the Claims Adjudicator for adjudication. All specialists' reports are to be referred to the Medical Officers before adjudication.

3. In cases where a claim is closed on the current information and medical reports, and where subsequent reports indicate a further short period of disability, such claims can be reopened and paid for the additional disability periods as merited on the authority of the Claims Adjudicator.

4. Re: Permanent Medical Impairment

   The granting of a permanent impairment indicates that the worker has an impairment of a permanent nature and this implies that it could improve, remain stable or worsen. Flare-ups of such a condition can be considered for payment of temporary earnings replacement if the medical evidence indicates that it is a recurrence of the compensable condition.

5. Whenever an Adjudicator makes a decision regarding payment of W.C.B. benefits (close, continue, reduce, etc.) following review of the file by a Board Medical Officer, the Adjudicator shall have the decision, with explanations for the decision, typed on a Form 51.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1)

Subsection 1.2 – Occupational Diseases

- **Policy Number: 1.2.1AR1 - Guidelines for Automatic Assumption – Injuries on or after January 1, 2000**
- **Policy Number: 1.2.1R1 - Guidelines for Automatic Assumption – Injuries prior to January 1, 2000**
- **Policy Number: 1.2.3R1 - Voluntary Autopsy Reports – Deceased Pneumonoconiosis Pensioners**
- **Policy Number: 1.2.4R - Carpal Tunnel Syndrome**
- **Policy Number: 1.2.5AR2 - Occupational Hearing Loss – Injuries on or after January 1, 2000**
- **Policy Number: 1.2.5R1 - Occupational Hearing Loss – Injuries prior to January 1, 2000**
- **Policy Number: 1.2.6R1 - Workplace Noise Levels**
- **Policy Number: 1.2.7R - Lead Poisoning**
- **Policy Number: 1.2.8R1 - Lung Cancer – Foundry Workers**
- **Policy Number: 1.2.9R1 - Lung Cancer – Coke Oven Workers**
- **Policy Number: 1.2.10 - Medical Conditions from Coke Oven Workers Other Than Lung Cancer**
- **Policy Number: 1.2.11 - Lung Cancer in Asbestos Workers**
- **Policy Number: 1.2.12 - Mesothelioma in Asbestos Workers**
- **Policy Number: 1.2.13 - Laryngeal Cancer – Asbestos and Nickel Workers**
- **Policy Number: 1.2.14 - General Entitlement – Occupational Disease Recognition**

Policy Number: 1.2.1AR1

Topic: Guidelines for Automatic Assumption – Injuries on or after January 1, 2000
Section: Entitlement
Subsection: Occupational Diseases

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. Section 35 of the Workers' Compensation Act states:

   "Any coal miner who a) has worked at the face of a mine or in similar conditions twenty years or more; and b) suffers from a permanent impairment that is a loss of lung function, shall be compensated according to the permanent impairment as calculated pursuant to Section 34."

2. The Board has defined that the expressions:

   2.1. **"Any coal miner who has worked at the face of a mine... twenty years or more"** means any coal miner who is/was employed by a coal company and works/worked underground for a period of twenty years or more;

   2.2. **"similar conditions"** applies to coal miners who are/were employed by a coal company and works/worked at the wash plant, at or near the bankhead or on the shipping/coal piers.

3. The Board further directs:

   3.1. that new applicants who qualify under Section 35 will need completed Forms 67, and 8 to open a claim;

   3.2. that once a claim has been opened, an appointment for a lung function test will be arranged and interpreted using the following pulmonary function guidelines:

Class	**Obstructive Disease FEV_1 /FVC (%) ***
1. No Disability	greater than 70%
2. Mild Disability 10% Award	60-70%
3. Moderate Disability 20% Award	55-60%
4. Severe Disability 35% Award	50-55%
5. Very Severe Disability 60% Award *(Automatic Review by Physician)*	less than 50%

Class	**Restrictive Disease Vital Capacity (%) Predicted ***
1. No Disability	greater than 85%
2. Moderate Disability 20% Award	75-85%
3. Severe Disability 35% Award	0-75%
4. Very Severe Disability 60% Award *(Automatic Review by Physician)*	less than 60%

* These are measurements of lung capacity. Lower numbers indicate a greater loss of lung function.

3.3. that an applicant who has been examined by lung function testing, whether allowed or disallowed, shall be recalled as soon as possible after three years have elapsed from the date of the applicant's last test for Automatic Assumption, unless medical evidence justifies an earlier re-examination; however, the Board strongly recommends that each applicant undergo a chest x-ray for their own personal health. These x-rays may be requested by the applicant's family doctor and reported on a Form 8;

3.4. that applicants who have previously made a claim that was allowed or disallowed will not be required to fill out new forms but will be obligated to keep the W.C.B. informed of any changes affecting their file;

3.5. that new applicants who do not qualify under Section 35 will be processed under our normal procedures;

3.6. that where an applicant is unable to obtain their work record, a sworn affidavit before a commissioner of the Supreme Court of the province is the only accepted document.

General Claims – Pneumonoconiosis

4. The provisions covering the general type of pneumonoconiosis claims are set out in Sections 13 and 14, inclusive, of the Statute.

5. The following guidelines as to procedures, handling and adjudication of such claims are established, subject to the fact that each claim, finally, has to be considered on its own merits or on any characteristics or elements peculiar to a particular claim or worker.

5.1. For each new pneumonoconiosis claim opened, the W.C.B. Administrator of Medical Services reviews the claim file along with the local chest films that are sent in. If the Administrator of Medical Services feels there is sufficient radiological evidence to make a diagnosis of pneumonoconiosis, the client is put on the list to be called in for full examination by a chest specialist.

If, however, the Administrator of Medical Services does not feel there is sufficient evidence to make a diagnosis of pneumonoconiosis, the x-rays, along with the work history of the client, are referred to two independent specialists for readings. If either one of these specialists feels there is sufficient evidence to warrant a diagnosis of pneumonoconiosis, then the client is brought in for full examination, which includes a complete clinical assessment along with pulmonary function tests and further chest x-ray examination. If both specialists agree that there is not sufficient evidence to warrant a diagnosis of pneumonoconiosis, then the claim is officially disallowed at that time.

5.2. Pulmonary Function Testing will be used to determine the existence and degree of a worker's permanent impairment rating, using the American Medical Associations "Guidelines to the Evaluation of Permanent Impairment – Fourth Edition" (the "AMA Guidelines").

5.3. On receipt of the two specialists' reports concerning either x-ray assessment or examination assessment, the Administrator of Medical Services puts forth the opinions and recommendations of these reports to the Claims Adjudicator who make the final decision on the claim. In some cases, additional medical information, etc. must be obtained before a final recommendation can be made.

Calculations for Automatic Assumption Costs

6. In the case of a miner who qualifies for Automatic Assumption and has worked for more than one employer, the mine where the miner worked the longest, that is, the total number of years employed under the conditions as set forth above, will be charged the amount for all funds expended, medical aid, pensions, etc.

Application

This policy is effective December 16, 2021. This Policy applies to injuries arising on or after January 1, 2000. This replaces Policy 1.2.1A that was effective January 1, 2000.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) (as amended), Sections 13, 14, 35.

Policy Number: 1.2.1R1

Topic: Guidelines for Automatic Assumption – Injuries prior to January 1, 2000
Section: Entitlement
Subsection: Occupational Diseases

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. Section 35 of the Workers' Compensation Act states:

   "Any coal miner who a) has worked at the face of a mine or in similar conditions twenty years or more; and b) suffers from a permanent impairment that is a loss of lung function, shall be compensated according to the permanent impairment as calculated pursuant to Section 34."

2. The Board has defined that the expressions:

   2.1. **"Any coal miner who has worked at the face of a mine... twenty years or more"** means any coal miner who is/was employed by a coal company and works/worked underground for a period of twenty years or more;

   2.2. **"similar conditions"** applies to coal miners who are/were employed by a coal company and works/worked at the wash plant, at or near the bankhead or on the shipping/coal piers.

3. The Board further directs:

   3.1. that new applicants who qualify under Section 35 will need completed Forms 67, and 8 to open a claim;

   3.2. that once a claim has been opened, an appointment for a lung function test will be arranged and interpreted;

   3.3. that an applicant who has been examined by lung function testing, whether allowed or disallowed, shall be recalled as soon as possible after three years have elapsed from the date of the applicant's last test for Automatic Assumption, unless medical evidence justifies an earlier re-examination; however, the Board strongly recommends that each applicant undergo a chest x-ray for their own personal health. These x-rays may be requested by the applicant's family doctor and reported on a Form 8;

   3.4. that applicants who have previously made a claim that was allowed or disallowed will not be required to fill out new forms but will be obligated to keep the W.C.B. informed of any changes affecting their file;

   3.5. that new applicants who do not qualify under Section 35 will be processed under our normal procedures;

   3.6. that where an applicant is unable to obtain their work record, a sworn affidavit before a commissioner of the Supreme Court of the province is the only accepted document.

General Claims – Pneumonoconiosis

4. The provisions covering the general type of pneumonoconiosis claims are set out in Sections 13 and 14, inclusive, of the Statute.

5. The following guidelines as to procedures, handling and adjudication of such claims are established, subject to the fact that each claim, finally, has to be considered on its own merits or on any characteristics or elements peculiar to a particular claim or worker.

    5.1. For each new pneumonoconiosis claim opened, the W.C.B. Administrator of Medical Services reviews the claim file along with the local chest films that are sent in. If the Administrator of Medical Services feels there is sufficient radiological evidence to make a diagnosis of pneumonoconiosis, the client is put on the list to be called in for full examination by a chest specialist.

    If, however, the Administrator of Medical Services does not feel there is sufficient evidence to make a diagnosis of pneumonoconiosis, the x-rays, along with the work history of the client, are referred to two independent specialists for readings. If either one of these specialists feels there is sufficient evidence to warrant a diagnosis of pneumonoconiosis, then the client is brought in for full examination, which includes a complete clinical assessment along with pulmonary function tests and further chest x-ray examination. If both specialists agree that there is not sufficient evidence to warrant a diagnosis of pneumonoconiosis, then the claim is officially disallowed at that time.

    5.2. On receipt of the two specialists' reports concerning either x-ray assessment or examination assessment, the Administrator of Medical Services puts forth the opinions and recommendations of these reports to the Claims Adjudicator who make the final decision on the claim. In some cases, additional medical information, etc. must be obtained before a final recommendation can be made.

Calculations for Automatic Assumption Costs

6. In the case of a miner who qualifies for Automatic Assumption and has worked for more than one employer, the mine where the miner worked the longest, that is, the total number of years employed under the conditions as set forth above, will be charged the amount for all funds expended, medical aid, pensions, etc.

Application

This policy is effective December 16, 2021. This Policy applies to injuries arising prior to January 1, 2000. This replaces Policy 1.2.1R that was effective January 1, 2000.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) (as amended), Sections 13, 14, 35.

Policy Number: 1.2.3R1

Topic: Voluntary Autopsy Reports – Deceased Pneumonoconiosis Pensioners
Section: Entitlement
Subsection: Occupational Diseases
Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. The following procedure is followed in connection with voluntary autopsy reports from pathologists on deceased miners who are receiving pneumonoconiosis disability pensions.

    1.1. The pathologists in the Cape Breton area be informed that in all cases in which autopsy is carried out on one of the claimants who has been diagnosed as having Coal Miners' Pneumonoconiosis and where it is felt this condition has directly caused or played a significant part in the claimant's death, that one whole lung be sent as soon as possible to the Pathology Institute in Halifax. Appropriate identification will be sent with each lung.

    1.2. The W.C.B. accepts responsibility for the cost of containers used to transport the lungs, together with the transportation costs.

    1.3. The Pathology Institute will review the lung in gross and microscopic detail and the report will be sent to the W.C.B. However, prior to this report, the Pathology Institute will have available all medical information that the W.C.B. has on file which will be sent as soon as the W.C.B. is aware that an autopsy as outlined in Item 1 has taken place, and all reports are received.

    1.4. Referral doctors will be sent all medical reports on file, including the autopsy report and hospital summary. They will then arrange to meet to discuss the claim fully.

    1.5. The doctors will send a final report giving their opinion concerning what role the claimant's occupational lung condition played in their death and whether responsibility should be accepted by the W.C.B.

    1.6. The Board should rely heavily on this aforementioned report regarding any decision concerning W.C.B. responsibility.

Application

This Policy is effective December 16, 2021. This replaces Policy 1.2.3 that was effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 68

Policy Number: 1.2.4R

Topic: Carpal Tunnel Syndrome
Section: Entitlement
Subsection: Occupational Diseases

Effective: February 7, 1997
Issued: February 7, 1997
Approved by Board of Directors: February 7, 1997

Definitions

Carpal Tunnel Syndrome is a compression of the median nerve as it passes through an area in the wrist known as the Carpal Tunnel.

Policy Statement

1. Claims for traumatic Carpal Tunnel Syndrome will be considered for acceptance if the condition arrises out of and in the course of employment. For example:

    1.1. the client's work involves repetitive flexion and extension of the wrist on fairly full time basis;

    or

    1.2. the client's work involves the use of vibratory tools;

    or

    1.3. the client's work involves the use of tools which place the wrist/hand in an awkward position

    or

    1.4. the client's work involves sustained or repeated stress over the base of the palm;

    or

    1.5. there is direct, blunt trauma to the integrity of the carpal tunnel structures (ie. crush injury, wrist fracture, etc.).

    Frequency, intensity and duration of force on the median nerve should all be considered in each claim.

2. The length of time doing a particular occupation should be considered. Short term work with appropriate factors present (as listed above) would favour a traumatic etiology. Long term work with a recent change, ie. overtime, would also favour a traumatic etiology.

3. Physical signs of trauma are often absent, but with appropriate history claims can still be considered for acceptance.

4. Where there is evidence that non-occupational factors have contributed to development of the condition, section 10(5) of the Act will apply.

5. There should be objective evidence of median nerve conduction delay at the wrist as compared to the ipsilateral ulnar nerve for carpal tunnel surgery. In cases when the electrodiagnostic studies are normal, and the diagnosis of carpal tunnel is being made and surgery contemplated, the Board requires a second opinion from a physician of its choice. If the first and second opinion are not in agreement, a third opinion by a physician mutually acceptable to the worker's physician and the Board will be sought. Regardless of the number of opinions received, all medical evidence must be weighed before a final decision on the surgery is made.

6. Before bilateral carpal tunnel is accepted, the criteria listed above must be met for each wrist independently.

Application

This Policy applies to all decisions made on or after February 7, 1997

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 10, 102

Policy Number: 1.2.5AR2

Topic: Occupational Hearing Loss – Injuries on or after January 1, 2000
Section: Entitlement
Subsection: Occupational Diseases

Effective: November 3, 2017
Issued: April 11, 2018
Approved by Board of Directors: March 29, 2018

Definitions

Noise-Induced Hearing Loss – Noise- induced hearing loss means the gradual deterioration of hearing as a result of exposure to hazardous noise over a period of time.

Sensorineural – Sensorineural hearing loss is due to damage to the cochlea of the cochlear nerve or the auditory pathways in the brain.

Tinnitus – Sounds heard in one or both ears or in the head (central tinnitus) in the absence of an external stimulus. Can include sounds like ringing, roaring, hissing, or buzzing.

American College of Occupational and Environmental Medicine (ACOEM) – ACOEM is the largest national college of its type in the United States that comprises a group of physicians encompassing specialists in a variety of medical practices to develop positions and policies on vital issues relevant to the practice of preventative medicine both within and outside of the workplace. It is considered the medical expert in occupational medicine.

Policy Statement

1. Noise-induced hearing loss (NIHL) is recognized as an occupational disease and must arise from an industrial process, trade or occupation wherein the noise exposure and hazard is characteristic of or particular thereto. This means that in addition to meeting the entitlement criteria set out in this policy, the injury must meet the definition of occupational disease set out in the Workers' Compensation Act and Policy 1.2.14—General Entitlement—Occupational Disease Recognition.

2. Claims for occupational NIHL will be considered as follows:

   Step 1: The worker has a history of occupational exposure to noise in excess of permissible levels outlined in Policy 1.2.6R. Where actual noise levels are unavailable the Workers' Compensation Board (WCB) may estimate the expected noise levels based on the information obtained from similar industries or types of work. Workers who have not been exposed to these levels will not receive compensation for NIHL because their hearing loss is not occupational.

   Step 2: After it has been determined that a worker was exposed to noise in excess of permissible levels, the worker must provide audiogram evidence that shows a pattern consistent with NIHL, as per the current ACOEM Guidance Statement. In determining a pattern consistent with NIHL, the WCB uses the ACOEM Guidance Statement[1] as highlighted by the following characteristics:

   - It is always sensorineural, primarily affecting the cochlear hair cells in the inner ear;

[1] Occupational Noise-Induced Hearing Loss. 2012

- It is typically bilateral, since most noise exposures are symmetric;
- There is insufficient evidence to conclude that hearing loss due to noise progresses once the noise exposure is discontinued. Nevertheless, on the basis of available human and animal data, which evaluated the normal recovery process, it is unlikely that such delayed effects occur; and
- Its first sign is a 'notching' of the audiogram at the high frequencies of 3000, 4000, or 6000 Hz with recovery at 8000 Hz.

The audiogram frequencies of 250-8000 Hz shall be assessed, evaluated, and rated to determine if the hearing loss pattern is consistent with NIHL as noted above.

Acknowledging some variance in specific cases, if the occupational NIHL does not meet the above pattern of hearing loss, the claim will not be accepted because the hearing loss is not caused by occupational noise.

Step 3: After it has been determined that the worker was both exposed to occupational noise and has hearing loss showing a pattern consistent with NIHL, it must then be established that the worker meets the definition of occupational disease by satisfying one of the following criteria: death, loss of earnings, or a permanent medical impairment. To determine a permanent medical impairment, hearing loss shall be assessed, evaluated, and rated on the basis of an audiogram, as specifically plotted at the frequency levels of 500, 1000, 2000, and 3000 Hz. If the worker does not meet the requirements of an occupational disease, the claim will not be accepted because the worker does not have an injury that meets the requirements under the *Workers' Compensation Act* and related policies.

3. Medical Aid in the form of a hearing aid shall be provided to a worker for hearing loss when necessary if they have a compensable NIHL.

4. The existence and degree of a worker's permanent medical impairment rating for NIHL will be determined using the American Medical Association's "Guides to the Evaluation of Permanent Impairment—Fourth Edition" (the "AMA Guides").

Tinnitus

5. To establish entitlement to a permanent impairment rating for tinnitus caused by NIHL, the following circumstances must apply:

    5.1. There is an acceptable claim for occupational NIHL; and

    5.2. There is a clear and adequate medically documented history of two or more years of continuous tinnitus.

6. Claims for tinnitus caused by occupational factors other than NIHL will be adjudicated as per Policy 1.3.7R—General Entitlement—Arising out of and in the Course of Employment.

7. To determine an impairment rating for tinnitus, the WCB shall use the AMA Guides.

Application

This Policy applies to decisions made on or after November 3, 2017.

This Policy replaces Policy 1.2.5AR1, approved by the Board on October 31, 2014.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), (as amended), Sections 2(v), 10, 12, 102.
Policy 1.2.6R1.

Policy Number: 1.2.5R1

Topic: Occupational Hearing Loss – Injuries prior to January 1, 2000
Section: Entitlement
Subsection: Occupational Diseases

Effective: January 1, 2000
Issued: December 1, 1999
Approved by Board of Directors: September 3, 1999

Policy Statement

1. Occupational hearing loss is recognized as an occupational disease and compensation for such hearing loss can be provided according to the criteria set out below.

2. The criteria for dealing with such claims arising from continued workplace noise exposure over a period of time shall be as set out in the following.

    2.1. The acceptance of such claims where proven to be valid and where the hearing loss is deemed to arise from workplace noise exposure is now considered to be permissive.

    2.2. Occupational loss of hearing in this regard must arise from an industrial process, trade or occupation wherein the noise exposure and hazard is characteristic of or peculiar thereto.

    2.3. Where a claim is made in respect to occupational loss of hearing, it should be fully documented and referred to the Medical Officers to have the hearing loss evaluated and charted.

    2.4. Earnings replacement payments can only be recognized where time loss is directly due to the hearing loss.

    2.5. Permanent Medical Impairment can be established on the basis of an audiogram and other medical evaluations and may be evaluated, rated and assessed on this basis. Audiograms can be done and accepted for review after removal from the source of noise for at least 48 hours.

    2.6. Permanent Medical Impairment evaluation and assessments shall be made in accordance with the report of the committee on Permanent Disability Evaluation to the Association of Workers' Compensation Boards of Canada dated September 1, 1986; and which Report and the Permanent Disability Rating Schedule contained in that report were adopted effective January 1, 1965, by resolution of the corporate Board made December 4, 1964; and as amended by resolution made July 14, 1966, in respect to revisions in the Permanent Medical Impairment 500, 1,000, 2,000, and 3,000 FR levels will be used.

    2.7. Where a claim for occupational loss of hearing is established, where accompanied by a loss of earnings capacity or not, a hearing aid may be authorized to be furnished as a Medical Aid provision if considered warranted by the Medical Officer of the Board.

    2.8. To assist adjudicators in assessing hearing loss claims in cases where actual noise levels are unavailable, it has been determined that we accept the worker's history of employment including whether or not he/she was exposed to "loud" noises on a regular and/or continuous basis. An "estimate" is to be made of the actual level of noise he/she would have been exposed to based on the information obtained from similar industries or type of work.

Application

This Policy applies to workers injured prior to January 1, 2000.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 2(v). Policy 1.2.6R1.

Policy Number: 1.2.6R1

Topic: Workplace Noise Levels
Section: Entitlement
Subsection: Occupational Diseases

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2017

Policy Statement

1. Hearing loss claims will be considered when noise exposure exceeds the levels adopted by the Department of Labour.

General

Permissible Noise Exposures (Steady-State Noise)

Steady-State Noise Levels (dBA)	Maximum Period of Exposure (per 24 hours)
80	24 hours
82	16 hours
85	8 hours
88	4 hours
91	2 hours
94	1 hours
97	30 minutes
100	15 minutes
103	7.5 minutes
106	3.75 minutes
109	1.88 minutes
112	.94 minutes
115	28.12 seconds
118	14.06 seconds
121	7.03 seconds
124	3.52 seconds
127	1.76 seconds
130	.88 seconds
133	.44 seconds
136	.22 seconds
139	.11 seconds

No exposure to steady-state noise in excess of 115 dBA is permitted, as determined by the N.S. Department of Labour (Occupation Health and Safety Division)

Permissible Noise Exposure (Impulse or Impact Noise)

Sound Level (dBA)	Permitted Number of Impulses or Impacts (per 24 hours)
Above 140*	0
140	100
130	1000
120	10000

* No exposure to impulse or impact noise in excess of 140 dBA peak sound pressure level is permitted, as determined by the N.S. Department of Labour (Occupational Health and Safety Division).

Application

This Policy applies to all decisions made on or after October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1). Policy 1.2.5R1 and Policy 1.2.5AR1

Policy Number: 1.2.7R

Topic: Lead Poisoning
Section: Entitlement
Subsection: Occupational Diseases

Effective: February 1,2000
Issued: January 31, 2000
Approved by Board of Directors: January 20, 2000

Policy Statement

1. Lead poisoning cases will be considered as per the following criteria:

    1.1. The Workers' Compensation Board, after having reviewed current information on lead poisoning, states that claims for lead poisoning be accepted with the blood levels in excess of 1.45μ moles/litre (30 ug/100ml) and that compensation be continued until the blood lead level falls below this level.

Application

This Policy applies to all decisions made on or after February 1, 2000.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) (as amended), Section 12.

Policy Number: 1.2.8R1

Topic: Lung Cancer – Foundry Workers
Section: Entitlement
Subsection: Occupational Diseases

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. Lung cancer in foundry workers will be considered under the following guidelines.

    1.1. Primary lung cancer in certain foundry workers shall be accepted as an occupational disease under Section 12 of the Act as peculiar to and characteristic of a process, trade or occupation involving exposure to foundry aerosols within a foundry unit.

    1.2. Based on medical studies, a review of past foundry conditions and analysis of claims reported to the Board, cases of primary lung cancer shall be favourably considered when the following appropriate combinations of circumstances regarding exposure, latency and cessation factors apply:

        1.2.1. Twenty years of minimum exposure within a ferrous foundry unit where the following conditions prevail:

            a) predominant use of sand moulds;

            b) 'floor pouring' of castings;

            c) evidence that ventilation has been less than satisfactory as determined by a review of records of the Ministry of Labour surveys (for silica) and/or historical data.

        1.2.2. The cessation interval (time between cessation of occupational risk and appearance of lung cancer) in a smoker shall be 15 years or less. (See definitions below.)

        1.2.3. The cessation interval in an ex-smoker or confirmed non-smoker shall be 20 years or less. (See definitions below.)

    1.3. Claims which do not meet the criteria in Section 1.2 (including those from nonferrous foundries) shall be individually judged on their merits taking into consideration the variations in intensity and duration of exposure.

2. Definitions of Smoking:

    2.1. **Non-smoker** – A never smoker. A person who has never smoked even occasionally.

    2.2. **Ex-smoker** – A person who has smoked during their lifetime but who has not smoked for the past ten or more years.

    2.3. **Smoker** – A person who currently smokes, or who has ceased smoking for less than the previous ten years.

Application

This Policy is effective December 16, 2021. This replaces Policy 1.2.8 that was effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 2(v), 12

Policy Number: 1.2.9R1

Topic: Lung Cancer – Coke Oven Workers
Section: Entitlement
Subsection: Occupational Diseases

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. Lung cancer in Coke Oven workers will be considered under the following guidelines.

    1.1. Lung cancer in Coke Oven workers is accepted as an occupational disease as peculiar to and characteristic of exposure to coke oven emissions in the steel industry.

    1.2. Based on medical studies, lung cancer claims shall be favourably considered when the following appropriate combinations of circumstances regarding exposure, latency, and cessation factors apply:

        1.2.1. Persons employed five or more years in full time topside exposure;

        1.2.2. Persons employed for ten or more years in mixed side-oven/topside exposure;

        1.2.3. Persons employed for fifteen or more years in side-oven exposure only;

        1.2.4. The inception (latent) period between first exposure and the acceptance of lung cancer be at least ten years;

        1.2.5. The cessation interval (CI) (time between cessation of occupational risk and appearance of lung cancer) in a smoker shall be fifteen years or less;

        1.2.6. The cessation interval (CI) in a confirmed non-smoker or ex-smoker shall be twenty years or less. (See definitions below.)

    1.3. Claims which do not meet with criteria outlined in 1.2 above, will be individually judged on their own merits, taking into consideration the variations in intensity and duration of exposure which would cause lung cancer. Where it seem reasonable that lung cancer resulted from exposure to coke oven emissions in the steel industry, consideration shall be given to these cases.

2. Definitions of Smoking:

    2.1. **Non-smoker** – A never smoker. A person who has never smoked even occasionally.

    2.2. **Ex-smoker** – A person who has smoked during their lifetime but who has not smoked for the past ten or more years.

    2.3. **Smoker** – A person who currently smokes, or who has ceased smoking for less than the previous ten years.

Application

This Policy is effective December 16, 2021. This replaces Policy 1.2.9 that was effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 2(v), 12

Policy Number: 1.2.10

Topic: Medical Conditions from Coke Oven Workers Other Than Lung Cancer
Section: Entitlement
Subsection: Occupational Diseases

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. All claims will be considered for compensation based on their merits. Each claim is to be considered based on nature of the medical condition, work history and medical evidence.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 12

Policy Number: 1.2.11

Topic: Lung Cancer in Asbestos Workers
Section: Entitlement
Subsection: Occupational Diseases

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. Lung cancer in asbestos workers will be considered under the following guidelines.

    1.1. Lung cancer in asbestos workers is to be accepted as an occupational disease under Section 12 of the Act as peculiar to and characteristic of a process, trade or occupation involving exposure to asbestos.

    1.2. Based on medical studies, lung cancer claims should be favourably considered when the following circumstances apply:

        1.2.1. There is a clear and adequate history of at least ten years occupational exposure to asbestos;

        1.2.2. There is a minimum interval of ten years between first exposure to asbestos and the appearance of lung cancer;

        1.2.3. Claims which do not meet the guidelines in 1.2.1 and 1.2.2 should be individually judged on their own merits, having regard to the intensity of exposure and other factors peculiar to the individual case.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 2(v), 12

Policy Number: 1.2.12

Topic: Mesothelioma in Asbestos Workers
Section: Entitlement
Subsection: Occupational Diseases

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. Mesothelioma in asbestos workers is to be considered under the following guidelines.

    1.1. Based on medical studies, mesothelioma claims are to be favourably considered when the following circumstances apply:

        1.1.1. There is a clear and adequate history of at least 10 years occupational exposure to asbestos;

        1.1.2. There is a minimum interval of 15 years between first exposure to asbestos and the appearance of mesothelioma;

        1.1.3. Claims which do not meet the guidelines in 1.1.1 and 1.1.2 above should be individually judged on their own merits having regard to the intensity of exposure and other factors peculiar to the individual case. Consideration will be given where it seems evident that the mesothelioma cancer resulted from occupational exposure to asbestos.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 12

Policy Number: 1.2.13

Topic: Laryngeal Cancer – Asbestos and Nickel Workers
Section: Entitlement
Subsection: Occupational Diseases

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. Claims for laryngeal cancer in industries related to asbestos exposure and nickel exposure are to be considered under the following guidelines.

    1.1. Laryngeal cancer in workers occupationally exposed to asbestos fibre and/or to nickel aerosol in specific industrial processes will be accepted as an occupational disease under Section 12 of the Act.

    1.2. Based on medical studies, claims for laryngeal cancer will be favourably considered under the following circumstances:

        1.2.1. Any industrial process in the nickel industry which produces nickel in aerosol dispersion, whether in combined or elemental form. This may include the following:

        * Roasting * Welding * Smelting

        * Refining * Electroplating

        1.2.2. Any occupation in which there is a clear and adequate history of occupational exposure to asbestos dust, and while such occupational exposure cannot be quantitatively described, it should be of continuous and repetitive nature and should represent or be a manifestation of the major component of the occupational activity.

2. **Duration of Exposure**

    2.1.1. Nickel: an accumulative minimum of 15 years exposure to nickel aerosols as defined in 1.2.1;

    2.1.2. Asbestos: an accumulative minimum of 10 years proven exposure as defined under 1.2.2;

    2.1.3. Nickel and asbestos: an accumulative minimum of 7.5 years nickel as well as 5 years asbestos exposures in the case of dual exposure.

3. **Inception Period**

    3.1. Nickel: this shall be a minimum of 20 years from the commencement of the first hazardous exposure.

    3.2. Asbestos: this shall be a minimum of 20 years from the commencement of the first hazardous exposure.

    3.3. Nickel and Asbestos: this shall be a minimum of 15 years from the commencement of the first hazardous exposure.

4. Claims which do not meet the guidelines should be individually judged on their own merits having regard to the intensity of exposure and other factors peculiar to the individual case.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 12

Policy Number: 1.2.14

Topic: General Entitlement – Occupational Disease Recognition
Section: Entitlement
Subsection: Occupational Diseases

Effective: February 11, 2010
Issued: February 16, 2010
Approved by Board of Directors: February 11, 2010

Preamble

The purpose of this policy is to: 1) identify the basic requirements that must be met to be eligible to receive compensation benefits and services for an occupational disease; and 2) describe the typical questions, general principles and sections of the *Workers' Compensation Act* (the "*Act*") the *Workers' Compensation Board* (the "WCB") considers in determining whether a disease is an occupational disease.

Definitions

Accident – is defined in section 2(a) of the *Act* and includes

(i) a wilful and intentional act, not being the act of the worker claiming compensation,

(ii) a chance event occasioned by a physical or natural cause, or

(iii) disablement, including occupational disease, arising out of and in the course of employment,

but does not include stress other than an acute reaction to a traumatic event.

Occupational disease – is defined in Section 2(v) of the *Act* and means a disease arising out of and in the course of employment and resulting from causes or conditions

(i) peculiar to or characteristic of a particular trade or occupation, or

(ii) peculiar to the particular employment,

and includes silicosis and pneumoconiosis.

Policy Statement

1. **Section 10 of the Act**

The WCB uses section 10 of the *Act* and *Policy 1.3.7R, General Entitlement – Arising Out of and in the Course of Employment*, to adjudicate all claims for compensation involving a personal injury by accident, including an occupational disease.

2. **Basic eligibility requirements**

To be eligible to receive compensation benefits and services a worker must:

a) be a worker as defined by Section 2(ae) of the *Act*;
b) meet the requirements for filing a claim for compensation in Section 83 of the *Act*;

c) be caused a personal injury by accident arising out of and in the course of employment as required by Section 10 of the *Act*; and

d) depending on the facts of the claim, meet any other applicable sections of the *Act*.

3. **Occupational disease claim adjudication process**

To accept a claim for compensation the WCB must determine whether the disease is an occupational disease that is arising out of and in the course of employment. To determine eligibility the WCB:

(a) Evaluates medical and scientific literature to determine if the disease is resulting from causes or conditions peculiar to or characteristic of a particular trade or occupation; or peculiar to the particular employment; and

(b) Gathers evidence specific to the claim to determine if the disease is arising out of and in the course of employment.

(a) Evaluating medical and scientific literature to determine if the disease is resulting from causes or conditions peculiar to or characteristic of a particular trade or occupation; or peculiar to the particular employment

e) The WCB considers medical and scientific literature to determine whether there is a causal connection between an exposure and a disease. The WCB *may* consider, among other things, the following questions:

- Is there a biologically plausible relationship between the reported exposure and the condition?
- Did the condition occur after a reasonable duration of exposure and latency based on current medical/scientific knowledge?
- Is the condition linked to a specific type of exposure as opposed to multiple exposures?
- Is there consistency across the literature on the relationship between the reported exposure and the condition?
- What is the incidence of the condition under study between those exposed and those not exposed?
- Does the employment expose the worker to a greater risk of this type of disease than the normal risk/incidence to the public at large?
- Is there an abnormal prevalence of the disease in people carrying out the same employment?

(b) Gathering evidence specific to the claim to determine if the disease is arising out of and in the course of employment

f) The WCB gathers evidence specific to the claim to determine whether the disease is arising out of and in the course of employment. The WCB *may* consider, among other things, the following:

- Where the exposure occurred
- Type, nature, duration and frequency of the worker's exposure
- Level of exposure
- Latency period specific to the disease
- Confirmation or diagnosis of a disease, and date of first diagnosis
- Medical history, specialists' reports, pathology reports
- Use/type of personal protective equipment to determine whether, and to what extent, the worker was protected from exposure

- Evidence of an alternate cause(s) of the worker's disease such as hobbies, medical conditions, exposures outside of employment, or exposures in employment not covered by the *Act*.

4. **Weighing the evidence**

   The WCB considers the evidence gathered throughout the claim adjudication process, and weighs the evidence to determine whether (a) the disease is resulting from causes or conditions peculiar to or characteristic of a particular trade or occupation; or peculiar to the particular employment; and (b) whether the disease is arising out of and in the course of employment.

5. **Compensation for occupational disease**

   Pursuant to section 12(1) of the *Act*, where an occupational disease is due to the nature of any employment to which Part I of the *Act* applies in which a worker was engaged, whether under one or more employments, and (a) the occupational disease results in loss of earnings or permanent impairment; or (b) the worker's death is caused by the occupational disease, the worker is entitled to compensation as if the occupational disease was a personal injury by accident

Application

This program policy applies to new claims for compensation made on or after February 11, 2010.

References

Workers' Compensation Act (Chapter 10, *Acts* of 1994-95), sections 2, 10, 12, and 83.

Subsection 1.3 – General

- **Policy Number: 1.3.1 - Loss of Wages While Undergoing Active Medical Treatment**
- **Policy Number: 1.3.2R - Interruption of Medical Treatment – Circumstances Beyond Worker's Control**
- **Policy Number: 1.3.4R1 - Volunteer Fire Fighters**
- **Policy Number: 1.3.5R1 - Criteria for psychiatric conditions: occupational stress**
- **Policy Number: 1.3.7R - General Entitlement – Arising out of and in the Course of Employment**
- **Policy Number: 1.3.8 - Recurrence of compensable injury**
- **Policy Number: 1.3.9R - Psychological Injury**

Policy Number: 1.3.1

Topic: Loss of Wages While Undergoing Active Medical Treatment
Section: Entitlement
Subsection: General

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. The acceptance of medical treatment by the Board does not necessarily imply client's total inability to work while undergoing treatment.

2. Consideration for payment of lost wages will depend on objective medical evidence of disability during the period of treatment.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1)

Policy Number: 1.3.2R

Topic: Interruption of Medical Treatment – Circumstances Beyond Worker's Control
Section: Entitlement
Subsection: General

Effective: January 9, 2003
Issued: January 27, 2003
Approved by Board of Directors: January 9, 2003

Policy Statement

1. Where a worker is unable to commence, or continue, medical treatment required with respect to the compensable injury for reasons which, in the opinion of the Board, are genuinely beyond the worker's control, compensation benefits will:

    1.1. continue to be paid for that period which the worker, in the opinion of the Board, would have been eligible to receive compensation benefits while undergoing treatment, had the treatment not been delayed or interrupted; or,

    1.2. be temporarily suspended and reinstated when the worker is once again able to commence or resume medical treatment,

    whichever appears to be in the best interests of the worker.

2. Where benefits are suspended, the worker will be provided a minimum two weeks written notice prior to suspension.

3. Policy statement 1 and 2 do not apply where the circumstance preventing the worker from commencing or continuing medical treatment is pregnancy. The Board shall continue to pay compensation benefits in circumstances where the effects of the compensable injury prevent the worker from returning to her employment but the worker's pregnancy, or health conditions related to pregnancy, present a valid medical reason for refusing or discontinuing medical treatment required with respect to the compensable injury.

    3.1. Notwithstanding the above, compensation benefits will not be paid to a worker in respect of those periods of time where her pregnancy or conditions related to the pregnancy, are themselves of a nature which prevent the worker from returning to her employment.

    3.2. The Board will normally require a medical opinion or certificate to confirm a pregnant worker's medical condition.

Guidelines

A minimum of two weeks notice is provided to the worker in order to allow an opportunity to secure coverage through an alternative illness coverage plan (if any) normally available to the worker.

Application

This Policy applies to all decisions made on or after January 9th, 2003.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1)

Policy Number: 1.3.4R1

Topic: Volunteer Firefighters
Section: Entitlement
Subsection: General

Effective: October 30, 2020
Issued: May 25, 2022
Approved by Board of Directors: May 25, 2022

Policy Statement

1. Pursuant to Section 2(ae)(v) and Section 5 of the *Act*, volunteer firefighters who are members of a fire department that is registered by a municipality under Section 294 of the *Municipal Government Act* or Section 305 of the *Halifax Regional Municipality Charter* shall have workers' compensation coverage when the volunteer firefighters are in the course of their employment.

2. Volunteer firefighters are considered workers for the purposes of the *Act*, and the municipality is considered to be their employer for purposes of the *Act*.

3. The amount of coverage purchased by the municipality will be based on the average earnings rate chosen by the municipality for the volunteer members of the fire department. The average earnings chosen by the municipality must be an amount between the minimum and maximum rate set by regulation.

4. As stipulated in regulation, the minimum average earnings for which coverage may be purchased is $10,200. The maximum average earnings for which coverage may be purchased is the assessable/insurable maximum in effect from time to time pursuant to s. 41(c) of the *Act*.

5. The average earnings rate chosen by the municipality applies to every volunteer member of the fire department.

6. Volunteer members of a fire department are considered to be in the course of their employment while:

    a) in the act of responding to an emergency call (this includes travelling directly from the place where the call was received to the site of the emergency);

    b) at the site of the emergency;

    c) in the act of returning from the site of the emergency to the place where the call was received, home, their place of regular employment or any place for treatment, refreshment or recreation, whichever is reached first;

    d) involved in the repair and maintenance of department's property or equipment;

    e) attending required or authorized training activities;

    f) attending required or authorized meetings related to the provision of fire fighting services; and

    g) participating in parades or similar public events on behalf of the department, when so directed or authorized by an appropriate official.

7. Volunteer members are not considered to be in the course of their employment while involved in activities of a strictly recreational, sporting or social nature (even if the event is officially under the auspices of the department).

8. A worker who is injured in the course of their employment as a volunteer firefighter will be paid benefits based on the greater of: (i) the worker's total actual earnings (from other employers and/or from self-employment); or (ii) the amount of coverage purchased by the municipality. For purposes of this Policy only, earnings can include earnings from employers in industries to which the Act applies and in industries to which the Act does not apply.

9. Those volunteer firefighters who have no other employer will be paid benefits based on the average earnings amount chosen by the municipality.

10. The full cost of the claim will be charged against the experience of the municipality concerned -- that is, for the purposes of this Policy only, the employer (the municipality) will not be relieved of any costs associated with the worker's concurrent employment.

Application

This Policy applies to all decisions made on or after October 30, 2020

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 2(ae)(v), 5, 41(c), 44, 47.

Policy Number: 1.3.5R1

Topic: Criteria for psychiatric conditions: occupational stress
Section: Entitlement
Subsection: General

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Preamble

1. To determine the existence and degree of a worker's permanent impairment due to compensable mental or behavioral (psychiatric) disorders, the Board relies on the American Medical Associations "Guidelines to the Evaluation of Permanent Impairment – Fourth Edition" (the "AMA Guidelines").

2. Section 2 (a) of the *Workers' Compensation Act* states that the definition of accident does not include stress other than that which is an "acute reaction to a traumatic event." The following provide guidelines used by the Board in adjudicating stress claims.

Policy Statement

3. An emotional reaction following an industrial injury is usually nothing more than a "startle reaction", or a short period of anxiety or depression which subsides very quickly.

4. This initial emotional reaction, although minor in most cases can, however, increase depending on several factors. Every worker reacts differently to stressful situations, according to their individual personality. Factors include:

   a) the severity of the injury;

   b) whether or not the accident was of a frightening nature; and

   c) the prior emotional stability of the worker.

5. The reaction to the injury may be aggravated as a result of prolonged medical treatment. Other factors, such as extended disablement and/or severe functional limitations, may also increase the emotional reaction to the point that the worker's ability to carry out the activities of daily life is affected.

6. The emotional reaction is generally a temporary condition and the worker is left with no permanent psychiatric impairment. In considering cases of permanent impairment, for claims purposes, a clear causal relationship must be established between the injury and the emotional reaction (i.e. the injury must be shown to be a significant contributing factor).

Application

This Policy is effective December 16, 2021. This Policy applies to injuries occurring on or after January 1, 2000. This Policy replaces Policy 1.3.5 that was effective January 1, 2000.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) (as amended), Section 2(a).

Policy Number: 1.3.7R

Topic: General Entitlement – Arising out of and in the Course of Employment
Section: Entitlement
Subsection: General

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Preamble

The purpose of this program policy is to: 1) identify the basic requirements that must be met to be eligible to receive compensation benefits and services; and 2) describe the typical questions, general principles and sections of the *Workers' Compensation Act* (the "Act") the *Workers' Compensation Board* (the "WCB") considers in determining if a personal injury by accident "arose out of and in the course of employment".

Definitions

"accident" - as defined in Section 2 (a) of the Act, includes

(i) a wilful and intentional act, not being the act of the worker claiming compensation,

(ii) a chance event occasioned by a physical or natural cause, or

(iii) disablement, including occupational disease, arising out of and in the course of employment,

but does not include stress other than an acute reaction to a traumatic event.

Policy Statement

1. **Real merits and justice of the case**

   Section 186 of the *Act* requires the WCB to base each general entitlement decision on the individual merits and justice of the case. The general principles and questions considered by the WCB, as outlined in this program policy, do not exclusively determine if an accident arose out of and in the course of employment. Rather, they provide the WCB with a framework for gathering and considering evidence to guide general entitlement decision - making.

2. **Basic eligibility requirements**

   To be eligible to receive compensation benefits and services a worker must:

   a) be a worker as defined by Section 2 (ae) of the *Act*;
   b) meet the requirements for filing a claim for compensation in Section 83 of the *Act*;
   c) be caused a personal injury by accident arising out of and in the course of employment as required by Section 10 of the *Act*; and
   d) depending on the facts of the claim, meet any other applicable Sections of the *Act*.

3. **Determining if an accident arose out of and in the course of employment**

The WCB generally considers the following principles and questions in determining if a personal injury by accident arose out of and in the course of employment.

a) Description of "arising out of" employment

The words "arising out of employment" refer to the origin of the cause of the injury. For an accident, and resulting injury, to be considered to have arisen out of employment there must be a causal connection between the worker's employment and the injury they received.

Generally, this means the accident and resulting injury must be caused by some risk related to the employment. The risk may be directly, or incidentally, related to the employment; and the injury may be the result of a single incident, or develop over a period of time. An injury, however, is not necessarily compensable simply because it happened, or symptoms occurred, at the workplace.

b) Description of "in the course of" employment

Generally, an accident, and resulting injury, is considered to have arisen in the course of employment when it occurs under the following circumstances:

i. at a time that is consistent with when the worker typically performs the employment, or at a time when the worker has been asked to perform activities for the employment;

ii. at a place that is consistent with the employment or the employer's premises; and

iii. while performing an activity directly, or incidentally, related to the employment.

The time and place of an accident, however, are not strictly limited to the normal hours of employment or the employer's premises; the forgoing are intended to be general principles.

c) Questions considered - "arising out of and in the course of employment"

In gathering evidence to determine if an accident, and resulting injury, arose out of and in the course of employment the WCB considers a series of questions that may include, but is not limited to, the following:

i. Was the activity part of the job, or a job requirement?

ii. Did the accident occur when the worker was in the process of doing something for the benefit of the employer?

iii. Did the injury occur while the worker was doing something at the instruction of the employer?

iv. Did the injury occur while the worker was using equipment or materials supplied by the employer?

v. Was the injury caused by some activity of the employer or another worker?

vi. Was the worker being paid or receiving some consideration for the activity from the employer at the time of the accident?

vii. Was the worker on the employer's premises at the time of the accident?

viii. Was the worker traveling for employment purposes at the time of the accident?

ix. Did the workers' employment expose them to a greater risk of injury than they would have been exposed to as a member of the general public?

x. Was the injury caused by an exposure in the workplace, or as part of the employment activities?

The WCB then:

i. considers the evidence gathered throughout the claim adjudication process;

ii. weighs the evidence;

iii. applies the statutory presumption in Section 10(4) and the benefit of the doubt provision in Section 187 of the *Act* where circumstances warrant; and

determines whether an accident arose out of and in the course of employment.

4. **Aggravation, activation, acceleration of pre-existing disease or disability and injuries due to other causes**

As stated in Section 10(5) of the *Act*, where the WCB has determined a personal injury by accident has arisen out of and in the course of employment and resulted in a loss of earnings or permanent impairment that was either due:

a) in part to the injury and in part to causes other than the injury; or

b) to an aggravation, activation, or acceleration of a disease or disability existing prior to the injury;

compensation is payable for the proportion of the loss of earnings or permanent impairment that may be reasonably attributable to the injury.

Where Section 10(5) of the *Act* is applicable, the WCB apportions benefits in accordance with *Policy 3.9.11R1 - Apportionment of Benefits*.

5. **Serious and willful misconduct**

Section 10(3) of the *Act* provides that where a personal injury is attributable wholly or primarily to the serious and willful misconduct of the worker, the WCB shall not pay compensation to the worker unless the personal injury:

a) results in death or serious and permanent impairment; or

b) is likely, in the opinion of the Board, to result in serious and permanent impairment.

6. **Presumption**

As required in Section 10(4) of the *Act*, if it is determined that the accident arose out of employment, it is presumed the accident arose in the course of employment, unless there is evidence to the contrary. Alternatively, if it is determined that the accident arose in the course of employment, it is presumed the accident arose out of the employment, unless there is evidence to the contrary.

7. **Benefit of the Doubt**

Section 187 of the *Act* establishes that a worker is not required to provide proof on a civil standard (on a balance of probabilities) in support of a claim for compensation. Rather, a worker must establish, through the provision of evidence, that it is as likely as not that a personal injury arose out of and in the course of employment. Where there is doubt on an issue respecting a worker's claim for compensation, and it is as likely as not that the accident arose out of and in the course of employment, the issue will be resolved in the worker's favour.

Application

This program policy applies to new claims for compensation made on or after October 27, 2016.

References

Workers' Compensation *Act* (Chapter 10, Acts of 1994-95), Sections 2 (a), 2(n), 2(ae), 10, 82, 83, 183, 186, and 187.

Policy Number: 1.3.8

Topic: Recurrence of compensable injury
Section: Entitlement
Subsection: General

Effective: March 15, 2012
Issued: March 22, 2012
Approved by Board of Directors: March 15, 2012

Preamble

The purpose of this program policy is to outline the factors considered by the WCB when determining if the evidence supports a finding that a worker has suffered a recurrence of their compensable injury. Where it is determined a worker has suffered a recurrence of their compensable injury, they may be eligible to receive benefits and services as provided for in the Workers' Compensation Act ("the *Act"*).

Definitions

"maximum medical recovery" means the point at which further medical treatment or intervention will not, in the opinion of the WCB, result in a significant improvement in the worker's medical condition.

"recurrence of compensable injury" is the return of, or increase in, clinically demonstrated disability or symptoms that are caused by the compensable injury after the worker has reached maximum medical recovery; the worker has returned to work; and/or the worker suffers a further injury, condition, or disablement caused by, and considered part of, the compensable injury.

Policy Statement

1. **Overview**

   Generally, in determining whether a worker has suffered a recurrence of the compensable injury, the WCB considers whether there is medical compatibility between the compensable injury and the current return of, or increase in, disability or symptoms.

   Where medical compatibility, by itself, is not a reliable indicator of the causal relationship between the compensable injury and the current return of, or increase in, disability or symptoms, the WCB may consider a combination of medical compatibility and continuity. If medical compatibility has been established, it is not required that continuity be considered.

2. **Medical compatibility**

   To establish medical compatibility, the current return of, or increase in, disability or symptoms must result from the compensable injury. In determining medical compatibility, the WCB compares the worker's current medical diagnosis to the diagnosis of the compensable injury (using, but not limited to, medical opinions, the worker's medical history, information collected about the circumstances of the recurrence claim, and medical/scientific literature). In particular, in gathering and weighing evidence of medical compatibility to determine if a worker has suffered a recurrence of their compensable injury, the WCB considers a series of questions that may include, but is not limited to, the following:

a) has the worker experienced an intervening event or exposure that may have caused the current disability or symptoms?

b) are the parts of the body affected now the same as, or related to, those affected initially?

c) are the body functions affected now the same as, or related to, those affected initially?

d) is the degree to which body functions are affected now similar when compared to the affect of the compensable injury?

e) what was the nature of, and medical prognosis for, the compensable injury?

Where a worker's current return of, or increase in, disability or symptoms arise from a further injury, condition, or disablement, the questions above may not always be appropriate in guiding the determination of medical compatibility. In these instances the WCB may, where circumstances warrant, consider questions other than (or in addition to) those noted above in establishing a causal relationship between the current increase in, or return of, disability or symptoms and the compensable injury.

When determining medical compatibility between the worker's current return of, or increase in, disability or symptoms and the compensable injury the WCB may, where appropriate, consider the relevance and/or impact of non work-related factors.

3. **Continuity**

The continuation of disability or symptoms after the achievement of maximum medical recovery and/or return to work may be an indicator of a causal relationship between the compensable injury and the current increase in disability or symptoms. Evidence of continuity may be used to support a finding that a worker has suffered a recurrence of their compensable injury where medical compatibility, by itself, is not a reliable indicator of the causal relationship between the compensable injury and the current disability or symptoms. If medical compatibility has been established, it is not required that continuity be considered.

In gathering and weighing evidence of continuity, the WCB considers a series of questions that may include, but is not limited to, the following:

a) has the worker had on-going treatment for the compensable injury?

b) has the worker required modified work duties and/or restrictions on some work activities?

c) has the worker demonstrated ongoing symptoms since the compensable injury?

d) has the worker complained to supervisors and co-workers on an on-going basis since the compensable injury?

The above list is not exhaustive, and a worker is not required to have carried out/experienced each of the items listed above for continuity to be established.

Application

This program policy applies to recurrence decisions made on or after March 15, 2012.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 2 (a), 2 (p), 2(ae), 40, 75, 183, 186, and 187.

Policy Number: 1.3.9R

Topic: Psychological Injury
Section: Entitlement
Subsection: General

Effective: October 26, 2018
Issued: February 12, 2019
Approved by Board of Directors: January 31, 2019

Preamble

The purpose of this policy is to establish criteria for the individualized adjudication of psychological injury claims under the *Nova Scotia Workers' Compensation Act*.

Definitions

1. The **"DSM"** is the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, which is a compendium of psychiatric diagnoses produced by the American Psychiatric Association. The manual codes and describes all recognized psychiatric diagnoses and is regarded as the definitive work on the subject. (Source: The Canadian Health Care Glossary).

2. **"Traumatic Event(s)"** is defined as a direct personal experience of an event or directly witnessing an event that is:

    - Sudden;
    - Frightening or shocking;
    - Having a specific time and place; and
    - Involving actual or threatened death or serious injury to oneself or others or threat to one's physical integrity.

3. "front-line or emergency-response worker" means front-line or emergency-response worker as defined in Section 12A(1)(a) of the *Workers' Compensation Act* and Section 41 of the *Workers' Compensation General Regulations*.

4. The "traumatic event(s)" must be assessed using an objective standard, which is a legal standard based on conduct and perceptions external to a particular person. The objective standard used is the reasonable person standard, which is considered an objective standard because it does not require a determination of what the individual was thinking. Rather it is based on a hypothetical person who exercises the degree of attention, knowledge, intelligence, and judgment that society requires of its members for the protection of their own and others' interests. The reasonable person acts sensibly, does things without serious delay, and takes proper but not excessive precautions[2].

[2] Black's Law Dictionary, Ninth Edition, 2009

Examples of Traumatic Events may include, but are not limited to:

- A direct personal experience of an event that involves actual or threatened death or serious injury;
- An actual or threatened violent physical assault;
- Witnessing or experiencing a horrific accident;
- Witnessing or being involved in a hostage taking; and
- Witnessing or being involved in an armed robbery.

Policy Statement

The WCB will consider claims for compensation under the Nova Scotia *Workers' Compensation Act* when the condition results from stress that is a reaction to one or more Traumatic Events and the specified criteria outlined below are satisfied.

More specifically, the WCB will consider claims for compensation in respect of:

> An acute response to one or more Traumatic Event(s) which involves witnessing or experiencing an event(s) that is objectively traumatic. Due to the nature of some occupations, some workers, over a period of time may be exposed to multiple traumatic events. If the worker has an acute reaction to the most recent traumatic event, entitlement may be considered even if the worker may experience these traumatic events as part of the employment and was able to tolerate the past traumatic events. An example is a drugstore pharmacist after multiple robberies.

Criteria for Traumatic Onset Stress

Claims for psychiatric or psychological injuries resulting from Traumatic Events may be compensable if all of the following four criteria are satisfied:

I. There must be one or more Traumatic Event(s) as defined herein;

II. The Traumatic Event(s) must arise out of and in the course of employment;

III. The response to the Traumatic Event(s) has caused the worker to suffer from a mental or physical condition that is described in the DSM; and

IV. The condition is diagnosed in accordance with the DSM and by a health care provider being either a psychiatrist or a clinically trained psychologist registered with the Nova Scotia Board of Examiners in Psychology.

Notwithstanding the criteria listed above, a claim for a psychological injury that is post-traumatic stress disorder (PTSD) by a front-line or emergency response worker will be adjudicated under Section 12A of the *Workers' Compensation Act* and Sections 40 -45 of the *Workers' Compensation General Regulations*.

Non-Compensable Work-related Events

Mental or physical conditions are not compensable when caused by labour relations issues such as a decision to change the worker's working conditions; a decision to discipline the worker; a decision to terminate the worker's employment or routine employment related actions such as interpersonal relationships and conflicts, performance management, and work evaluation.

Application

This policy applies to all decisions made on or after October 26, 2018 pursuant to the *Nova Scotia Workers' Compensation Act*.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 2.

The most current edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*

Subsection 1.4 – Decision Making

- **Policy Number: 1.4.3 - Weighing Conflicting Medical Evidence**

Policy Number: 1.4.3

Topic: Weighing Conflicting Medical Evidence
Section: Entitlement
Subsection: Decision Making

Effective: February 1, 2000
Issued: December 16, 1999
Approved by Board of Directors: December 3, 1999

Definitions

For the purposes of this policy, the following definitions shall apply:

"objective" means perceptible to the senses of another person.

"subjective" means pertaining to or perceived only by the affected individual; not perceptible to the senses of another person.

"treating physician" means any physician who directs, prescribes, or administers medical treatment

Policy Statement

1. The following general principles shall be applied by decision makers in situations where conflicting medical evidence is being considered in the determination of benefits:

    1.1. A statement by a lay witness on a medical question may be considered as evidence if it relates to matters recognizable by a lay person; but not if it relates to matters that can only be determined by a person with expertise in medical science.

    1.2. When addressing conflicting medical evidence, decision makers will not automatically prefer the medical evidence of one category of physicians or practitioners over that of another. Decision makers shall consider the following criteria in deciding what weight to give to such evidence:

        (a) the expertise of the individual providing the opinion

        (b) the application of the expertise of the individual providing the opinion to the medical question being addressed

        (c) the correctness of the facts relied upon by the provider of the opinion

        (d) the timeliness of the opinion

        (e) any issues of credibility within the opinion

        (f) the credibility of the individual providing the opinion

        (g) subjective versus objective medical evidence

        (h) the findings of any relevant scientific studies referenced by a qualified medical practitioner

        (i) the fact that treating physicians may have an advocacy role on behalf of their patients

    1.3. Where the weight to give conflicting medical evidence cannot readily be determined by applying the above criteria, the decision maker may consult with a WCB Medical Advisor to determine:

        (a) whether all appropriate medical evidence has been obtained; and/or

(b) if further investigations (including examination of the worker by a WCB Medical Advisor) are required

1.4. Nothing in this Policy is intended to detract from the benefit of the doubt provisions under Section 187 of the *Workers' Compensation Act*, SNS, 1994-95, c. 10, as amended.

Application

This Policy applies to all decisions made on or after February 1, 2000.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) (as amended), Sections 185, 186 and 187.

Section 2 - Health Care

Overview

Note: This Overview is intended to provide a general guide to Board policies and programs. It does not constitute official Board policy.

The Board covers the cost of most health care services to help in the worker's recovery from the workplace injury. Health care includes physicians' treatment, prescription medicine, orthotic/prosthetic devices, physical rehabilitation, hospitalization and some personal expenses incurred by the worker in obtaining treatment (eg. travel).

Health care coverage is available to injured workers from, and including, the day of their accident.

The policies in this section of the manual detail some of the expenses and services covered, as well as the circumstances in which they are covered.

This section also includes policies relating to the Functional Restoration Program, a pro-active program designed to assist clients in preventing and managing Chronic Pain. This program is offered in conjunction with case management activities to clients identified as potentially benefiting from its services.

Subsection 2.1 – Workers' Expenses

- **Policy Number: 2.1.1R16 - Workers' Travel Expenses for Health Care**
- **Policy Number: 2.1.5R3 - Clothing Allowance**
- **Policy Number: 2.1.6R1 - Attendant Allowance**
- **Policy Number: 2.1.7R1 - Eyeglasses**
- **Policy Number: 2.1.8 - Loss of Personal Items**

Policy Number: 2.1.1R16

Topic: Workers' Travel Expenses for Health Care
Section: Health Care
Subsection: Workers' Expenses

Effective: April 1, 2022
Issued: April 21, 2022
Approved by Board of Directors: April 21, 2022

Policy Statement

1. **General**

   The Board may provide for any injured worker any medical aid the Board considers necessary or expedient as a result of the compensable injury. Expenses related to transportation, meals and accommodation incurred by injured workers during case management, and as a result of the compensable injury, will be considered for coverage. Workers will be advised of this policy when they are approved to begin treatment.

   Meal Allowance

   A meal allowance may be provided to workers who must be away from their home over a meal period. Coverage of meals must be pre-authorized by the WCB case worker. A per diem amount of $43.00 (including gratuities) can be paid, comprised of:

Breakfast	$8.00
Lunch	$15.00
Dinner	$20.00
Total	$43.00

   Future meal allowance rates will be adjusted, on a go-forward basis, following notification from the Director of Human Resources that the rates for Workers' Compensation Board employees have increased; and

   Rates will not be retroactive; and

   Future rates will be effective on the "Effective Date" specified in the revised policy.

2. Commercial Travel (within province)

   When a worker accesses commercial travel within the province, subject to pre-authorization by the case worker, coverage is as follows:

   a) bus or train fare – actual fare, based on receipts
   b) air fare – actual fare, based on receipts

3. Travel in Local Areas:

   Cost of travel in local areas for medical treatment and Board-arranged appointments, will be paid as follows:

   a) actual bus, train fares;
   b) private vehicle - mileage at 57.70 c/km and
   c) taxi fares will be paid if pre-authorized, or circumstances justify, and proper receipts are provided.

Use of Private Vehicle

A client may use their own vehicle for transportation purposes to access services necessitated by the compensable injury, if this use has been pre-authorized by the Board. Authorized vehicle use will be reimbursed at the rate of 57.70 c/km.

Future travel rates will be adjusted, on a go-forward basis, following notification from the Director of Human Resources that the rates for Workers' Compensation Board employees have increased; and

Rates will not be retroactive; and

Future rates will be effective on the "Effective Date" specified in the revised policy.

4. Out-of-Province Travel

   All out-of-province travel must be pre-authorized by the case worker. The most appropriate mode of travel (taking into account the worker's needs, and the need for economical travel) will be approved. Actual costs will be reimbursed based upon receipts. Where possible (e.g. commercial travel, hotel accommodations) costs will be charged directly to the Board.

5. Accommodations – Public and Private

   Workers will be provided with overnight accommodations when the need arises, pre-authorized by the Board. Where possible, costs will be charged directly to the Board, otherwise reimbursements will be based on receipts.

6. Escorts

   Expenses related to escorts may be paid. Each claim must be reviewed on individual merit.

Application

This Policy is effective April 1, 2022 and replaces Policy 2.1.1R15.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 102.

Policy Number: 2.1.5R3

Topic: Clothing Allowance
Section: Health Care
Subsection: Workers' Expenses

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. Provided the conditions to entitlement set out in sections 2 and 5 of this policy are met, a worker is entitled to a clothing allowance in the following circumstances:

   a) as the result of a work related injury:

      (i) the worker has been prescribed by a medical specialist a prosthetic device for an amputation at or above the wrist or at or above the ankle; or

      (ii) the worker has been prescribed by a medical specialist a **back brace**, which is defined as a device which has a rigid frame or is made from rigid material (e.g. thick plastic) for supporting the back but does not include soft belts or corsets lacking a rigid frame or components of rigid materials; or

      (iii) the worker has been prescribed by a medical specialist a major joint brace, which is defined as a device which has a rigid frame or is made from rigid material (e.g. thick plastic, rigid polymers, metal or leather) for supporting a major joint but does not include soft belts or sleeves lacking a rigid frame or components of rigid materials; or

      (iv) The worker uses a wheelchair; and

   b) the use of the prosthetic device, back brace, major joint brace or wheelchair is causing excessive or premature wear to the worker's clothing.

   Note: A 'Schedule of Orthotic and Prosthetic Devices Eligible for Clothing Allowance' is attached.

2.

   (i) Generally, as a condition to entitlement, it must be determined that, in the opinion of the Board, the worker has or is likely to have a permanent medical impairment as a result of a work related injury.

   (ii) However, in some cases, the Board may determine that a worker should be provided with an orthotic or prosthetic device, of the type described in the Schedule to this policy (a "prescribed device") for short term use even though the worker does not and is not likely to have a permanent medical impairment as a result of a work related injury. In such cases, and provided the worker satisfies the other conditions of entitlement set out herein, the worker is entitled to the payment of a clothing allowance, in the annual amount determined in accordance with this policy, on a one-time basis. An application on behalf of a worker by a Medical Specialist for the payment of a clothing allowance in subsequent years will be considered upon the receipt of a completed application form and of medical evidence acceptable to the Board substantiating the need to wear the prescribed device for a period longer than one year as a result of a work related injury.

3. A worker is entitled to a clothing allowance in the amounts as outlined in the following table:

Annual Clothing Allowance by Condition

	Prosthetic Device	Back Brace	Uses a Wheelchair	Major Joint Brace
Upper Body	$350.00	$350.00	NA	$350.00
Lower Body	$400.00	NA	NA	$400.00
Both	$750.00	NA	$750.00	$750.00

NA = Not Applicable

Note: The amounts in the table are additive within columns but not between columns within the same row. If the worker is eligible for more than one benefit, the worker will receive the higher of the benefit amounts to a maximum of $750.00 per year.

4. The annual clothing allowance will be effective on July 1st of every year. Awards made during the year will be prorated on a monthly basis.

5. The application form for the clothing allowance shall be created by the Board and provided to the Medical Specialist.

Application

This Policy applies to all decisions made on or after December 16, 2021. This Policy replaces Policy 2.1.5R2 issued on July 6, 1998. With the exception of subsection 2 (ii), this Policy is effective April 3, 1997 and is applicable to clothing allowances effective July 1, 1997 and thereafter (i.e. the Policy takes effect beginning with the 1997/98 clothing allowance 'benefit year,' which runs from July 1, 1997-June 30, 1998). Subsection 2(ii) applies to all workers for whom the Board approves a prescribed device on or after June 12, 1998 and to all workers who were, on that date, continuing, as the result of a work related injury, to wear a prescribed device which was previously approved by the Board.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 102.

Schedule of Prosthetic and Orthotic Devices Eligible for Clothing Allowance

The following are the prosthetic and orthotic devices that when worn give rise to eligibility for the Clothing Allowance under Policy 2.1.5:

1. Any prosthesis that a client has as result of a compensable injury in accordance with Policy 2.1.5

2. Any wheelchair that a client uses as a result of a compensable injury in accordance with Policy 2.1.5

3. With respect to Back Braces, a Harris type brace (rigid frame) or one of the following braces are considered eligible for the clothing allowance:

    - EIM Lumbar Stabilizer
    - Model P-160: Custom Plastic Body Jacket with Anterior Thoracic Extension (TLSO)
    - Model P-165: Custom Plastic Body Jacket with Anterior Thoracic Extension and Cervical Orthosis (CTLSO)
    - Model P-150: Custom Plastic Body Jacket (LSO or TLSO)
    - Model L-25: Hyperextension TLSO with Swivel Sternal Pad
    - Model 107: Norton Brown LSO
    - Model B-52: TLSO
    - Model L-30: Hyperextension TLSO with Deltopectoral Pads and Pelvic Bar
    - Model L-31: Adjustable Flexion Orthosis (LSO)

    or similar type brace that is custom made, or any other back brace that the Workers Compensation Board deems appropriate for the purpose of Policy 2.1.5.

4. With respect to knee braces, braces that are custom made or one of the following knee braces are considered eligible for a clothing allowance (manufacturer's name is in parentheses) :

    - Ottawa Knee Stabilizing Orthosis
    - Double Graphite Knee Orthosis (Karl Hager Limb & Brace Ltd.)
    - MVP Knee Brace (Innovation Sports)
    - Orthotec Controller (Orthotec)
    - C.Ti.2 Custom Functional Brace (Innovation Sports)
    - Donjoy ACL Brace (Donjoy)
    - Donjoy PCL Brace (Donjoy)
    - Donjoy Gold Point (Donjoy)
    - Poli Axial G II (Generation Orthotics)
    - Lennox Hill Brace (Lennox Hill Inc.)
    - Townsend Knee Brace (Townsend)
    - Talon Knee Brace (Sutter Corp.)

    or permanent leg brace, or any other knee brace that the Workers Compensation Board deems appropriate for the purpose of Policy 2.1.5.

5. Any other prosthetic, orthotic or assistive device, not in this schedule, that the Workers Compensation Board deems appropriate for the purpose of Policy 2.1.5.

Definitions

Back Brace - A device which has a rigid frame or is made from rigid material, e.g. thick plastic, for supporting the back.

Prosthetic Device - An artificial device designed to replace a missing part of the body.

Orthotic Device - An artificial device applied externally to modify structural and functional characteristics of the body.

Major Joint Brace - A major joint brace is defined as a device which has a rigid frame or, is made from rigid material, e.g. thick plastic, rigid polymers, metal or leather for supporting a major joint. Note: this does not include soft belts or sleeves lacking a rigid frame or components of rigid materials.

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Policy Number: 2.1.6R1

Topic: Attendant Allowance
Section: Health Care
Subsection: Workers' Expenses

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

This allowance is usually paid where a worker suffers 100% Permanent Medical Impairment, but in some instances may be payable in other cases where a worker is, either temporarily or permanently, unable to perform necessary personal care as a result of a work injury.

Guidelines

1. The allowance is approved and paid after direct consultation with Board staff. In certain claims, special medical reports may be required.

2. In general, the allowance is based upon the severity of the compensable medical impairment of the worker. Basically, the allowance is to assist claimants regarding mobility, self-care and any "in house" treatment that is required for the compensable condition.

3. The allowance may be paid directly to the injured worker, to the worker's spouse or to another attendant.

Application

This Policy applies to all decisions made on or after December 16, 2021 and replaces Policy 2.1.6R that was effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 103.

Policy Number: 2.1.7R1

Topic: Eyeglasses
Section: Health Care
Subsection: Workers' Expenses

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. Eyeglasses damaged as the result of an accident arising from a worker's employment will be repaired or replaced. Generally, the eyeglasses must have been worn at the time of the accident. The Board will not pay for glasses that are lost, broken, or damaged as a result of the actions of the worker.

2. Eyeglasses will be repaired/replaced when glasses are being worn and the damage results from an accident arising out of and in the course of employment.

3. Eyeglasses may be repaired/replaced when:

    a) damage results from excessive pitting from the use of electrical welding and/or sanding machines;

    b) damage results from putting on or taking off necessary safety equipment (i.e. goggles, helmets, etc.); or

    c) damage results from a hazard of employment (i.e., brushing away an insect, or other reflexive, protective movement).

4. Eyeglasses will not usually be repaired/replaced when damaged/broken when:

    a) damage results from the eyeglasses falling from the worker's pocket or damage while in the worker's pocket due to an action by the worker;

    b) damage results from the eyeglasses being dropped during routine cleaning, etc.;

    c) damage results from the eyeglasses falling from a worker's face without any accident (i.e., improperly fitted glasses, excessive sweating).

5. Repair and replacement will be limited to the part(s) damaged in the work-related accident (i.e., if frames are damaged, frames will be repaired/replaced; if one lens is damaged, one lens will be replaced, etc).

6. The repair/replacement must be done within three months of the date the worker is notified that the repair/replacement must be carried out within a three-month period.

7. A maximum of $150.00 will be allowed for frames.

Application

This Policy applies to all decisions made on or after October 27, 2016. It replaces Policy 2.1.7R issued on October 21, 1997 and effective October 2, 1997.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 102.

Policy Number: 2.1.8

Topic: Loss of Personal Items
Section: Health Care
Subsection: Workers' Expenses

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

The Board does not accept responsibility for clothing, footwear or jewellery lost or damaged in an industrial accident.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 104.

Subsection 2.2 – Services/Treatments

- **Policy Number: 2.2.1R - Spinal Fusion – Second Opinion**
- **Policy Number: 2.2.3R - Home Breathing Machines**
- **Policy Number: 2.2.4 - Chemonucleolysis**
- **Policy Number: 2.2.5 - Treatment: Pain Clinic**
- **Policy Number: 2.2.6R - Home Oxygen Therapy**
- **Policy Number: 2.2.7R - Portable Home Oxygen Therapy**
- **Policy Number: 2.2.8R - Epidural Analgesia and Paravertebral Blocks**

Policy Number: 2.2.1R

Topic: Spinal Fusion – Second Opinion
Section: Health Care
Subsection: Services/Treatments

Effective: March 6, 1997
Issued: April 30, 1997
Approved by Board of Directors: March 6, 1997

Policy Statement

1. The Board will accept responsibility for spinal fusions and repeat spinal operations when the following criteria have been met.

    1.1. **Spinal Fusions**

    The Board requires a second opinion of its choice in all cases in which a spinal fusion is to be done for conditions other than a spondylolisthesis. No second opinion is necessary regarding spondylolisthesis as long as this is a first spinal operation.

    1.2. **Repeat Spinal Surgery**

    The Board requires a second opinion of its choice in all cases in which repeat spinal surgery for any condition is being considered.

2. If the first and second opinion are not in agreement, a third opinion by a physician mutually acceptable to the worker's physician and the Board will be sought. In making a final decision on funding the surgery, all medical evidence including the second opinion must be weighed.

Application

This Policy applies to all decisions made on or after March 6, 1997

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 102, 104.

Policy Number: 2.2.3R

Topic: Home Breathing Machines
Section: Health Care
Subsection: Services/Treatments

Effective: February 11, 2010
Issued: February 25, 2010
Approved by Board of Directors: February 11, 2010

Policy Statement

1. The Board accepts responsibility for purchasing home breathing machines for clients with occupational lung diseases and under Section 35 of the Act, when the following criteria are met.

    1.1. These machines will only be accepted by the Board if they are recommended by a recognized Respirologist.

    1.2. These machines will only be purchased for the treatment of obstructive lung disease and not for restrictive lung disease or for a diffusion defect.

    1.3. In cases where the obstructive lung disease is only partly compensable, it will have to be ascertained if a significant degree of the airway obstruction is occupational before the Board will accept responsibility (this will be ascertained after a full review of all facts, etc.)

    1.4. These machines will be supplied on a loan basis only and will be returned to the Board when their use is completed.

    1.5. This is to be authorized by the Health & Extended Benefits Department.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 102. Policy 2.2.6, 2.2.7

Policy Number: 2.2.4

Topic: Chemonucleolysis
Section: Health Care
Subsection: Services/Treatments

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. Chemonucleolysis will be accepted by the Board when the following criteria are met.

    1.1. The treatment must be carried out in a hospital setting by a specialist qualified in this particular procedure, Neurosurgeon or Orthopaedic Surgeon.

    1.2. The patient has been given a minimum of three weeks consecutive treatment prior without improvement. This may be in the form of bed rest, medication, back bracing, physiotherapy, etc.

    1.3. There is clinical evidence of nerve root irritation or deficit which preferably is supported by a positive myelogram, C.T. scan or epidural venogram.

2. The Board accepts no responsibility for this treatment if there is

    2.1. A history of previous spinal surgery.

    2.2. The presence of spinal stenosis, myelographic block, cauda equina compression, severe spondylolisthesis, or acute paralysis.

    2.3. Myelographic evidence of only bulging discs associated with only back pain and no nerve root deficit.

3. The Board expects that all patients who satisfy the criteria for this treatment will be adequately educated regarding not only its potential benefits but its possible side effects.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 102.

Policy Number: 2.2.5

Topic: Treatment: Pain Clinic
Section: Health Care
Subsection: Services/Treatments

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. Treatment at the Victoria General Hospital Pain Clinic will be accepted under the following criteria.

    1.1. Treatment at the Pain Clinic will not be accepted without prior authorization from this Board.

    1.2. The initial period of treatment will consist of four visits and one re-assessment, which is to be completed within three months. This will not include the initial assessment (maximum of two sessions).

    1.3. An additional two-month period may be granted upon request from the Pain Clinic to the Board's Medical Department, in which there should be evidence and information to indicate that such further treatment will be of significant and lasting benefit to the client.

    1.4. Requests for repeat referrals to the Pain Clinic will be handled in the same way as the initial referral after a minimum period of three months has elapsed.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 102.

Policy Number: 2.2.6R

Topic: Home Oxygen Therapy
Section: Health Care
Subsection: Services/Treatments

Effective: February 11, 2010
Issued: February 25, 2010
Approved by Board of Directors: February 11, 2010

Policy Statement

1. Home oxygen therapy will be provided for clients with occupational lung diseases and under Section 35 of the Act, when the following criteria are met.

    1.1. This treatment must be recommended by a qualified chest specialist.

    1.2. The medical criteria for such use are properly documented.

    1.3. This is to be authorized by the Health & Extended Benefits Department.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 102. Policy 2.2.3, 2.2.7

Policy Number: 2.2.7R

Topic: Portable Home Oxygen Therapy
Section: Health Care
Subsection: Services/Treatments

Effective: February 11, 2010
Issued: February 25, 2010
Approved by Board of Directors: February 11, 2010

Policy Statement

1. Portable home oxygen therapy will be provided for clients with occupational lung diseases and under Section 35 of the Act, when the following criteria are met.

    1.1. The need for this treatment is directly related to the client's compensable condition.

    1.2. The treatment is recommended by a qualified chest specialist.

    1.3. Individuals being considered for such treatment must be considered to be reasonably active and that with the use of this particular type of oxygen therapy they are able to get out of the house and engage in a moderate amount of outside activity.

    1.4. This is to be authorized by the Health & Extended Benefits Department.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 102. Policy 2.2.3, 2.2.6

Policy Number: 2.2.8R

Topic: Epidural Analgesia and Paravertebral Blocks
Section: Health Care
Subsection: Services/Treatments

Effective: April 3, 1997
Issued: May 2, 1997
Approved by Board of Directors: April 3, 1997

Policy Statement

1. The Board accepts responsibility for epidural analgesia and paravertebral blocks for low back pain as per the following criteria.

    1.1. Referrals may be made by an Orthopaedic Surgeon, Neurosurgeon, Neurologist or Physiatrist.

    1.2. Qualified Anaesthetists are usually the persons to whom these problems are referred for the procedure. Practitioners in the referring specialties mentioned above may carry out the procedures if they have an interest in them.

    1.3. These procedures may be either diagnostic or therapeutic with the intention of breaking self-perpetuating cycles of chronic pain.

    1.4. Proper consultations and reports are required for payment of the appropriate fee.

    1.5. No more than three consecutive treatments are accepted unless there is a written request which receives the authorization of the Board.

    1.6. These procedures may be carried out in the overall management at a Pain Clinic and in these circumstances the need for referral from an appropriate specialist does not apply.

Application

This Policy applies to all decisions made on or after April 3, 1997. It replaces Policy 2.2.8 issued on December 1, 1995 and effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 102.

Subsection 2.3 - General

- **Policy Number: 2.3.1R - Provision of Health Care Services**
- **Policy Number: 2.3.2 - Hospital Admissions: Semi-Private**
- **Policy Number: 2.3.3 - Double Doctoring – Prescriptions**
- **Policy Number: 2.3.4R - Prescription Drugs**
- **Policy Number: 2.3.5 - Medical Aid – General Principles**

Policy Number: 2.3.1R

Topic: Provision of Health Care Services
Section: Health Care
Subsection: General

Effective: June 1st, 2004
Issued: May 14, 2005
Approved by Board of Directors: May 13th, 2004

Policy Statement

1. The WCB will assist in providing health care (services and treatments) by WCB-approved service providers to injured workers. Assistance is provided where the health care is:

   (a) appropriate for the type of compensable injury, and

   (b) consistent with standards of health care practices in Canada.

2. The WCB uses the following information to determine the most appropriate, effective and efficient health care for its clients:

   a) recommendations from WCB-approved health care providers;

   b) up-to-date scientific evidence about effective health care;

   c) evidence-based guidelines developed by professional health organizations across Canada and the United States; and

   d) standards developed by the WCB to ensure quality health care.

3. The WCB may obtain additional information and opinions, as needed, to determine the appropriateness of any type of health care.

4. The WCB will not pay for health care that is not considered appropriate as set out in this policy.

Application

This Policy applies to all decisions made on or after June 1st, 2004.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 102, 104.

Policy Number: 2.3.2

Topic: Hospital Admissions: Semi-Private
Section: Health Care
Subsection: General

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. When a worker is to be admitted to hospital for treatment, investigation, etc., and is placed on a waiting list, semi-private accommodation will be authorized if this will result in earlier admission.

Application

This Policy applies to all decisions made on or after February 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 102.

Policy Number: 2.3.3

Topic: Double Doctoring – Prescriptions
Section: Health Care
Subsection: General

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. The Board defines "double doctoring" as a situation where a worker seeks or obtains a prescription for a controlled drug or narcotic from more than one doctor to treat the same condition for the same period of time.

2. In case of double doctoring, the Board will not reimburse the cost of the duplicate prescription.

3. When double doctoring is encountered or suspected, the following course is to be taken.

    3.1. The worker shall be advised that reimbursement for any prescription for a controlled drug or narcotic beyond the accepted recommended dosage will not be made.

    3.2. The doctors concerned shall be contacted and advised of this situation. The physicians shall not be identified to each other.

    3.3. If the situation does not resolve after contacting the physicians concerned, the matter should be reported to the municipal police or the RCMP.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 102.

Policy Number: 2.3.4R

Topic: Prescription Drugs
Section: Health Care
Subsection: General

Effective: June 1st, 2004
Issued: May 14, 2004
Approved by Board of Directors: May 13th, 2004

Policy Statement

1. The WCB will use a formulary (i.e. a list of prescription drugs recommended in the treatment of specific injuries) whenever possible to determine:

   (a) which prescription drugs are appropriate for the type of compensable injury;
   (b) the quantity of the prescription drug;
   (c) whether the WCB will pay for the prescription drugs.

2. In the cases where prescription drugs are not listed in the formulary, or if an alternative prescription drug is determined to be more appropriate:

   (a) the WCB will decide what is appropriate;
   (b) approval must be obtained from a WCB case worker on the advice of a medical advisor; and
   (c) decisions will be provided in writing to the injured worker and treating physician.

3. Prescription drugs must be prescribed by a physician, dentist or recognized health care provider who is authorized to do so under provincial legislation.

4. Medications that normally do not require a prescription, known as over-the-counter medication, will be covered if:

   (a) they are appropriate for the type of compensable injury; and
   (b) the health care provider writes a prescription.

5. Medications must be obtained from a provincially licensed pharmacy.

6. If a brand-name medication can be replaced with a generic medication, the WCB will pay the cost of the generic medication unless:

   (a) it can be medically demonstrated that the brand-name medication is required; or
   (b) the brand-name medication is available at a lower price.

   Generic medication substitutes must be listed in the Nova Scotia Formulary issued by the Department of Health (www.gov.ns.ca/health/pharmacare/benefits_faq.htm#formulary).

7. This policy does not apply to other health care (services and treatment) covered by the WCB.

Application

This Policy applies to all decisions made on or after June 1st, 2004.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 102 and 104.

Policy Number: 2.3.5

Topic: Medical Aid – General Principles
Section: Health Care
Subsection: General

Effective: February 25, 2011
Issued: March 7, 2011
Approved by Board of Directors: February 25, 2011

Preamble

The purpose of this program policy is to describe the general principles the *Workers' Compensation Board* (the "WCB") considers in the delivery of medical aid to injured workers who have been caused a personal injury as the result of a workplace accident.

Definitions

"**medical aid**", as defined in Section 2(r) of the *Workers' Compensation Act* (the "Act"), includes

(i) any health care service, product or device that may be authorized by the Board and is provided to a worker as a result of a compensable injury, including those forms and reports required by the Board respecting the aid or services, and

(ii) reasonable expenses, authorized by the Board, incurred by a worker in order to obtain medical aid.

Policy Statement

1. **General**

   In accordance with Section 102 of the *Act*, the WCB may provide any medical aid the WCB considers necessary or expedient as a result of the compensable injury. In making this determination, the WCB considers *Policy 2.3.1R – Provision of Health Care Services* and other medical aid policies which are applicable in specific circumstances.

   In providing medical aid, the WCB is responsible to determine the necessity, character and sufficiency of medical aid, as per Section 104 of the *Act*. This means the WCB determines the need for medical aid; the type of medical aid; and the extent to which medical aid is required.

2. **General principles in the delivery of medical aid**

   In the provision of medical aid, the WCB generally considers, but is not limited to, the following principles.

   (a) The WCB uses only WCB-approved health care service providers to deliver medical aid services, as described below.

   The WCB is committed to ensuring that injured workers receive appropriate standards of care from health care service providers. Accordingly, the WCB authorizes payments to only WCB-approved health care service providers. WCB-approved health care service providers include those that the WCB recognizes as licensed or accredited to deliver health care services in Nova Scotia through

provincial or national licensing agencies. If provincial or national licensing agencies do not exist for a particular service provider class, the WCB may approve the use of those service providers to deliver medical aid services to injured workers.

(b) The WCB promotes timely access to medical aid services, as described below.

Prompt access to appropriate treatment and services is important to aid the recovery of injured workers and to reduce the effects of the compensable injury. Where appropriate, the WCB may arrange for an injured worker to receive treatment or services in an alternate location if local sources of services are unavailable, or delayed.

(c) The WCB requires injured workers to co-operate in any medical aid service that promotes the worker's recovery, as described below.

This principle reflects Section 84 of the *Act*, which states that the worker has a duty to co-operate in any medical aid or treatment that promotes the worker's recovery and provides the authority for the WCB to suspend, reduce or terminate compensation where the worker fails to co-operate.

Also implicit under this principle is the requirement for a worker to submit to a medical examination if requested to do so by the worker's employer, the WCB or the Appeals Tribunal, as per Section 85 of the *Act*. If the worker objects to a request, the WCB may determine if the request is reasonable.

(d) The WCB requires employers to provide, at their own expense, immediate and appropriate transportation to a hospital or physician to any worker in their employment, who is in need of it as the result of a workplace injury, as described below.

This principle reflects Section 107 of the *Act*, which states that, following a workplace injury, every employer must provide a worker, who is in need of it, with immediate and appropriate transportation to a hospital or a physician located within the area or within a reasonable distance of the place of injury, at the employer's expense.

(e) Best efforts will be made by the WCB to support injured workers in their initial choice of WCB-approved health care service provider, as described below.

Once the WCB has approved a particular type of medical aid service or treatment, best efforts will be made to support the injured worker's choice of health care service provider to deliver that service or treatment, from among those that are WCB-approved and qualified to deliver the medical aid. The WCB may limit the number of visits to health care service providers to what is appropriate for the injured worker's compensable condition.

When authorizing appointments with WCB-approved health care service providers, the WCB considers the condition of the injured worker, waiting times, and distance to be traveled for the appointment or treatment.

(f) The WCB establishes the fees it pays for medical aid related services through negotiation with individual WCB-approved health care service **providers or WCB-approved health care service provider groups or by adoption of health care service provider fee schedules, as appropriate.**

(g) The WCB ensures the appropriate medical aid in the form of a product or device is provided in a cost-effective manner, as described below.

While the WCB's foremost responsibility is to ensure the quality care and rehabilitation of injured workers, the WCB also has a responsibility to mitigate costs to the workers' compensation system where appropriate. Where there is a choice in the type of medical aid product or device that will satisfy a worker's needs, best efforts will be made to ensure that the product or device that satisfies the worker's needs is chosen in the most cost-effective manner.

Application

This program policy applies to all decisions made on or after February 25, 2011.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 2 (r), 102, and 104.

Subsection 2.4

- **Policy Number: 2.4.7R1 - Normal Recovery Times**

Policy Number: 2.4.7R1

Topic: Normal Recovery Times
Section: Health Care
Subsection: General

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Definitions

"**Normal recovery time**" means an estimate determined by the Board of the normal time required for workers with a specific type of personal injury to return to work after the injury.

Policy Statement

1. Estimates of "normal recovery times" may be made by the Board based on the expected length of disability for the injured worker's type of injury as set out in *The Medical Disability Advisor: Workplace Guidelines for Disability Duration*, Presley Reed, M.D., LRP Publications, Horsham, Pennsylvania (as amended from time to time), unless that publication does not address the specific type of injury in question.

2. If the *Medical Disability Advisor* does not address the specific type of injury in question, or if other pathophysiological factors significantly impact the duration of the disability, the Board's estimate of "normal recovery time" for that type of injury will be made by a Board Medical Adviser, based on any other current relevant published sources and the Medical Adviser's professional opinion.

3. Determination of the duration of disability in accordance with the *Medical Disability Advisor also* requires an assessment of the injured worker's job classification and assignment into one of the following categories: sedentary work, light work, medium work, heavy work, or very heavy work.

The Board will apply the definitions used in the introduction to *The Medical Disability Advisor: Workplace Guidelines for Disability Duration*, Presley Reed, M.D. LRP Publications, Horsham, Pennsylvania (as amended from time to time).

Application

This Policy replaces Policy 2.4.7R issued September 13, 2004 and effective September 10, 2004.

This Policy applies to all decisions made on or after October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Policy 3.3.5R

Section 3 - Short-Term and Long-Term Benefits

Overview

Note: This Overview is intended to provide a general guide to Board policies and programs. It does not constitute official Board policy.

Generally, workers of a registered firm are eligible for financial compensation if they:

1. are injured or become ill due to an accident "arising out of and in the course of employment; and
2. suffer a loss of earnings as a result of the injury.

Workers' compensation benefits are based on an earnings replacement system, meaning that an injured worker is paid a percentage of lost earnings for their time off work due to a compensable injury. Depending on the severity of the worker's injury, the WCB may offer short-term or long-term financial benefits payable to the worker, plus medical aid and vocational rehabilitation required to treat and rehabilitate the worker.

Earnings Profiles

The WCB uses normal weekly earnings to determine an *initial earnings profile*, which is used for the first 26 weeks of workers' compensation benefits. In cases where a worker is injured longer than 26 weeks, the WCB collects more detailed earnings information to set a *long-term earnings profile*. Depending on the category of the worker's employment (ie. seasonal, long-term/permanent, etc.), the WCB can utilize up to three years of earnings to determine a long-term earnings profile.

Maximum Insurable/Assessable Earnings

The Workers' Compensation Board has a maximum insurable/assessable earnings based on a percentage of the average industrial wage for the Province of Nova Scotia. The maximum insurable/assessable earnings for 2003 is $41,800.

Waiting Period

In order to be eligible for temporary earnings-replacement benefits, an injured worker must undergo a *waiting period* or deductible. As a result, 2/5ths of the injured worker's net weekly compensation rate will be deducted from their first compensation cheque. If an injury results in a loss of earnings for more than five calendar weeks, the deducted amount will be reimbursed.

Short-term Benefits (TERB)

If an employee suffers a compensable injury at work, and experiences an earnings loss for more than a period equivalent to 2/5ths of their net weekly compensable benefit, the employee is entitled to temporary benefits. *Temporary Earnings Replacement Benefits (TERB)* are based on 75% of the worker's net earnings prior to the

loss of earnings due to the accident (up to the maximum insurable earnings). After 26 weeks, the Temporary Earnings Replacement Benefit increases to 85% of the worker's net earnings loss. These benefits are paid every two weeks for as long as a worker is medically unable to return to work.

Long-term Benefits (EERB, PIB)

The *Workers' Compensation Act* (the "Act") provides for a dual compensation system which recognizes that, an injured worker may suffer both a permanent injury and, therefore, a loss of physical ability, as well as a loss of earnings ability. If a worker suffers a permanent injury due to a work-related injury or occupational disease, the worker is entitled to a *permanent medical impairment (PMI)* assessment. This assessment is used to determine the injured worker's *Permanent Impairment Benefit, (PIB)*. The Permanent Impairment Benefit is a life-long award made to injured workers to compensate them for their physical loss due to accident. The PIB is usually paid as a lump sum, but may be paid periodically.

An *Extended Earnings Replacement Benefit* (or *EERB*) compensates a worker for a percentage of the long-term loss of earnings due to their injury. The WCB determines the difference between an injured worker's pre-accident earnings and post-accident earnings (actual and estimated) to arrive at their compensable earnings loss. This benefit is only payable to injured workers whose compensated loss of earnings is greater than the amount of their Permanent Impairment Benefit. The worker is then compensated for a percentage of this difference -- generally 85%. This benefit is paid to workers until they are 65 years old, at which time it is replaced by an annuity. The level of an EERB is reviewed 36 months after it is established, and may also be reviewed at 60 months.

Apportionment of Benefits

Under the Act, benefits are payable only for the proportion of a worker's permanent impairment or loss of earnings which can reasonably be attributed to a work-related injury. If some proportion of the worker's permanent impairment or long-term loss of earnings has resulted from a cause other than the work-related injury or a disease or disability which existed prior to the work-related injury, the level of *Permanent Impairment Benefits* and *Extended Earnings Replacement Benefits* may be reduced.

Annuity

An amount equivalent to five percent (5%) of total *Extended Earnings Replacement Benefits* and *Permanent Impairment Benefits* are set aside to provide an *annuity*. The annuity is meant to compensate for the loss of retirement income, and is calculated from the date the worker started receiving long-term benefits until the worker reaches age 65. Once the worker reaches age 65, this Annuity may be paid either as a monthly benefit or as a lump sum, depending on the amount payable.

Supplementary Benefits

The Supplementary Benefits Program provides additional benefits to workers with permanent disabilities who were injured prior to March 23, 1990. To be eligible for supplementary benefits an injured worker must:

a) have had a work-related injury before March 23, 1990;

b) be under the age of 65;

c) be receiving, or eligible to receive, a CPP/QPP disability pension for the work-related injury;

d) have a total personal annual income below one-half the average industrial wage for Nova Scotia as prescribed by regulation; and

e) be receiving periodic compensation.

The amount of a Supplementary Benefit is the amount necessary to increase an applicant's individual annual personal income to an amount equal to one-half of the average industrial wage for Nova Scotia.

Combining Worker's Compensation Benefits

Under the *Workers Compensation Act*, a ceiling is placed on the level of earnings an injured worker can receive while on compensation. This level is generally equal to 85 percent of the net maximum assessable earnings in place the year the injury occurred. If, due to previous claims that an individual may have with the Board, their total WCB benefits exceeds this ceiling, their most recent benefit award would be reduced by the excess amount.

Policies with respect to earnings replacement benefits (short- and long-term), permanent impairment benefits, apportionment of benefits and annuities, as well as former Act pensions and Supplementary Benefits, follow.

Subsection 3.1 – Earnings Profiles

- **Policy Number: 3.1.1R4 - Calculation of Gross Earnings**
- **Policy Number: 3.1.2R1 - Calculation of Net Earnings**

Policy Number: 3.1.1R4

Topic: Calculation of Gross Earnings
Section: Short-Term and Long-Term Benefits
Subsection: Earnings Profiles

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

Initial Earnings Profile

1. Where a worker's loss of earnings results from an injury, the 'pre-LOE' average weekly gross earnings will initially be calculated based on the normal weekly earnings.

2. Normal weekly earnings means the worker's normal rate of pay prior to the injury, as calculated over the worker's normal pay period. This initial earnings profile will be used during the first 26 weeks the worker receives a Temporary Earnings Replacement Benefit (TERB).

3. Normal weekly earnings includes the worker's regular salary or wages, less earnings-related expenses. Regular Salary or wages includes, but is not limited to, the following:

   i) regular overtime,

   ii) commissions,

   iii) bonuses,

   iv) vacation pay,

   v) a profit sharing arrangement with the worker's employer,

   vi) tips and gratuities, and

   vii) taxable benefits, if reportable on a worker's T4 slip.

   Note: Taxable benefits are included in the worker's earnings profile only for injuries occurring on or after January 1, 2000.

4. For greater certainty, the types of income listed in clause #3 will be included in the initial earnings profile if they form part of the worker's regular pay.

Long Term Earnings Profile

5. Effective week 27 of the claim (i.e. after the worker has received TERB for 26 weeks), a **long-term earnings profile** will be set, which will usually be used for the purposes of any further TERB payable, plus EERB (Extended Earnings-Replacement Benefit) where applicable.

6. For purposes of establishing the long-term earnings profile, and for all workers, the average weekly gross earnings will be calculated based on the worker's actual pre-accident earnings. The worker's pre-accident earnings will include all regular salary or wages, as listed in clause #3, plus federal employment insurance benefits and overtime which is not regular salary or wages.

   Note: If the worker received EI maternity or parental benefits during the pre-LOE earnings period used, those benefits and the time period during which they were paid will be excluded from the calculation.

7. The Board will calculate the long-term earnings profile over a period up to three years immediately preceding the worker's loss of earnings. The Board may choose any period that, in the opinion of the Board, allows it to best represent the actual loss of earnings suffered by the worker as a result of the injury.

8. The long-term profile will also be used for establishing a worker's pre-LOE earnings for purposes of Permanent Impairment Benefits (PIB) [1] and Survivor Benefits. Also, if a worker is awarded an EERB prior to week 26 of the claim, the long-term earnings profile will be used.

9. **Workers Under 30 Years of Age** (Section 46)

   For purposes of the long-term earnings profile, where the Board determines that the pre-LOE average earnings at the time of the accident do not represent the worker's probable earnings because of the worker's age, the probable increase in earnings may be included in the long term profile. This only applies to workers who have not reached the age of 30 by the time of the accident.

10. If the Board has not received sufficient earnings information to establish a long-term earnings profile within 26 weeks, the earnings used to determine the initial profile may be reduced. An adjustment for any difference between this amount and the long-term earnings profile will be made when the earnings information has arrived. The adjustment will be retroactive to the end of the initial 26 week period.

Learner (Section 45)

11. For a learner [i.e. "an apprentice, or any person who, although not under a contract of service, becomes subject to hazards...as a preliminary to employment" - s. 2(q)]:

    For purposes of establishing the long-term earnings profile (which is set after 26 weeks), the Board will generally deem the learner's earnings at the level they would have achieved within the next 12 months.

    For purposes of calculating the EERB, the Board will generally deem the learner's earnings at the level of the probable annual earnings of the learner in the learner's home area had they become qualified in their trade or occupation.

Concurrent Employment: (Section 44)

12. For purposes of both the initial and long-term earnings profile, when a worker is employed by more than one employer, the pre-LOE average earnings will be computed based on what the worker was earning from all employers. The word 'employers' is defined as per Section 2(a) of the Act - i.e. employers covered by the *Act*.

Self-Employed Workers with 'Special Protection' Personal Coverage (s.4(7))

13. For purposes of both the initial and long-term earnings profile, pre-LOE average earnings for a self-employed worker with Special Protection will be based on normal weekly earnings, except where personal coverage is less than the worker's normal weekly earnings. In these cases, the Earnings Replacement Benefit will be based on the amount of Special Protection in place at the time of the injury. This will be achieved via Section 4(7) by the Board setting appropriate terms of admission for self-employed workers.

Determination of contractor's earnings

14. To determine the contractor's gross average earnings the WCB will calculate the labour portion of the contract. The labour component is determined by subtracting a proxy amount for materials and equipment from the gross amount of the contract.

15. The following percentages are to be used to calculate the labour portion of a contractor's earnings:

    i) Labour and Materials: 50%

    ii) Logging (Chain Saw): 75%

    iii) Courier Service: 50%

    iv) Trucking and Leased Equipment: 25%

    v) all others: 100%

    Note: The WCB may use a percentage based upon actual labor expenses if actual figures are submitted by the worker.

Recurrences and Reopenings (Section 40(2))

16. Where there is a recurrence of a loss of earnings from an injury more than 12 months after the end of the original loss of earnings from that injury, the worker's average earnings for purposes of the recurrence shall be based on the worker's average earnings before the original loss of earnings, or the worker's average earnings before the recurrence of the loss of earnings, whichever appears to the Board to best represent the worker's actual loss of earnings from the injury.

Loss of Earnings More Than 12 Months After Injury (Section 40(3))

17. Where a worker's loss of earnings from an injury begins more than 12 months after the injury, the worker's average earnings shall be based on the average earnings before the injury, or the average earnings before the loss of earnings, whichever represents the worker's actual loss of earnings from the injury.

Maximum Insurable Earnings (Section 41)

18. A worker's average earnings may not exceed the maximum insurable earnings in place at the time of the injury/initial loss of earnings/recurrence of loss of earnings (whichever is applicable).

[1] Where a worker suffers an injury and is awarded a PIB but never had any earnings loss related to the injury (e.g. this may arise in some occupational disease cases, such as hearing-loss), the key date for rate-setting purposes is the date of injury, not the date when the loss of earnings commenced. In occupational disease cases where there is no earnings loss, the date of injury is the date on which the Board determines the worker has a permanent impairment caused by the occupational disease (per Section 12(2) of the Act).

Application

This Policy applies to all decisions made on or after October 27, 2016. It replaces Policy 3.1.1R3 issued on January 8, 2015 and effective December 18, 2014.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) (as amended), Sections 37-48.

Workers' Compensation General Regulations, Section 20.

Policy Number: 3.1.2R1

Topic: Calculation of *Net* Earnings
Section: Short-Term and Long-Term Benefits
Subsection: Earnings Profiles

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. Net average earnings will be calculated by deducting the following from the worker's gross earnings (as calculated in accordance with Policy 3.1.1R4):

   i) the probable income tax payable by the worker;

   ii) the probable Canada Pension Plan (CPP) premiums or Quebec Pension Plan (QPP) premiums payable by the worker; and

   iii) the probable Employment Insurance (EI) premiums payable by the worker.

   Any changes in income tax rates or rates of CPP/QPP or EI premiums which come into effect during a given calendar year will be taken into account by the Board effective January 1 of the following calendar year for the purpose of calculating net average earnings.

2. The probable income tax payable by the worker is calculated by using the worker's Personal Tax Credits Return (TD 1 code). The TD 1 code that will be used will be the one provided by the employer.

3. When such information cannot be obtained for whatever reason, the Board will use the TD 1 code for a worker with no dependants (Code 1).

4. If the Board believes that the code supplied by the employer is not accurate, the Board may assign a different code to the worker.

5. If the worker wishes to change the TD 1 code, the worker must provide appropriate documentation from the Canada Revenue Agency that supports the request.

6. If a decrease in the net value of the worker's earnings results from changing the TD1 code, it will generally not result in an overpayment. If the change in the TD1 code results in an increase, the effective date of the increase will be the day benefits commenced or the day the circumstances changed, whichever is later.

Guidelines

This Policy applies to all decisions made on or after October 27, 2016. It replaces Policy 3.1.2R issued on December 15, 1997 and effective November 6, 1997.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 39(1) and 39(3)

Subsection 3.2 – Temporary Earnings-Replacement Benefits

- **Policy Number: 3.2.1R - Calculation of Temporary Earnings-Replacement Benefit**
- **Policy Number: 3.2.2R1 - Waiting Period Without Compensation (Deductible)**
- **Policy Number: 3.2.3R - TERB – Examination, Treatment, etc.**

Policy Number: 3.2.1R

Topic: Calculation of Temporary Earnings-Replacement Benefit
Section: Short-Term and Long-Term Benefits
Subsection: Temporary Earnings - Replacement Benefit (TERB)

Effective: April 16, 1999
Issued: May 17, 1999
Approved by Board of Directors: May 14, 1999

Policy Statement

1. Where a loss of earnings (LOE) results from a work-related injury and extends beyond the waiting period (see Policy 3.2.2), the worker shall receive a Temporary Earnings-Replacement Benefit (TERB). This benefit is subject to the maximum assessable earnings in place at the time of the injury.

2. The amount of the TERB for the first 26 weeks is equal to 75% of the worker's net loss of earnings. After 26 cumulative weeks of compensation, the amount of the TERB will be increased to 85% of the worker's net loss of earnings.

3. The loss of earnings is equal to the net pre-LOE earnings less net post-LOE earnings. The following will be included in post-LOE earnings:

   i) net earnings from employment;

   ii) net earnings that the Board estimates the worker is capable of earning in suitable and reasonably available employment; and

   iii) net 50% of Canada Pension Plan (CPP) or Quebec Pension Plan (QPP) disability benefits.

4. Once the TERB has been calculated, it must be reduced if the TERB, combined with any other compensation paid pursuant to this Act and any benefits (excluding Survivors Benefits) from a predecessor Act, are greater than 75% (first 26 weeks) or 85% (after 26 weeks) of the net maximum assessable earnings at the time of the injury (the net calculation will be based on the individual worker's tax credits which include TD1 code amount, UIC and CPP).

5. The amount of the reduction of TERB is equal to the amount which exceeds the prescribed limits.

6. In the case of recurrence of any injury in which a Permanent Impairment Benefit (PIB) is being paid, the TERB paid to the worker will be equal to 75% of the loss of earnings for the first 26 weeks and 85% thereafter, less the PIB for that injury.

Application

This Policy applies to loss of earnings decisions made on or after April 28, 1999. It replaces Policy 3.2.1, issued on December 1, 1995, and effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 37, 38, 48.

An Act to Amend Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act* (Chapter 1, Acts of 1999), Clauses 4 and 5.

Policy Number: 3.2.2R1

Topic: Waiting Period Without Compensation (Deductible)
Section: Short-Term and Long-Term Benefits
Subsection: Temporary Earnings - Replacement Benefit (TERB)

Effective: April 28, 1999
Issued: May 17, 1999
Approved by Board of Directors: May 14, 1999

Policy Statement

1. An injured worker must undergo a waiting period following an injury without receiving any income replacement from the Workers' Compensation Board before being eligible for a Temporary Earnings-Replacement Benefit (TERB).

   The waiting period is based on remuneration rather than on a time factor. Therefore, the waiting period is equivalent to two-fifths of the worker's weekly TERB. The Board shall deduct from the first TERB payment an amount equal to two-fifths of the weekly TERB that would have otherwise been payable.

2. In the case of a recurrence of an injury, a waiting period will not apply if the recurrence occurs within one year of the worker last receiving a TERB.

Guidelines

3. The waiting period deduction is made before any deductions pursuant to Section 48 of the *Act* (Refer to Policy 3.9.3- Combining of Worker's Compensation Benefits) and before any deductions for recovery of overpayments of compensation benefits.

Application

This Policy applies to loss of earnings decisions made on or after April 28, 1999. It replaces Policy 3.2.2R issued on May 2, 1997 and effective April 3, 1997.

References

An Act to Amend Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act* (Chapter 1, Acts of 1999), Clause 4.

Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act* (Chapter 1, Acts of 1999), section 37(4).

Policy Number: 3.2.3R

Topic: TERB – Examination, Treatment, etc.
Section: Short-Term and Long-Term Benefits
Subsection: Temporary Earnings - Replacement Benefit (TERB)

Effective: April 3, 1997
Issued: May 2, 1997
Approved by Board of Directors: April 3, 1997

Policy Statement

1. Workers can be paid for loss of earnings when they are called or instructed by the Board to report for an examination, treatment, etc.

Application

This Policy applies to all decisions made on or after April 3, 1997. It replaces Policy 3.2.3 issued on December 1, 1995 and effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1)

Subsection 3.3 – Permanent Impairment Benefit (PIB)

- **Policy Number: 3.3.1R2 - Calculation of Permanent Impairment Benefit (PIB)**
- **Policy Number: 3.3.2R4 - Permanent Impairment Rating Schedule**
- **Policy Number: 3.3.3R2 - Review of Permanent Impairment Benefit**
- **Policy Number: 3.3.4R2 - Determining Permanent Medical Impairment Ratings using the Guides to the Evaluation of Permanent Impairment (AMA Guides – 4th Edition) – Injuries on or after January 1, 2000**
- **Policy Number: 3.3.5R1 - Eligibility Criteria and Compensation related to chronic pain**

Policy Number: 3.3.1R2

Topic: Calculation of Permanent Impairment Benefit (PIB)
Section: Short-Term and Long-Term Benefits
Subsection: Permanent Impairment Benefit (PIB)

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. When it has been determined by the Board that a worker has a permanent impairment as the result of a work related injury, the worker will be entitled to a Permanent Impairment Benefit (PIB).

2. The existence and degree of the permanent impairment will be determined by the Board. The Board's determination of the permanent impairment will be based on the rating schedule established by the Board (see Policy 3.3.2R4).

3. A PIB will be calculated in the following manner:

   The percentage of the permanent impairment as determined by the Board multiplied by 30% of 85% of the worker's net average earnings before the injury occurred.

4. A PIB is payable for the life of the worker.

Application

This Policy is effective December 16, 2021. This Policy replaces Policy 3.3.1R1 that was effective October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 34.

Policy Number: 3.3.2R4

Topic: Permanent Impairment Rating Schedule
Section: Short-Term and Long-Term Benefits
Subsection: Permanent Impairment Benefit (PIB)

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. For injuries prior to January 1, 2000, in order to determine the existence and degree of a worker's permanent medical impairment, the Board shall use the permanent medical impairment-rating schedule attached to this Policy (`Guidelines for Assessment of Permanent Medical Impairment').

2. Injuries arising on or after January 1, 2000 shall be assessed under Policy 3.3.4R2, "Determining Permanent Impairment Ratings using the *Guides to the Evaluation of Permanent Impairment – 4th Edition* (AMA Guides – 4th Edition)."

3. Notwithstanding paragraphs 1 and 2, in cases of chronic pain, the Board shall determine the existence and degree of a worker's pain-related impairment using a modified approach to Chapter 18 of the American Medical Association "Guides to the Evaluation of Permanent Impairment – Fifth Edition as outlined in Policy 3.3.5R1 – *Eligibility Criteria and Compensation related to Chronic Pain*.

Application

This Policy is effective December 16, 2021 and replaces Policy 3.3.2R3 that was effective October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), (as amended), Sections 34, 37(2), 37(3).

Guidelines for Assessment of Permanent Medical Impairment

Approved: September, 1995
Revised: February, 1996

Introduction

These guidelines were approved by the Board of Directors of the Workers' Compensation Board of Nova Scotia on September 15, 1995. These guidelines are to be used for the evaluation of medical impairment.

Impairment is basically the loss of, loss of use of, or derangement of any body part, system or function (after maximum recovery).

The evaluation of permanent medical impairment is a medical matter which can be measured accurately and objectively. This is carried out by Board physicians, who have years of specialized training and experience in this particular field and occupational and compensation medicine.

In some instances (e.g. psychiatric, heart, lung) an outside specialist may be used.

Judgement ratings are made to determine a percent of impairment when the impairment does not fit into a specific category of the schedule. This, in general, relies on the experience of the examiner and the guideline values of this schedule.

The figures contained in this guideline are the percentage of medical impairment of the total body with one hundred percent (100%) being the maximum rating. Therefore, multiple injuries are evaluated on the basis of the whole person.

Special Considerations

Enhancement in Multiple Injuries

This is something to be considered where injuries involve parts of the body which perform identical functions: e.g. both arms, both legs or both eyes. Ordinarily there would be no enhancement factor as between a hand and a foot, a foot and an eye, etc. An enhancement of up to fifty percent (50%) might be warranted in injuries to both hands or both feet, but regard must always be had that the sum of the two individual ratings plus an added percentage for enhancement is not disproportionate when applied to the whole person.

Dominant Upper Limb or Hand

When there is a permanent medical impairment of an upper limb or hand, up to twenty percent (20%) of the assessed rating may be added, as it is recognized that a greater impairment exists in such cases.

Extremities

Impairment of Upper Extremity

Amputations	Percentage
Proximal third of humerus or disarticulation of shoulder	70%
Middle third of humerus	65%
Distal third of humerus of biceps insertion	60%
Biceps insertion to wrist (depending on usefulness of stump)	50-60%

Immobility of Joints	Percentage
Shoulder, without either articular or scapula movement (the totally 'frozen shoulder')	35%
Shoulder joint (gleno humeral) ankylosed but with full scapular movement	15%
Shoulder, abduction limited to 90^0 but with good rotation and pivotal movement	5%
Elbow	25%
Wrist	15%
Pronation and supination complete in mid-position	10%
Pronation alone lost	3%
Supination alone lost	5%

Denervation	Percentage
Median, complete at elbow	40%
Median, complete at wrist	20%
Ulnar, complete at elbow	10%
Ulnar, complete at wrist	8%
Radial, complete at elbow	25%

Chart 1 - Thumb or Single Finger (Award half value shown if impairment only involves a single phalanx.)

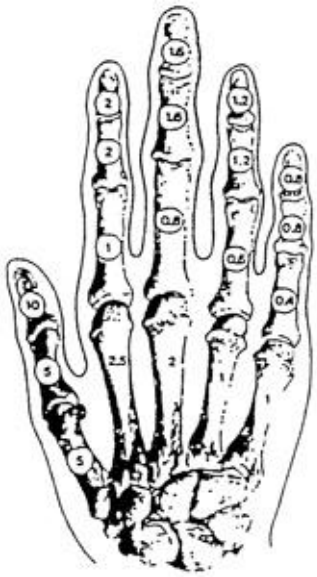


Chart 2 - Two Fingers (One-and-One-Half Times the Sum of the Single Values)	**Percentage**
Index & Middle at Distal	5.4%
Index & Ring at Distal	4.8%
Index & Little at Distal	4.2%
Middle & Ring at Distal	4.2%
Ring & Little at Distal	3.0%
Index & Middle at P.I.P.	10.8%
Index & Ring at P.I.P	9.6%
Index & Little at P.I.P.	8.4%
Middle & Ring at P.I.P.	8.4%
Middle & Little at P.I.P.	7.2%
Ring & Little at P.I.P.	6.0%
Index & Middle at Metacarpal	13.5%
Index & Ring at Metacarpal	12.0%
Index & Little at Metacarpal	10.5%
Middle & Ring at Metacarpal	10.5%
Middle & Little at Metacarpal	9.0%
Ring & Little at Metacarpal	7.5%

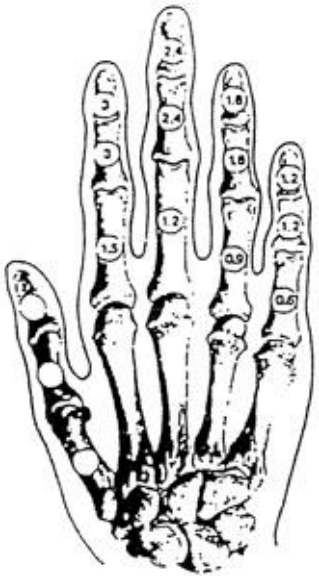


Chart 3 - Three Fingers (Twice the Sum of the Single Values)	**Percentage**
Index & Middle With Ring at Distal	9.6%
Index & Middle With Little at Distal	8.8%
Index & Ring With Little at Distal	8.0%
Middle & Ring With Little at Distal	7.2%
Index & Middle With Ring at P.I.P.	19.2%
Index & Middle With Little at P.I.P.	71.6%
Index & Ring With Little at P.I.P.	16.0%
Middle & Ring With Little at P.I.P.	14.4%
Index & Middle With Ring at Metacarpal	24.4%
Index & Middle With Little at Metacarpal	22.0%
Index & Ring With Little at Metacarpal	20.0%
Middle & Ring With Little at Metacarpal	18.0%

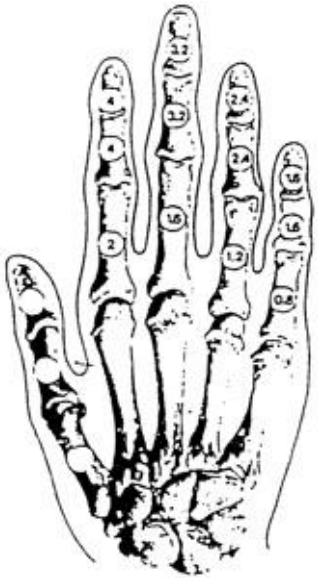
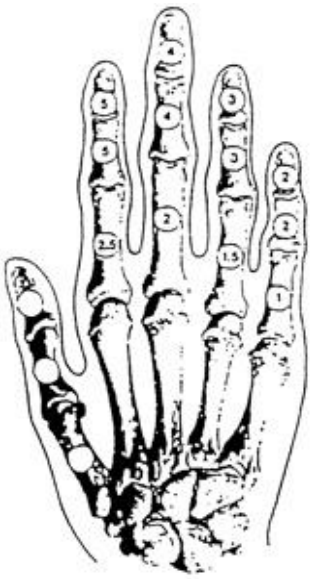


Chart 4 - Four Fingers (Two-and-One-Half Times the sum of the Single Values)	**Percentage**
Index, Middle, Ring & Little at Distal	14.0%
Index, Middle, Ring & Little at P.I.P.	28.0%
Index, Middle, Ring & Little at Metacarpal	35.0%



Impairment of Lower Extremity

Amputations	**Percentage**
Hip disarticular or short stump requiring an ischial bearing prosthesis	65.0%
Thigh, site of election	50.0%
End bearing knee or short below knee stump not suitable for a conventional below	45.0%
Leg, suitable for below knee prosthesis	35.0%
Leg, at ankle, end bearing	25.0%
Through foot	10-25.0%
All toes	6.5%
Toe, great	2.5%
Toe, great at distal	1.0%
Toe, other than great, each	1.0%

Immobility of Joints	**Percentage**
Hip	30.0%
Knee	25.0%
Knee, flexion limited to 90 degrees	5.0%
Ankle	12.0%
Great toe, both joints	2.5%
Great toe, distal joint	0.5%

Shortening of Leg	Percentage
Up to 2 cm	1.5%
Up to 5 cm	6.0%
Up to 8 cm	15.0%

Denervation	Percentage
Peroneal, complete	12.0%
Foot drop, complete	12.0%

Spine

The following are guideline values for various types of injuries to the cervical, thoracic and lumbar spine. In assessing these injuries judgement becomes a very important factor, which takes into account not only the clinical judgement but also the examiner's experience in this field. The various medical reports on the file are also taken into consideration.

Cervical Spine - Soft Tissue Injury	Percentage
1. Ongoing subjective complaints with no significant objective abnormalities on examination	0%
2. Same as (1) but with persistent spasm and other objective abnormalities on examination	0-10%
3. Same as (2) but with gross degenerative changes on x-ray. Awards here are generally under Section 10(5) with only a portion of the total amount granted	5-20%

Cervical Spine - Fracture	Percentage
1. No fusion required but with persistent symptoms and some objective findings on physical examination	3-10%
2. Fusion required with symptoms and minimal objective findings on physical examination	5-15%
3. Fusion required with symptoms and significant objective findings on physical examination	10-20%
4. Spinal cord damage	up to 100%

Cervical Spine - Cervical Disc	**Percentage**
1. Symptoms with minimal residual objective abnormalities on examination - surgery usually done	0-10%
2. Same as (1) but with more significant objective abnormalities on examination	10-20%
3. Same as (1) and (2) but with fusion	10-25%

Thoracic Spine - Soft Tissue Injury	**Percentage**
1. Persistent symptoms with spasm and underlying degenerative changes	0-10%

Thoracic Spine - Fracture	**Percentage**
1. No fusion required with persistent symptoms and minimal objective findings on examination	0-5%
2. Fusion required with persistent symptoms and significant abnormalities on examination	5-15%
3. Spinal cord damage	Up to 100%

Lumbar Spine - Soft Tissue Injury	**Percentage**
1. Ongoing subjective complaints with no significant objective abnormalities on examination	0%
2. Ongoing symptoms with significant objective abnormalities on examination, usually associated with degenerative changes on x-ray. Section 10(5) may be used here	0-10%

Lumbar Spine - Fracture	**Percentage**
1. No fusion required and with minimal symptoms and objective findings on physical examination	0-10%
2. Same as (1) but with fusion	5-15%
3. Fusion required with significant symptoms and objective findings on physical examination	10-40%
4. Spinal Cord Damage	Up to 100%

Lumbar Spine - Lumbar Disc	**Percentage**
1. No surgery required with minimal symptoms and objective findings on physical examination	0-10%
2. Same as (1) but with laminectomy	0-10%
3. Same as (2) but with significant symptoms and objective abnormalities on physical examination	10-20%
4. Disc excision with fusion	10-30%

Lumbar Spine - Spondylolisthesis	**Percentage**
In these claims awards are give under Section 10(5) with only a portion being granted. The only exception to this is a traumatic spondylolisthesis, which is considered fairly	
1. No fusion but with persistent symptoms and significant objective findings on physical examination	0-20%
2. Fusion with symptoms and significant objective abnormalities on examination	10-30%

Central Nervous System

Head Injuries

The following medical impairments can occur after head injuries:

1. Sensory and motor disturbances;
2. Language disturbances;
3. Disturbances of complex, integrated cerebral functions;
4. Emotional disturbances;
5. Consciousness disturbances;
6. Episodic neurological disorders (i.e. epilepsy);
7. Sleep and arousal disorders.

It is advisable that impairment ratings not be done until at least two years after the injury. In these cases the award is based on reports from psychologists, psychiatrists, neurologists, etc. and may or may not require an examination by a Board physician. The final rating is basically a judgement one, based on all available information and an examination, if done.

Guide

Mild impairment	0-20%
Moderate impairment	20-50%
Severe impairment	50-100%

Reassessments can be done as medically indicated.

Psychiatric Impairment

An emotional reaction following an industrial injury is usually nothing more than a "startle reaction", or a short period of anxiety or depression which subsides very quickly.

This initial emotional reaction, although minor in most cases, can however, increase depending on several factors. These factors include the severity of the injury; whether or not the accident was of a frightening nature; and the prior emotional stability of the worker. Every worker reacts differently to stressful situations, according to their individual personality.

The reaction to the injury may be aggravated as a result of prolonged medical treatment. Other factors, such as extended disablement and/or severe functional limitations, may also increase the emotional reaction to the point that the worker's ability to carry out the activities of daily life is affected.

Every effort is made to identify any psychiatric problem, as well as its severity, early in the onset of the worker's claim. In this way necessary psychiatric treatment can be instituted at the earliest possible date, thereby assisting the workers in their recovery and lessening any long term effects of the emotional reaction.

The emotional reaction is generally a temporary condition and the worker is left with no permanent psychiatric impairment. In considering cases of permanent impairment, for claims purposes, a clear causal relationship must be established between the injury and the emotional reaction (i.e. the injury must be shown to be a significant contributing factor).

As a rule, the emotional reaction must have appeared shortly after the injury. However, the WCB will consider all cases in which a psychiatric condition develops within five years of the accident, or five years after the last major surgical procedure.

The evaluation of compensable psychiatric conditions is usually done by psychological testing and a single or multiple psychiatric assessment(s) (as required).

The Board physicians use these reports to arrive at a final medical impairment rating. Guidelines for these ratings are as follows.

Permanent impairment due to post-traumatic neurosis is evaluated in line with the following clinical entities, one or more of which may be present:

1. Anxiety neurosis with depressive features;
2. Anxiety neurosis with psychosomatic manifestations (psychological factors affecting physical condition);
3. Obsessive-compulsive neurosis;
4. Anxiety neurosis with phobic features;
5. Anxiety neurosis with hypochondriasis.

Consideration will be given to the predominant symptoms, but clinically it is always a mixed state, including not only the accident-related anxiety depressive reaction, but also the superimposed personality tendencies which are important preconditioning factors.

Category I - Minor Impairment of the Total Person (0 - 10%)

In this category the worker's daily activity is slightly limited and no apparent difficulties are reported in personal adjustment. There is also some loss in personal or social efficiency and the secondary psychogenic aggravations are caused by the emotional impact of the accident. The outstanding symptom is the worker's statement of persistent pain which has restricted, to a limited degree, the functioning ability of the person.

A mild anxiety reaction shall be apparent. The display of symptoms indicates a form of restlessness, some degree of subjective uneasy feelings and tension caused by anxiety. There shall be some resultant subjective limitations in functions.

The condition, from the psychiatric point of view, is not expected to be permanent.

Category II - Moderate Impairment of the Total Person (15 - 25%)

In this category, the worker is still capable of looking after personal needs in the home environment but, at times insidiously, confidence will diminish and the worker will become more dependent on the members of the family in all extramural activities. The worker demonstrates a moderate, at times episodical, anxiety state, agitation with 'traumatophobia', and nurtures strong passive dependency tendencies.

Category III - Major Impairment of the Total Person (30 - 50%)

In this category the worker displays a severe anxiety state, definite deterioration in family adjustment, incipient breakdown of social integration, and longer episodes of depression (depressive neurosis). The worker tends to withdraw from the family, develops severe noise intolerance and a significantly diminished stress tolerance. A phobic pattern or conversion reaction will surface with some bizarre behaviour, tendencies to avoid anxiety-creating situations, and everyday activities restricted to such an extent that the worker may be homebound or even roombound at frequent intervals.

Category IV - Severe Impairment of the Total Person (60 - 100%)

In this category, the worker displays a clear indication of chronic severe limitation of adaptation and function in the home and outside environment. The worker is withdrawn, forgetful, unable to concentrate, needs continuous emotional support within the family setting, and is incapable of self-care and neglects personal hygiene. There may be an obvious loss of interest in the environment and the worker becomes extremely irritable, showing significant emotional instability, changes of mood (near to a psychotic, depressive level) and uncontrolled outbursts of temper. The worker may be severely depressed with outstanding features of psychomotor retardation and psychological regression. The worker is usually homebound or even roombound.

Hemiplegia, Paraplegia, and Quadriplegia

These conditions require clinical judgement for their evaluation. In many instances, the condition is complete and static and a rating of 100% made.

However, there are cases in which the impairment is not total and a lesser rating is judged appropriate. (See 'Spinal Cord' Guide)

Cardiovascular System

The majority of cardiac claims which are evaluated for permanent impairment are those in which the worker has suffered a myocardial infarction following some unusual stress or the inhalation of fumes. There are also rare cases related to trauma or infection. Cases for consideration are usually those in which there is no to little pre-existing disease and the incident of precipitation is considered medically significant. The Board's usual practice is to evaluate the permanent impairment in these cases one year after the myocardial infarction. However, if the condition is not considered static at the one-year interval, the rating is deferred until the condition becomes static. A consultation with a cardiologist is done prior to the impairment rating being assessed.

The guidelines used by the WCB for rating of cardiovascular impairment are those developed by the American Medical Association and the American Heart Association. Patients are categorized as Class I, Class II, Class III, or Class IV. The percentage values are as follows:

Class I	0-20%
Class II	20-40%
Class III	50-80%
Class IV	80-100%

These classifications are standard terminology for cardiologists in North America and are used in routine clinical practice.

Persons in **Class I** include those with known organic heart disease who:

1. have few or no symptoms;
2. can walk, climb stairs, and perform the usual activities of daily living without having symptoms;
3. show no serious adverse reactions to prolonged exertion or emotional stress;
4. show no signs of congestive heart failure.

Included in **Class II** are patients having organic heart disease who:

1. are without symptoms while at rest;
2. have the ability to walk freely on the level, climb at least one flight of stairs and perform the usual activities of daily living without discomfort;
3. have symptoms attending prolonged exertion, emotional stress, hurrying, hill climbing and recreational or similar activities;
4. have no signs of congestive heart failure.

Persons in **Class III** having organic heart disease who:

1. are without symptoms while at rest;
2. have symptoms walking more than one or two blocks on the level and climbing one flight of stairs, or performing the usual activities of daily living;

3. have major symptoms attending emotional stress, hurrying, hill climbing, or recreational activities;

4. have signs of congestive heart failure that are usually relieved by therapy.

Finally, persons in **Class IV** have:

1. symptoms even while at rest;

2. increasing discomfort when performing any of the activities of daily living;

3. occasional symptoms of cardiac insufficiency;

4. signs of congestive heart failure that are usually resistant to therapy.

This classification of the American Heart Association puts greater emphasis on the restriction of the activities of daily living than on the pathological lesions themselves. However, the utilization of a stress or exercise test is standard procedure to assist in the impairment rating.

It should be stated that in those claims in which an impairment award is justified, Section 10(5) of the Act will usually apply.

In such cases the preponderance of medical evidence must point to the injury as the main cause of residual impairment rather than pre-existing factors.

Respiratory System

Automatic Assumption

Section 35 of the Workers' Compensation Act (Chapter 10, Acts of 1994-95) states as follows:

"Any Coal miner who (a) has worked at the face of a mine or in similar conditions twenty years or more; and (b) who suffers from a permanent impairment that is a loss of lung function, shall be compensated according to the permanent impairment as calculated pursuant to Section 34".

Special pulmonary function guidelines have been drawn up regarding entitlement under this Section of the Act, which are as follows:

Class	Obstructive Disease FEV_1 / FVC (%) *
No Disability	greater than 70%
Mild Disability 10% Award	60-70%
Moderate Disability 20% Award	55-60%
Severe Disability 35% Award	50-55%
Very Severe Disability 60% Award *(Automatic Review by Physician)*	less than 50%

Class	Restrictive Disease Vital Capacity (%) Predicted *
No Disability	greater than 85%
Moderate Disability 20% Award	75-85%
Severe Disability 35% Award	60-75%
Very Severe Disability 60% Award *(Automatic Review by Physician)*	less than 60%

* These are measurements of lung capacity. Lower numbers indicate a greater loss of lung function.

Unless medical evidence indicates otherwise, re-assessments are done every three years.

Regular

Impairment of function of the respiratory system necessitates a judgement rating.

Points to Consider

- History of exposure and illness;
- Assessment of symptoms and physical findings;
- Chest x-rays;
- Pulmonary function studies (PFS).

Outside chest specialist evaluates the worker's condition and makes a recommendation of permanent impairment rating to the Board. In some instances second opinions are obtained.

The rating is expressed as a percentage of impairment of lung function taking into consideration all of the factors listed above. Ratings can vary from 10% to 100%.

Listed below are the conditions normally evaluated for impairment of the respiratory system:

1. All Pneumonoconioses including:
    - Silicosis
    - Asbestosis
    - Coal Worker's Pneumonoconiosis
2. Occupational Asthma
3. Asthma aggravated by industrial exposure
4. Acute toxic exposures
5. Chest malignancies
   Lobectomy
   Pneumonectomy
6. Traumatic Pneumothorax *(Usually no permanent impairment)*

7. Chronic obstruction lung disease (*In these cases plus some of the others listed above, a smoking history will have a significant effect on any medical impairment rating.*)

In general, the re-assessment interval varies from one to five years and depends on the specialist's recommendations. It should be pointed out that in general, lung function tests reflect impairment, whereas the chest x-ray is used mainly for diagnosis.

Visual System

Impairment of Vision

Impairment of function due to eye injuries may result in a decrease of visual acuity, per se, and/or other visual problems, such as double vision.

Permanent impairment is based on corrected visual acuity (with contact lenses or glasses).

It is also necessary to take into consideration any prior condition of the injured eye and the condition of the uninjured eye at the time of injury.

In cases of bilateral eye injury, or where there is a pre-existing problem with the uninjured eye, the multiple table ("Partial Loss of Vision in Both Eyes" on next page) will be used.

Impairment of Vision	Percentage
Enucleation (removal of eye) *	18%
Total loss of sight (one eye)	16%
Total loss of sight (both eyes)	100%
Hemianopia (field defect)	
• *Right*	25%
• *left*	20%
Scotomata (blind spot) – depending on location and extent	up to 16%
Diplopoa (double vision)	
• *all fields*	10%
• *upward gaze*	1.5%
• *medial or lateral gaze*	2.5% each
• *downward gaze*	3.5%

Aphakia (removal of lens) - *See table below*	
20/20, 20/30	6%
20/40	6+1=7%
20/50	6+2=8%
20/60	6+3=9%
20/80	6+4=10%
20/100	6+5=11%
20/200	6+6=12%
Photophobia (light sensitivity)	up to 2%
Tearing	up to 2%
Traumatic Mydriasis (dilatation of pupil)	up to 3%
Aniridia (partial or complete loss of iris)	up to 10%

* The extra 2% given for an enucleation is for the actual loss of the organ and the requirement of caring for the artificial eye and socket.

Partial Visual Loss in One Eye (Corrected vision based on Snellen chart)	**Percentage**
20/30 (6/9)	0%
20/40 (6/12)	1%
20/50 (6/15)	2%
20/60 (6/18)	4%
20/80 (6/24)	6%
20/100 (6/30)	8%
20/200 (6/60)	12%
20/400 (6/120) (including finger or hand movements)	14%

Partial Loss of Vision in Both Eyes (Corrected vision based on Snellen Chart)

	20/30 6/9	**20/40 6/12**	**20/50 6/15**	**20/60 6/18**	**20/80 6/24**	**20/100 6/30**	**20/200 6/60**	**20/400 6/120**	**BLIND**
20/30 6/9	0	1	2	4	6	8	12	14	16
20/40 6/12	1	6.3	7.3	9.3	11.3	13.3	17.3	19.3	21.3
20/50 6/15	2	7.3	12.5	14.5	16.5	18.5	22.5	24.5	26.5
20/60 6/18	4	9.3	14.5	25	27	29	33	35	37

20/80 6/24	6	11.3	16.5	27	37.5	39.5	43.5	45.5	47.5
20/100 6/30	8	11.3	18.5	29	39.5	50	54	56	58
20/200 6/60	12	17.3	22.5	33	43.5	54	75	77	79
20/400 6/120	14	19.3	24.5	35	45.5	56	77	87.5	89.5
BLIND	16	21.3	26.5	37	47.5	58	79	89.5	100

Auditory System

The auditory system consists of the auricle, the external canal, the tympanic membrane, the middle ear, the eustacian tube, the mastoid, the internal ear, the central pathways and the auditory cortex.

The functions of the ear are hearing and equilibrium.

Hearing

Threshold of hearing for pure tones is represented by the number of decibels (dB) above the standard audiometric zero for each frequency. It is the reading on the so-called 'hearing threshold level' (hearing loss) dial of an audiometer that is calibrated according to American National Standard specifications for audiometers.

Estimated hearing level for speech is the average of hearing level at the four speech frequencies of 500, 1000, 2000 and 3000 Hz. If the average hearing level is 25 dB A.N.S.I. or I.S.O. or less, no impairment exists in the ability to hear everyday speech under everyday conditions.

Equilibrium

Equilibrium or a state of balance is maintained by the visual, kinaesthetic and labyrinthine-vestibular mechanism.

Trauma to the labyrinthine-vestibular function is evidenced by peripheral vertigo. This is characterized by sensations of rotation and may also be associated with varying degrees of nausea, vomiting, headache, syncope, ataxia, and nystagmus.

Occupational Hearing Loss

(1) **Traumatic** - sudden deafness, one or both ears affected e.g. by blast or head injury. The deafness may be of varying degrees, with or without tinnitus. In some cases surgery may improve the hearing.

	Percentage
Deafness, complete in one ear	5%
Deafness, complete in both ears	30%
Sudden and traumatic complete deafness	60%

Hearing Loss – one ear only	
• *over 30 dB A.N.S.I.*	1%
• *over 40 dB*	2%
• *over 50 dB*	3%
• *over 60 dB*	4%
• *over 70 dB*	5%
Traumatic Vertigo	2.5%
Tinnitus	up to 5%

(2) **Noise Induced** - gradual onset, both ears affected. To establish a claim, all the following circumstances must apply:

(a) There is a clear and adequate history of five or more years of exposure to hazardous noise, 85 decibels 'A' scale for eight hours per day, or equivalent as noted below.

Steady-State Noise Level (dBA)	*Maximum Period of Exposure*
80	24 hours
82	16 hours
85	8 hours
88	4 hours
91	2 hours
94	1 hour
97	30 minutes
100	15 minutes
103	7.5 minutes
106	3.75 minutes
109	1.88 minutes

Steady-State Noise Level (dBA)	*Maximum Period of Exposure*
112	.94 minutes
115	28.12 seconds
118	14.06 seconds
121	7.03 seconds
124	3.52 seconds
127	1.76 seconds
130	.88 seconds
133	.44 seconds
136	.22 seconds
139	.11 seconds

Permitted Number of Impulses or Impacts per 24 Hours	Sound Level (dBA)
0	above 140 *
100	140
1,000	130
10,000	120

*No exposure to impulse or impact noise in excess of 140 decibels peak sound pressure level is permitted.

NOTE: *Sound levels in excess of 85 decibels ('A' Scale) will reduce the five or more year exposure requirement.*

(b) The frequency level and type of exposure is known.

(c) The average of the four speech frequency levels 500, 1000, 2000 and 3000 Hertz (Hz) in the American National Standards Institute (ANSI) or International Standards Organization (ISO) audiograms is 25 decibels in at least one ear.

Hearing aids will only be supplied in ear(s) with at least a 25 decibel loss. A presbycusis factor of .5 dB for each year that the age exceeds sixty is deducted in determining eligibility for a hearing aid.

(d) A presbycusis factor of .5 dB for each year that the age exceeds sixty is deducted.

(e) The audiogram has a pattern consistent with noise induced hearing loss.

Since individual susceptibility to noise varies, cases which do not meet the criteria set out above are individually judged on their own merits having regard to the nature of the occupation, the extent of exposure and any other factors peculiar to the individual case.

To establish entitlement to permanent impairment all of the following circumstances must apply:

(i) The average of the four speech frequency levels, 500, 1000, 2000 and 3000 Hz in the ANSI or ISO audiograms is 35 decibels in at least one ear.

(ii) A presbycusis factor of .5 dB for each year that the age exceeds sixty is deducted;

(iii) Hearing Loss in decibels is converted into percentage of impairment in accordance with the following schedule:

Hearing Loss Where Both Ears are Affected:

dB Hearing Loss	Percentage
In single ear 35 dB ANSI/ISO	0.4%
In single ear 40 dB ANSI/ISO	0.7%
In single ear 45 dB ANSI/ISO	1.0%
In single ear 50 dB ANSI/ISO	1.4%
In single ear 55 dB ANSI/ISO	1.8%
In single ear 60 dB ANSI/ISO	2.3%
In single ear 65 dB ANSI/ISO	2.8%
In single ear 70 dB ANSI/ISO	3.4%
In single ear 75 dB ANSI/ISO	4.0%
In single ear 80 dB ANSI/ISO	5.0%

NOTE: In bilateral deafness the poorer ear is rated according to the above scale; the better ear according to the scale multipled by five. The sum of the two gives the combined rating.

(f) The level of rating is not influenced by any improvement in hearing attained through the use of a hearing aid.

Industrial Noise-Induced Tinnitus

To establish entitlement for permanent impairment for tinnitus, all of the following circumstances must apply:

(a) There is an acceptable claim for industrial noise-induced hearing loss.

(b) There is a clear and adequate history of two or more years of continuous and severe tinnitus.

(c) The condition has been confirmed by a consultant with facilities for testing peculiar to tinnitus.

(d) Permanent impairment rating for tinnitus shall not exceed two percent, except under unusual circumstances (maximum 5%).

(e) Claims which do not meet the above criteria are individually judged on their own merit.

Internal Organs

The impairment of function of internal organs necessitates judgement ratings.

	Percentage
Loss of one kidney	10%
Loss of spleen	10%

Permanent Surgically Created Stomata	Percentage
Esophagotomy	0.4%
Gastrostomy	0.7%
Jejunostomy	1.0%
Ileostomy	1.4%
Colostomy	1.8%

The impairment of bowel and bladder function requires a judgement rating.

Reproductive and Uriniary System

In evaluating permanent impairment in the reproductive and urinary system, a distinction must be made between physical damage and psychological damage. For guidance in evaluating psychological damage, see the section on the Central Nervous System.

Impotence and/or sterility can be caused by direct physical injury. Sterility can also result form exposure to high doses of radiation, or from exposure to certain industrial chemicals, such as the soil insecticide dibromochloroproprane.

The following guidelines are used in assessing permanent impairment in the reproductive and urinary system.

	Percentage
Direct trauma to penis resulting in impotence	10%
Loss of penis and/or partial loss resulting in impotence	10%
Loss of testes giving rise to sterility	
• *loss of both testes*	10%
• *loss of one testicle*	2%
Loss of penis and/or partial loss of penis and/or both testes	10%
Urethral stricture or other impairment requiring ongoing treatment	judgement rating
Impotence in females	judgement rating
Sterility due to non-traumatic causes, including radiation and exposure to toxic chemicals	10%
Loss of one kidney	10%
Injuries to the urinary bladder	judgement rating

Integumentary System

Dermatitis

Permanent medical impairment awards are made in cases of occupational dermatitis when the diagnosis is firmly established and the skin disease has stabilized. It is also desirable that the worker has been returned to suitable employment, avoiding the skin hazard.

Prior to consideration of award a dermatology consultation is arranged by the family doctor or Board staff. Any relevant medical investigation is authorized, for example, patch tests if applicable. Hospitalization may be arranged for more intensive care of the skin, for intricate tests, as for photosensitivity, or for general medical investigation to rule out systemic disease which may cloud the issue.

Avoidance of the irritant or allergic material clears the rash in most cases, and this may be achieved by protective clothing, improved ventilation, change to an enclosed process, change of the chemical, or more stringent hygiene on the part of the worker (more frequent hand-washing and avoidance of such solvents as varsol for clean-up at the end of a shift).

Permanent medical impairment ratings, if justified, may be awarded under the Board's regular guidelines (in many cases also using Section 10(5) of the Act). Awards can vary from 0-100% depending on many factors. In general, the rating is a judgement one, although the following guidelines may be used.

Class	
Class 1 *0-5%*	**Clinical** *(Medical)* No rash present. No treatment necessary. Little or no limitation exits in the performance of the activities of daily living, although unavoidable contact with specific irritant or allergic substances might temporarily increase the extent of limitation.
Class 2 *5-10%*	**Clinical** *(Medical)* Signs and symptoms exist - minimal rash. Intermittent treatment necessary (*creams and ointment - minor*).
Class 3 *20-50%*	**Clinical** *(Medical)* Signs and symptoms exist - moderate rash. Continuous treatment is required - may include intermittent courses of parenteral steroids, with complication. Limitation of many daily activities. Frequent exacerbations due to unavoidable contact.
Class 4 *50-100%*	**Clinical** *(Medical)* Signs and symptoms are present - widespread rash. Continuous treatment is required, including frequent parenteral steroids (*may involve complication*). Treatment may require confinement at home or other domicile. Severe limitation of activities of daily living.

Vibration-Induced White Finger Disease

Medical impairment assessments are carried out when the diagnosis is confirmed (*as occupational*) and the symptoms and signs have been present for a minimum of two years.

An occupational diagnosis usually requires the following:

1. history of long term use of certain tools that cause significant vibration;
2. examination by a specialist in this field;
3. specific laboratory and x-ray examinations.

In some cases the condition can be accepted on an aggravation basis with the primary disease being basically non-occupational.

The impairment rating is judgement in nature and usually will range from 0-20%. Reassessments can be carried out if medical evidence justifies this.

Disfigurement

Disfigurement is defined for Claims purposes as a conspicuous alteration of the features of the head, face, or neck and/or substantial scarring of these areas. This includes loss of hair which cannot be replaced by artificial means.

There are four degrees of disfigurement:

Category 1: *(1-5%)*

Noticeable scarring, alteration of the shape of the facial features or loss of hair which cannot be replaced without difficulty.

Category 2: *(6-10%)*

Substantial scarring, burns or alteration of the shape of facial features.

Category 3: *(10-15%)*

Major disfigurement caused by scarring, burns, etc., which affect or partially obliterate the shape of facial features.

Category 4: *(10-20%)*

Gross disfigurement with obliteration of features and normal skin appearance due to burns, multiple scars or other causes.

Ratings for disfigurement are basically judgement in nature and should not be carried out until any reconstructive surgery is completed.

Policy Number: 3.3.3R2

Topic: Review of Permanent Impairment Benefit
Section: Short-Term and Long-Term Benefits
Subsection: Permanent Impairment Benefit (PIB)

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. A Permanent Impairment Benefit may be reviewed and adjusted only after 16 months have passed since the last determination of the worker's permanent impairment rating.

2. A review of the PIB will only be undertaken if there was a change in the worker's compensable condition that was not taken into account during the last assessment of the worker's permanent medical impairment rating by the Board. The permanent medical impairment rating is based on the schedule established pursuant to Section 34 (see Policy 3.3.2R4).

3. If an adjustment is warranted, the effective date of the adjustment will be the date of the most recent determination of the worker's permanent medical impairment rating.

Application

This Policy is effective December 16, 2021. This Policy applies to workers injured on or after March 23, 1990 who have been awarded a PIB. This Policy replaces Policy 3.3.3R1 effective October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 34, 71, 228.

An Act to Amend Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act*, Clause 8.

Policy Number: 3.3.4R2

Topic: Determining Permanent Medical Impairment Ratings using the *Guides to the Evaluation of Permanent Impairment* (AMA Guides – 4th Edition) – Injuries on or after January 1, 2000

Section: Short-Term and Long-Term Benefits
Subsection: Permanent Impairment Benefit (PIB)

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Preamble

Under the Workers' Compensation Act (the "Act") a worker who has a permanent impairment as the result of a compensable injury is entitled to the payment of a permanent-impairment benefit based on the degree of that permanent impairment. In order to calculate the amount of the permanent-impairment benefit the worker is entitled to receive, the Board is required by the Act to establish a permanent impairment rating schedule and to use that schedule to determine the existence and degree of the worker's permanent impairment.

Definitions

For the purposes of this Policy, the following definitions shall apply:

"**compensable injury**" means a personal injury by accident arising out of and in the course of employment;

"**disability**" means the decreased capacity or loss of ability of an individual to meet personal, social or occupational demands;

"**impairment**" means the loss of, loss of use of, or derangement of any body part, system or function;

"**permanent impairment**" means impairment associated with a permanent medical impairment and/or a pain-related impairment.

"**permanent medical impairment**" means any impairment that has become static or stabilized and that is unlikely to improve despite further medical treatment. A permanent medical impairment also accounts for the usual pain that accompanies the type of injury and resulting impairment.

"**Usual pain**" means all pain except for chronic pain as defined by the *Act*, *Chronic Pain Regulations* and Policy 3.3.5R1.

"**pain-related impairment**" means impairment associated with chronic pain.

Determining Permanent Medical Impairment Ratings using the *Guides to the Evaluation of Permanent Impairment* (AMA Guides – 4th Edition) – Injuries on or after January 1, 2000

Policy Statement

1. Subject to the limitations set out in this Policy and in other Board policies, for injuries on or after January 1, 2000, the Board shall use the American Medical Associations "Guides to the Evaluation of Permanent Impairment – Fourth Edition" (the "AMA Guides – 4th Edition") to determine the existence and degree of a worker's permanent medical impairment. The permanent medical impairment rating determined in

accordance with the AMA Guides –4th Edition will be used to calculate the amount of the permanent-impairment benefit payable to the worker as a result of a compensable injury.

2. In determining the existence and degree of a pain-related impairment the Board shall use a modified approach to Chapter 18 of the American Medical Association "Guides to the Evaluation of Permanent Impairment - Fifth Edition as outlined in Policy 3.3.5R1 – *Eligibility Criteria and Compensation related to Chronic Pain*.

3. A worker's entitlement to be assessed with respect to any permanent medical impairment as the result of a compensable injury will be determined by the Board in accordance with the provisions of the *Act*, the Regulations made pursuant to the *Act* and other Board policies. The AMA Guides – 4th Edition will be used to determine the *degree* of the worker's permanent medical impairment once *entitlement* to the assessment has been established.

4. The Board will use the method outlined in the AMA Guides – 4th Edition, "Chapter 14, Mental and Behavioural Disorder", to assess the existence and level of a worker's permanent medical impairment due to a compensable mental or behavioural (psychiatric) disorder. The impairment classifications in Chapter 14 range from Class 1-No Impairment to Class 5-Extreme Impairment; a rating or percentage scale is not included. The Board will use the following rating scale, in conjunction with the AMA Guides – 4th Edition, to determine the worker's permanent medical impairment rating:

	Classification	Impairment Rating
Class 1	No Impairment	None
Class 2	Mild Impairment; impairment levels compatible with most useful functioning	10-20%
Class 3	Moderate Impairment; impairment levels compatible with some, but not all, useful functioning	25-50%
Class 4	Marked Impairment; impairment levels significantly impede useful functioning	55-75%
Class 5	Extreme Impairment; impairment levels preclude useful functioning	>75%

5. Permanent impairment ratings established under section 35 of the *Act* (automatic assumption) are to be determined in accordance with the criteria and ratings specified under Policy 3.3.2R4, "Respiratory System - Automatic Assumption."

6. The existence and degree of a permanent impairment will be assessed by the Board. In general, the assessment will not be performed until the worker's condition has stabilized and no further major medical interventions are planned (i.e., the worker has reached maximum medical recovery). The appropriate time for the permanent impairment assessment will be determined by the Case Manager in consultation with a Board Medical Adviser.

7. A worker's permanent medical impairment rating will be determined by a Board Medical Adviser, taking into consideration the following factors:

   (a) a review of all pertinent information contained in the worker's WCB claim file(s);

   (b) the results of a physical examination of the worker conducted by a Board Medical Adviser or, where the Board considers it appropriate, by an external medical specialist appropriate to the type of impairment; and

(c) the criteria set out in the AMA Guides – 4th Edition, as applicable.

If an impairment description does not match the AMA Guides – 4th Edition, the Board Medical Adviser will make a judgement rating following discussion with other Board Medical Advisers if necessary. A judgement rating may be determined by the Medical Adviser at any time if the scheduled rating is inappropriate to the worker's condition.

8. Permanent impairment ratings are expressed as a percentage of total body impairment with one hundred percent (100%) being the maximum possible rating.

9. Where multiple injuries result in more than one impairment, the impairments are evaluated on the basis of the whole person, rather than by adding the individual values. This is done with the use of the Combined Values Chart contained in the AMA Guides – 4th Edition.

10. When there is a permanent medical impairment of a dominant upper limb or hand, up to twenty percent (20%) of the assessed rating may be added, as it is recognized that a greater impairment exists in such cases.

11. The AMA Guides – 4th Edition are used to assess impairment, not disability. The existence and degree of permanent medical impairment are determined by medical means and are based solely on a demonstrable loss of bodily function.

12. The permanent-impairment benefit calculated based on the permanent impairment rating is not intended to compensate the worker for any loss of earnings as the result of a compensable injury. Therefore, the ability or inability of the worker to engage in gainful employment, the loss of employment or the loss of earnings as a result of a compensable injury are not considerations in the determination of the level of permanent impairment.

Application

This Policy is effective December 16, 2021. It replaces Policy 3.3.4R1 that was effective October 27, 2016. Permanent medical impairment ratings for injuries prior to January 1, 2000 will be determined in accordance with Policy 3.3.2R4. Pain-related impairment ratings will be determined in accordance with Policy 3.3.5R1.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), (as amended), Sections 34, 37(2), 37(3), 35.
Policy 3.3.2R3.

Policy Number: 3.3.5R1

Topic: Eligibility Criteria and Compensation related to chronic pain
Section: Short-Term and Long-Term Benefits
Subsection: Compensation related to chronic pain

Effective: November 19, 2007
Issued: October 1, 2008
Approved by Board of Directors: September 18th, 2008

Preamble

The *Chronic Pain Regulations* provide a high level framework and general eligibility criteria for compensation related to chronic pain.

Policy Statement

Subject to the limitations set out in this Policy and in other Board policies, the Board shall use an individualized assessment based on Chapter 18 of the American Medical Association "Guides to the Evaluation of Permanent Impairment - Fifth Edition", as modified by the *Chronic Pain Regulations* and this policy, to determine the existence and degree of a worker's pain-related impairment.

Definitions

1. "**Chronic Pain**," as defined in section 10A, means pain:

   (a) continuing beyond the normal recovery time for the type of personal injury that precipitated, triggered or otherwise predated the pain; or

   (b) disproportionate to the type of personal injury that precipitated, triggered, or otherwise predated the pain;

   and includes chronic pain syndrome, fibromyalgia, myofascial pain syndrome, and all other like or related conditions, but does not include pain supported by significant, objective, physical findings at the site of the injury which indicate the injury has not healed.

2. "**Individualized assessment**" means an assessment consisting of a medical examination and/or a file review depending on which approach, in the opinion of the Board, is most appropriate.

3. "**Normal recovery time**" means an estimate determined by the Board of the normal time required for workers with a specific type of personal injury to return to work after the injury.

4. "**Permanent impairment**" means impairment associated with a permanent medical impairment and/or a pain-related impairment.

5. "**Permanent medical impairment**" means any impairment that has become static or stabilized and that is unlikely to improve despite further medical treatment. A permanent medical impairment also accounts for the usual pain that accompanies the type of injury and resulting impairment.

6. "**Usual pain**" means all pain except for chronic pain as defined by the *Act*, *Chronic Pain Regulations* and this policy.

7. "**Pain-related impairment**" means impairment associated with chronic pain.

8. "**Slight**" pain-related impairment means a pain-related impairment that has, in the opinion of the Board, increased the impact of the worker's original compensable injury mildly to moderately as described in Table 18-3 of Chapter 18 of the American Medical Association "Guides to the Evaluation of Permanent Impairment-Fifth Edition." In determining the appropriate class of impairment, the WCB will use a Pain-Related Impairment Assessment Tool as outlined in Appendix A.

9. "**Substantial**" pain-related impairment means a pain-related impairment that has, in the opinion of the Board, increased the impact of the worker's original compensable injury moderate severely to severely as described in Table 18-3 of Chapter 18 of the American Medical Association "Guides to the Evaluation of Permanent Impairment-Fifth Edition". In determining the appropriate class of impairment, the WCB will use a Pain-Related Impairment Assessment Tool as outlined in Appendix A.

10. "**Original compensable injury**" means a personal injury by accident arising out of and in the course of employment

    ii. that the Board has accepted or may accept as compensable under the Act; and

    that pre-dates the commencement of the worker's chronic pain.

11. "**Unratable pain**", as contemplated by the American Medical Association "Guides to the Evaluation of Permanent Impairment-Fifth Edition," means controversial and ambiguous pain syndromes that cannot be related to a well-established medical condition and are not widely accepted by physicians as having a well-defined pathophysiological basis. Unratable pain includes chronic pain syndrome, fibromyalgia and myofascial pain syndrome.

Eligibility

12. A worker is entitled to an assessment to determine eligibility for benefits and services outlined in the *Chronic Pain Regulations* where the medical evidence establishes that on or after April 17, 1985, the worker had chronic pain that is causally connected to an original compensable injury.

13. A pain-related impairment will be assessed using a modified approach to Chapter 18 of the American Medical Association "Guides to the Evaluation of Permanent Impairment-Fifth Edition". In determining the appropriate class of impairment, the WCB will use a Pain-Related Impairment Assessment Tool as outlined in Appendix A. In cases where a worker's pain is considered "unratable", the worker will be assessed using the approach described in this policy. Considering the overall assessment findings, the Board Medical Adviser will make a clinical judgment as to the recommended pain-related impairment in accordance with the rating schedule outlined in paragraph #14.

14. Where a worker is found to have a pain-related impairment, the Board shall pay the worker a permanent benefit based upon a permanent impairment rating of 3% where the worker experiences a slight pain-related impairment or 6% where the worker experiences a substantial pain-related impairment.

15. Permanent impairment ratings are expressed as a percentage of total body impairment with one hundred percent (100%) being the maximum possible rating. Subject to paragraph #26, in the case of a pain-related impairment 6% is the maximum possible rating any one person can receive for chronic pain.

16. Where a worker's original compensable injury occurred before March 23, 1990, and the worker is found to have a pain-related impairment, the worker's permanent benefit will be calculated in accordance with sections 226 and 227 of the *Act* and the worker is not eligible to receive an Extended Earnings Replacement Benefit (EERB).

17. Where a worker's original compensable injury occurred on or after March 23, 1990 and the worker is found to have a pain-related impairment, the worker's permanent benefits will be calculated in accordance with sections 34-48 of the *Act* and the worker may be eligible to receive an EERB.

18. Subject to sections 34-48 and 229 of the *Act*, where a worker is eligible to receive a permanent benefit in accordance with this Policy, the Board will commence payment of the benefit from the date on which the Board determines the worker has a pain-related impairment.

Section 10D – AIEL Population

19. Where a worker with chronic pain has been awarded benefits in accordance with section 10D of the *Act*, the worker is entitled to an individualized assessment and where eligible a calculation of benefits in accordance with the *Chronic Pain Regulations* and Policy.

20. Subject to sections 226 and 227 of the *Act*, for periods in which a worker was in receipt of a Clinical Ratings Scale (CRS) pension for the original compensable injury, the worker is eligible to receive a benefit in accordance with this Policy commencing the date on which the Board determines the worker has a pain-related impairment.

21. With the coming into force of the current *Act,* where an Amended Interim Earnings Loss (AIEL) award was replaced by a CRS pension, the worker is eligible to receive a benefit in accordance with this policy commencing the date the CRS pension was reinstated.

22. For periods in which a worker, now in receipt of a section 10D award, was in receipt of an AIEL award, the Board shall compare the AIEL benefit including the pain-related impairment for chronic pain to the cumulative CRS pension including the pain-related impairment for chronic pain, and shall pay the worker which ever is greater until age 65.

23. Upon reaching the age of 65 years, a worker who was in receipt of an AIEL award shall receive an amount equivalent to the cumulative CRS pension, including the pain-related impairment for chronic pain.

Section 10E Population

24. Where a worker with chronic pain has been awarded benefits in accordance with section 10E of the *Act*, the worker is entitled to an individualized assessment and recalculation of benefits in accordance with the *Chronic Pain Regulations* and Policy.

25. Subject to sections 34 to 48 of the *Act*, where the recalculation results in a greater combined EERB/PIB benefit than that awarded under section 10E, the Board will pay the worker

    i. the recalculated award from the date the Board determines the worker has a pain-related impairment until the date section 10E benefits commenced; and

    the difference between the recalculated award and the section 10E benefits from the date the worker's section 10E benefits commenced until the coming into force of the *Chronic Pain Regulations*; and

    effective the date the *Chronic Pain Regulations* come into force, the recalculated award.

26. Subject to sections 34 to 48 of the *Act*, where the recalculation results in a lesser combined EERB/PIB benefit than that awarded under section 10E, the worker shall be entitled to:

    i. the recalculated award from the date the Board determines the worker has a pain-related impairment until the date section 10E benefits commenced; and

    ii. effective the date the worker's section 10E benefits commenced, the section 10E award is continued.

Application

This Policy applies to all decisions made on or after November 18, 2007 as it relates to chronic pain. This Policy replaces Policy 3.3.5 issued on September 13, 2004 and effective September 10, 2004.

References

An Act to Amend Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act* (Chapter 1, Acts of 1999). *Chronic Pain Regulations*. Policy 2.4.7R1 and Policy 7.3.14

Appendix A - PRI Assessment Tool

Assessment Questions	**Descriptors for pain related impairment categories**			**Supporting documentation Medical Adviser's reasoning for decision**
Section A **Medical Information** - Sources: GP reports, Specialist reports, Board Medical Adviser For claims closed prior to the passing of the chronic pain regulations, the medical adviser may deviate from the above sources when information is not available, and use the worker's self report tool(s) such as I3 or ADL questionnaire.				
	No Pain related impairment	**Slight**	**Substantial**	**Medical Adviser's Comments**
1. Examining the worker's medical history, what level of pain has the worker exhibited? **Score 0 for no pain, 10 for most severe pain** a) What is the level of pain on average? (0-10) b) What is the level of pain at its worst? (0-10) c) How frequently does the worker experience pain? (1-10) **Average score = (a+b+c) / 3**	Average score = 0 out of 10 ❑	Average score = 1 to 5 out of 10 ❑	Average score = 6 to 10 out of 10 ❑	
2. Again, using the worker's medical history, is the worker's pain aggravated by activity?	No pain at rest or during activity ❑	Pain is mildly or moderately aggravated by activity ❑	Pain is severely aggravated by activity ❑	

3. How often does the worker visit a physician due to their pain?	Worker does not see physician ❑	Worker sees physician no more than once per month ❑	Worker sees physician more than once per month ❑
4. Is the worker using medication due to their pain?	Worker does not take medication ❑	Worker takes medication daily or as needed. May take OTC meds on a regular basis, but does not have a regular prescription for pain ❑	Worker takes the regular maintenance dosage of prescription medication to control pain ❑
5. Upon examination, does the worker demonstrate any limitations in their functional abilities due to their pain? *ie range of motion*	Worker appears to be able to perform with no difficulty and no modifications ❑	Worker has minimal or moderate difficultly performing them and is able to perform with reasonable modifications ❑	Worker has extreme difficultly performing them and is only able to perform with substantial modifications or assistance ❑

Section B

Activities of Daily Living Information - Source: Worker's self report information (i.e. Impairment Impact Inventory Form (I3) or Activities of Daily Living questionnaire)

	No Pain related impairment	**Slight**	**Substantial**	**Medical Adviser's Comments**
1. Considering only information provided by the worker, what is the increased impact of pain on the following types of activities? • Impact on Walking • Impact on Standing • Impact on Sitting • Impact on Lifting • Other: *Household chores, dressing, bathing, eating, shopping, etc.* • Impact on worker's socialization and recreation	Overall, worker is able to perform with no difficulty and no modifications ❑	Overall, worker has minimal or moderate difficultly performing them and is able to perform with reasonable modifications ❑	Overall, worker has extreme difficultly performing them and is only able to perform with substantial modifications or assistance ❑	
2. What is the impact on the worker's sleep due to their pain? *Determine both sleep interference & requirement for sleep aids.*	No interference & no aids required ❑	Minor interference. Sleep aids required occasionally ❑	Major interference Regular use of sleep aids ❑	

3. What is the impact on the worker's sexual activities due to their pain? *Use only if information is already available or volunteered, do not specifically request from worker.*	No impact ❑	Workers has minimal or moderate difficulty performing ❑	Worker has extreme difficultly performing or not able to perform at all ❑	
4. What is the impact on the worker's cognitive abilities due to their pain? *i.e. Their ability to concentrate; to write letters, answer the phone, etc.*	No impact ❑	Workers has minimal or moderate difficulty performing ❑	Worker has extreme difficultly performing or not able to perform at all ❑	
Section C **Emotional Distress -** Sources: psychiatrists, psychologists, worker, employer, GPs or specialists, physiotherapists, case workers.				
	No Pain related impairment	**Slight**	**Substantial**	**Medical Adviser's Comments**
1. Does the worker appear to be experiencing emotional distress due to pain? *i.e. Depressed, frustrated, anxious, irritable, worried, afraid, stressed.*	Worker's emotional state is not affected by pain ❑	Worker's emotional state is occasionally affected by pain ❑	Worker's emotional state is frequently affected by pain ❑	

Section D

Functional Abilities - Sources: health professional (i.e. Physiotherapist, Occupational Therapist, Kinesiologist)

	No Pain related impairment	**Slight**	**Substantial**	**Medical Adviser's Comments**
1. Does the worker have the functional ability to perform activities such as: • Range of Motion • Lifting, Pushing & Pulling • Hand Strength • Sitting & Standing • Gross Mobility *(ie. Walking, carrying, climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling)*	Overall, worker is able to perform with no difficulty and no modifications ❑	Overall, worker has minimal or moderate difficultly performing them and is able to perform with reasonable modifications ❑	Overall, worker has extreme difficultly performing them and is only able to perform with substantial modifications or assistance ❑	
2. During the evaluation, what degree of pain does the worker exhibit? *Ie. What are the objective signs of pain, frequency of pain, need for unscheduled breaks b/c of pain, etc.*	Worker is aware of pain but no handicap in the performance of activity ❑	Worker can tolerate pain but there is <u>some</u> to <u>marked</u> handicap in the performance of activity ❑	Worker cannot tolerate pain and it <u>precludes</u> them from performing the activity ❑	

Subtotal	**No Pain related impairment**	**Slight**	**Substantial**	
Subtotal the number of ratings in each PRI category to determine the pain picture.				The Board Medical Advisor performs a consistency check to determine if the tool presents a consistent picture of the impact pain is having on the original compensable injury before recommending the final PRI rating.

Section E

Final considerations

In this section, the Board Medical Adviser should consider each of the questions included in Section E and provide responses to those question that are relevant to the claim at hand.

The Medical Adviser needs to consider if the information is presenting a consistent or conflicting picture of the impact pain is having on the worker's original compensable injury. In contemplating this issue, the Medical Adviser may want to consider the following:	If information is conflicting, the Medical Adviser should: (1) Determine if there is any outstanding formal tests that could be performed; and/or (2) Perform a formal in-person PRI exam to gather more information. If the Medical Adviser does not believe additional information is available or would help resolve the discrepancy, he/she will make a clinical judgment re the appropriate PRI rating.
Is worker's report of Activities of Daily Living ability consistent with Functional Abilities (FA) information?	
Does FA information support pain related limitations identified during PRI exam? Does FA information related to degree of pain support level of pain in medical section?	
Is information about worker's pain level consistent with emotional distress level?	

Does the worker exhibit any pain behaviors upon interview or examination? *(As outlined in Chapter 18, Table 18-5)*	
Section F **Final PRI Determination**	
PRI Rating recommended:	Medical Advisor's final comments:
Section G **Summary of Permanent Impairment**	

Step #1 Document the worker's diagnosis

Step #2 Document the worker's PMI rating (if any)

Step #3 Is the worker's pain already compensated for under their existing PMI?

Step #4 Complete the PRI Assessment Tool

Step #5 Document the PRI Rating recommended

Step #6 Document the worker's **Total Impairment Rating**:

PMI = _____ **PRI =** _____

(1) If PMI assigned under PMI Guidelines,

PMI + PRI = _____ *Total Impairment Rating*

(2) If PMI assigned under AMA 4th Guides,

PMI combined with PRI = _____ Total Impairment Rating

Subsection 3.4 – Extended Earnings-Replacement Benefit (EERB)

- **Policy Number: 3.4.1R1 – Calculation of Extended Earnings-Replacement Benefit**
- **Policy Number: 3.4.2R2 - Review of Extended Earnings-Replacement Benefit**

Policy Number: 3.4.1R1

Topic: Calculation of Extended Earnings-Replacement Benefit
Section: Short-Term and Long-Term Benefits
Subsection: Extended Earnings-Replacement Benefit (EERB)

Effective: September 10th, 2004
Issued: September 13th, 2004
Approved by Board of Directors: September 9th, 2004

Policy Statement

1. An Extended Earnings-Replacement Benefit (EERB) may be paid to a worker whom the Board determines has been left with a permanent impairment as a result of a work-related injury and who is experiencing a loss of earnings as a result of the permanent impairment.

2. An EERB is payable from the later of:

    a) the date on which the Board determines the worker has a permanent impairment (i.e. The worker has attained maximum medical recovery and a permanent impairment assessment has been completed); or

    b) the date on which the worker completes a rehabilitation program (this includes the date vocational rehabilitation services have been determined to be inappropriate or discontinued).

3. The amount of the EERB, if it is payable within the first 26 weeks of compensation, will be 75% of the worker's net loss of earnings (LOE) less the Permanent Impairment Benefit (PIB) for that injury. After 26 cumulative weeks of compensation the amount of the EERB will be increased to 85% of the worker's net loss of earnings less the PIB for that injury.

4. The loss of earnings is equal to the net pre-LOE average earnings less net post-LOE earnings. The following will be included in post-LOE earnings:

    i) earnings from employment;

    ii) earnings that the Board estimates the worker is capable of earning in suitable and reasonably available employment; and

    iii) 50% of Canada Pension Plan (CPP) or Quebec Pension Plan (QPP) disability benefits.

5. The EERB must be reduced if the EERB, combined with any other compensation paid pursuant to this Act and any benefits (excluding Survivors Benefits) from a predecessor Act, are greater than 75% (first 26 weeks of compensation) or 85% (after 26 weeks) of the net maximum assessable earnings at the time of the injury (the net calculation of the maximum assessable earnings will be based on the individual worker's tax credits).

Application

This Policy replaces Policy 3.4.2R, issued May 17, 1999, and effective April 16, 1999. This Policy applies to workers injured on or after March 23, 1990 who have been awarded an EERB.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 37, 38, 48, 75(3), 228. An Act to Amend Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act* (Chapter 1, Acts of 1999), Clauses 4 and 5.

Policy Number: 3.4.2R2

Topic: Review of Extended Earnings-Replacement Benefit
Section: Short-Term and Long-Term Benefits
Subsection: Extended Earnings-Replacement Benefit (EERB)

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. Extended Earnings-Replacement Benefits (EERBs) will be reviewed 36 months after the date the EERB was determined.

2. This review will also take place for all workers who would be receiving an EERB if it were not for the fact that their Permanent Impairment Benefit (PIB) is greater than 85% of their loss of earnings. In these cases, the review date will be 36 months after the permanent impairment rating determination. Subsequent reviews (see paragraphs 3, 4, and 5) will be based on the same criteria as the EERB.

3. An EERB may be reviewed 24 months after the 36-month review, if it is determined to be necessary by the Board at the time of the 36 month review. As a general guideline, an EERB will be reviewed a second time if the worker has not established a consistent earnings pattern during the first 36 months the worker was in receipt of the EERB or the worker has shown significant deterioration in their compensable condition. The Board may choose not to set another review date if the information on the file indicates the worker's employment pattern, although casual or seasonal, is still an established pattern.

4. An EERB may be reviewed at any time if:

    a) a review of a permanent impairment rating results in an adjustment to the Permanent Impairment rating of at least ten percentage points, or
    b) it is determined the EERB was based on misrepresentation of fact.

5. The EERB (or EERB that would be payable but for the fact that the worker's PIB is greater then 85% of the loss of earnings) will not be increased or decreased unless the adjustment is equal to or greater than 10% of the compensation currently being paid to the worker as a result of the injury.

Application

This Policy is effective for decisions made on or after December 16, 2021. This Policy applies to workers injured on or after March 23, 1990 who have been awarded an EERB. This Policy replaces Policy 3.4.2R1 that was effective September 10, 2004.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 73, 228. An Act to Amend Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act,* Clause 9.

Subsection 3.5 – Estimation of Earnings Ability

- **Policy Number: 3.5.1 - Definition of Suitable Employment**
- **Policy Number: 3.5.2 - Definition of Reasonably Available Employment**
- **Policy Number: 3.5.3 - Wage Rate to be Used in Estimating Earning Ability**

Policy Number: 3.5.1

Topic: Definition of *Suitable* Employment
Section: Short-Term and Long-Term Benefits
Subsection: Estimation of Earnings Ability

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: November 19, 1993

Policy Statement

1. 'Suitable' employment is any employment which the worker has the necessary skills to perform, is medically able to perform, and which does not pose a health or safety hazard to the worker or any co-worker.

Guidelines

1. Where a worker experiences a loss of earnings (LOE), the WCB is required--in order to calculate the worker's compensable loss of earnings--to determine the amount, if any, that the worker is capable of earning in suitable and reasonably available employment.

2. For employment to be suitable for a given worker, it must be in keeping with the worker's physical and mental capacities. The employment cannot involve adverse consequences for the worker's health, either immediately or in the long term.

3. For employment to be suitable does not require that the employment necessarily be "the same as" or "comparable to" the worker's pre-accident employment. However, estimation of potential earning ability (EPEA) will occur after the worker has been considered for a vocational rehabilitation plan, based on a hierarchy of objectives which emphasizes a return to work with the pre-accident employer.

4. In instances where a worker fails to cooperate in the development or implementation of a vocational rehabilitation program, suitable employment can include employment that would have been suitable for the worker (using the above criteria to define 'suitable') had the worker successfully completed an appropriate vocational rehabilitation program.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 38(b)(ii).

Policy Number: 3.5.2

Topic: Definition of *Reasonably Available* Employment
Section: Short-Term and Long-Term Benefits
Subsection: Estimation of Earnings Ability

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: November 19, 1993

Policy Statement

1. Employment will be said to be 'reasonably available' if there are currently employment opportunities within the worker's home area (as defined below), and the worker has a reasonable chance of securing employment.

2. The 'home area' of a worker is defined as all points up to 100 km from the worker's ordinary place of residence, or a greater distance if the worker was travelling a greater distance to work prior to the accident.

3. Employment opportunities outside the worker's home area may be taken into consideration when:

    a) it is reasonable to do so, considering relevant characteristics of the worker (age, skills, occupation, education attainment, family situation, etc.); AND

    b) the worker has:

        (i) received a specific job offer at the new location; or

        (ii) in the opinion of the Board, not made a genuine effort to secure employment or a reasonable effort to present himself/herself well at job interviews. If the worker refuses to avail of such employment opportunities (which include relocation at Board's expense), the Board may base an estimation of potential earning ability (EPEA) on such an employment opportunity.

Guidelines

1. Where a worker experiences a loss of earnings (LOE), the WCB is required - in order to calculate the worker's compensable loss of earnings - to determine the amount, if any, that the worker is capable of earning in suitable and reasonably available employment.

2. In determining whether employment is reasonably available to an injured worker, there are two key dimensions to consider:

    a) **employment opportunities** - how much demand is there for the occupations which are suitable for the worker; and

    b) **distance** - the distance from the worker's pre-accident home to the place(s) of potential employment.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 38(b)(ii).

Policy Number: 3.5.3

Topic: Wage Rate to be Used in Estimating Earning Ability
Section: Short-Term and Long-Term Benefits
Subsection: Estimation of Earnings Ability

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: November 19, 1993

Policy Statement

The wage rate to be used in estimating a worker's earning ability will be determined on a case-by-case basis, with the general guideline that the regional ('home area') average wage for the occupation in question should generally be used - or, where that information is not available, the provincial average wage rate for the occupation in question.

Guidelines

1. Where a worker experiences a loss of earnings (LOE), the WCB is required - in order to calculate the worker's compensable loss of earnings - to determine the amount, if any, that the worker is capable of earning in suitable and reasonably available employment.

2. Once it has been determined that a specific occupation is suitable for a worker, and that employment in that occupation is reasonably available to that worker, the issue arises of which wage/salary rate should be used to determine the amount the worker is capable of earning in that occupation/employment.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 38(b)(ii).

Subsection 3.6 – Annuities

- **Policy Number: 3.6.1 - Amounts to be Reserved to Provide Annuity**
- **Policy Number: 3.6.2 - Annual Reporting of Amount in Annuity Accounts**
- **Policy Number: 3.6.3 - Payment at Age 65**
- **Policy Number: 3.6.4 - Payment When EERB Commuted**
- **Policy Number: 3.6.5 - Payment Where Intended Recipient Dies Before Becoming Eligible to Receive Payments**
- **Policy Number: 3.6.6 - Payment Where Intended Recipient Dies After Becoming Eligible for Payments**
- **Policy Number: 3.6.7R - Apportionment Where More Than One Spouse Qualifies**
- **Policy Number: 3.6.8 - Interest to be Applied to an Annuity Account**
- **Policy Number: 3.6.9R1 - Periodic Payment of Annuities**

Policy Number: 3.6.1

Topic: Amounts to be Reserved to Provide Annuity
Section: Short-Term and Long-Term Benefits
Subsection: Annuities

Effective: February 1, 1996
Issued: December 15, 1995
Approved by Board of Directors: March 2, 1995

Policy Statement

1. When a worker becomes entitled to an extended earnings replacement benefit (EERB), an amount equal to five percent of the combined value of the EERB and the worker's permanent impairment benefit (PIB) will be set aside by the Board to provide an annuity for the worker.

2. Where a loss of earnings results from an injury and the worker is in receipt of a Permanent Impairment Benefit and no Extended Earnings Replacement Benefits are payable, contributions at five percent of the lesser of

   a) 85% of the loss of earnings; or

   b) the worker's Permanent Impairment Benefit for that claim

   will be set aside to provide an annuity for the worker.

3. Further, when a person is eligible for a survivor's pension, the Board shall set aside an amount equal to five percent of the value of the survivor pension to provide an annuity for the surviving spouse.

Application

This Policy applies to workers injured on or after March 23, 1990.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 50 and 66(1).

Policy Number: 3.6.2

Topic: Annual Reporting of Amount in Annuity Accounts
Section: Short-Term and Long-Term Benefits
Subsection: Annuities

Effective: February 1, 1996
Issued: December 15, 1995
Approved by Board of Directors: March 2, 1995

Policy Statement

1. When a person is eligible to have an annuity reserved on their behalf (i.e. contributions are being made to an annuity account) a report shall be made to that person on an annual basis which describes

    a) the accumulated principal, to date;

    b) the accumulated interest, from prior years; and

    c) the current year's interest.

Application

This Policy applies to workers injured on or after March 23, 1990.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 50.

Policy Number: 3.6.3

Topic: Payment at Age 65
Section: Short-Term and Long-Term Benefits
Subsection: Annuities

Effective: February 1, 1996
Issued: December 15, 1995
Approved by Board of Directors: March 2, 1995

Policy Statement

1. When a worker reaches 65 years of age, payment of the annuity shall be made by lump sum when the annuity account (principal + interest) is below the level prescribed by regulation pursuant to Section 52(1)(b) ($10,000), unless the worker elects otherwise.

2. When a surviving spouse reaches 65 years of age, or the deceased worker would have reached 65 years of age (whichever is later) payment of annuity shall be made by lump sum when the accumulated value of the annuity account (principal + interest) is below the level prescribed by regulation pursuant to Section 52(1)(b) ($10,000), unless the surviving spouse elects otherwise.

Application

This Policy applies to workers injured on or after March 23, 1990.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 52(1)(b).

Policy Number: 3.6.4

Topic: Payment When EERB Commuted
Section: Short-Term and Long-Term Benefits
Subsection: Annuities

Effective: February 1, 1996
Issued: December 15, 1995
Approved by Board of Directors: March 2, 1995

Policy Statement

Where a worker has received payment of an extended earnings replacement benefit (EERB) as a lump sum (i.e. commuted value) in lieu of periodic instalments, payment of annuity as a lump sum (i.e. commuted value) prior to age 65 will be considered.

Application

This Policy applies to workers injured on or after March 23, 1990.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 52(1)(b) and 74.

Policy Number: 3.6.5

Topic: Payment Where Intended Recipient Dies Before Becoming Eligible to Receive Payments
Section: Short-Term and Long-Term Benefits
Subsection: Annuities

Effective: February 1, 1996
Issued: December 15, 1995
Approved by Board of Directors: March 2, 1995

Policy Statement

1. Where a person entitled to receive an annuity dies before becoming eligible to receive annuity payment, then an amount equivalent to the accumulated capital and interest shall be paid as a lump sum [pursuant to Section 56(1)]

    a) where the person is survived by a spouse, to the spouse; or

    b) where the person is survived by the dependent children, but not a spouse, to the dependent children.

2. In accordance with Section 58(1), where there is no surviving spouse or dependent child for the purpose of Section 56, the accumulated capital and interest shall be paid into the Accident Fund.

Application

This Policy applies to workers injured on or after March 23, 1990.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 56(1) and 58(1).

Policy Number: 3.6.6

Topic: Payment Where Intended Recipient Dies After Becoming Eligible for Payments
Section: Short-Term and Long-Term Benefits
Subsection: Annuities

Effective: February 1, 1996
Issued: December 15, 1995
Approved by Board of Directors: March 2, 1995

Policy Statement

1. When a person for whom an annuity account has been established becomes eligible to receive annuity payments the Board shall pay the accumulated annuity account (capital and interest) as a lump sum if less than the amount established by regulation, pursuant to Section 52(1)(b) [$10,000], unless the person elects otherwise.

2. In the event of the recipient's death after becoming eligible for annuity payment, the annuity account shall be paid to any person designated by the recipient in a manner satisfactory to the Board. The payment shall be made as a lump sum unless the designated person elects otherwise.

3. If there is no such designation made, the annuity account shall be paid to the surviving spouse or, if there is no surviving spouse, to the dependent children (if any). The payment shall be made as a lump sum unless the spouse/children (as applicable) elect otherwise.

Application

This Policy applies to workers injured on or after March 23, 1990.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 57.

Policy Number: 3.6.7R

Topic: Apportionment Where More Than One Spouse Qualifies
Section: Short-Term and Long-Term Benefits
Subsection: Annuities

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. Where the Board apportions a survivor pension among more than one surviving spouse [pursuant to Section 63(2)], annuity contributions will be made for each spouse, based on five percent of the value of the survivor pension payable to each spouse.

2. Once one spouse ceases to qualify for the survivor pension the whole of the survivor pension will be reapportioned among the remaining surviving spouses. Annuity contributions will then be based on five percent of the reapportioned amount payable to each remaining spouse.

Application

This Policy applies to workers injured on or after March 23, 1990.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 63(2) and 66(1).

Policy Number: 3.6.8

Topic: Interest to be Applied to an Annuity Account
Section: Short-Term and Long-Term Benefits
Subsection: Annuities

Effective: February 1, 1996
Issued: July 19, 1996
Approved by Board of Directors: April 12, 1996

Policy Statement

1. At the end of each month, an amount of interest, based on the Annual Five-Year Guaranteed Investment Certificate Rate of Return as reported by the Bank of Canada as of December 31 of the preceding year, shall be applied to the accumulated value of the annuity account (including interest applied to date).

Guidelines

1. The interest applied monthly will be the annual rate (as stated above) prorated. For example, if the annual rate for 1995 was 8%, the rate applied to the balance of the annuity account in 1996 would be 0.67% per month (8%/12 months).

Application

This Policy applies to workers injured on or after March 23, 1990.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 52(1).

Policy Number: 3.6.9R1

Topic: Periodic Payment of Annuities
Section: Short-Term and Long-Term Benefits
Subsection: Annuities

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. If the accumulated value (interest and principal) of the annuity is over $10,000, or if requested by the worker, the payments will be made periodically (monthly).

2. Administration of the annuities payments, on behalf of the Board, will be done by a financial institution. All payments made by the financial institution will maintain their tax-free status.

3. Upon application, the Board may allow the worker to choose a financial institution other than the one employed by the Board to administer their annuity.

Application

This Policy is effective December 16, 2021. This Policy applies to workers injured on or after March 23, 1990. This Policy replaces Policy 3.6.9 that was effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 52(1).

Subsection 3.7 - Permanent Disability Pensions: Injuries Before March 23, 1990

- **Policy Number: 3.7.1 - Pension Benefits**
- **Policy Number: 3.7.2R1 - Commutation of Pensions**

Policy Number: 3.7.1

Topic: Pension Benefits
Section: Short-Term and Long-Term Benefits
Subsection: Permanent Disability Pensions: Injuries Before March 23, 1990

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: March 3, 1995

Policy Statement

1. Where:

   a) a worker was injured before March 23, 1990; and

   b) as of February 1, 1996, is receiving or entitled to receive compensation for permanent disability;

   the Board shall pay the compensation (calculated in accordance with the former Act) for the lifetime of the worker.

2. Indexing of these awards will be pursuant to Section 70 of the Act (Chapter 10, Acts of 1994-95).

3. Review of these awards will be pursuant to Section 71 of the Act.

Guidelines

Under the former Act (Chapter 508, Revised Statutes of Nova Scotia, 1989), compensation for permanent disability was 75% of the gross average weekly earnings of the worker before the accident, multiplied by the permanent impairment rating determined by the Board.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 70, 71, 226, and 227.

Policy Number: 3.7.2R1

Topic: Commutation of Pensions
Section: Short-Term and Long-Term Benefits
Subsection: Permanent Disability Pensions: Injuries Before March 23, 1990

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. The overriding principle in workers' compensation is to provide a replacement of income lost as a result of injury and there is a presumption in favour of periodic payments.

2. The Board may commute permanent-disability pension payments due or payable to a worker to a lump sum in accordance with the Act and this Policy.

3. "Commutation" means the calculation of the present value of all or part of a periodic permanent disability pension, and payment to a worker of an equivalent lump sum.

4. A commutation is final. A claim will only be re-opened in accordance with Section 71 of the Act.

5. A worker who has received a commuted pension maintains eligibility for medical aid, rehabilitation and other services to which the worker is otherwise entitled under the Act.

Stability

6. It is normally a pre-condition for commutation of a worker's periodic pension that the worker's injury-related medical condition is stable.

Commutation if Impairment is 10% or Less

7. The Board will provide a worker who has been assessed as having a permanent impairment rating of 10% or less with the option of receiving their pension as a series of periodic payments or as an equivalent lump sum. This option will also be provided to a worker who has previously received a commuted pension and whose pension is reviewed and adjusted by the Board in accordance with Section 71 of the *Act*.

8. Nevertheless, the Board may choose not to commute a pension where, in the Board's opinion, it would not be to the worker's advantage to do so.

9. For example, the Board will not normally commute a pension if the Board becomes aware that the worker is likely to use the lump sum otherwise than for the benefit of the worker and the worker's dependants.

Commutation If Impairment is More Than 10%

10. There are four types of commutation that will be considered by the Board:

    i) a commutation of the whole pension, resulting in termination of pension payments;

    ii) a commutation for a term of years, resulting in suspension of pension payments for a fixed term followed by resumption of full payment;

iii) a commutation of a portion of the pension, resulting in a reduced pension level for life;

iv) a commutation of a portion of the pension for a term of years resulting in a reduced pension for a fixed term followed by resumption of full payments.

11. Regardless of which type of commutation is requested, this Policy will be applied as if the request were for commutation of the whole pension.

12. As a guide to the exercise of its discretion, the Board will normally not commute a periodic pension if it is satisfied that:

    a) the commuted pension is to be applied for a purpose other than an approved purpose;

    b) the worker is now or is likely in the future to be dependent on the periodic pension for the necessities of life;

    c) the commutation is not in the best long-term interests of the worker;

    d) there are other sources of funds that are accessible and appropriate.

13. An approved purpose is, in general, a purpose that is calculated to strongly enhance the worker's vocational rehabilitation.

Application

This Policy is effective December 16, 2021. This Policy applies where a worker was injured before March 23, 1990 and is awarded compensation for permanent disability. It replaces Policy 3.7.2R that was effective April 3, 1997.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 74(2), 226, 227.

Subsection 3.8 - Supplementary Benefits

- **Policy Number: 3.8.1R4 - Eligibility Criteria**

Policy Number: 3.8.1R4

Topic: Eligibility Criteria
Section: Short-Term and Long-Term Benefits
Subsection: Supplementary Benefits

Effective: September 10th, 2004
Issued: September 13th, 2004
Approved by Board of Directors: September 9th, 2004

Policy Statement

1. To be eligible for a supplementary benefit, a WCB pensioner must:

   a)

   (i) be an injured worker receiving a permanent-disability pension for an injury incurred before March 23, 1990;

   (ii) be receiving a pension, pursuant to the former *Act*, as a surviving spouse or invalid child of a worker whose compensable death occurred before February 1, 1996; *or*

   (iii) be receiving a reinstated amended interim earnings loss benefit pursuant to section 10D of "An Act to Amend Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act* (Chapter 1, Acts of 1999)."

   and

   b) be receiving *periodic* compensation--that is, be receiving a monthly pension, as opposed to having received a lump sum pension;

   and

   c) have a personal income below one-half the average industrial wage for Nova Scotia as prescribed by regulation. ("Personal income" shall be equal to 'Total Income' as defined by Canada Customs and Revenue Agency for purposes of individual income tax returns, minus income received that year in the form of Supplementary Benefits from the Board).

   Retroactive payments made under the *Chronic Pain Regulations* will not be considered income for purposes of paragraph 1(c).

   and

   d) meet any additional conditions prescribed by regulation.

Guidelines

1. In order to be eligible for supplementary benefits, WCB pensioners referred to in paragraph 1(a)(i) of this policy must meet the following additional conditions prescribed by regulation:

   a) be receiving a disability pension under the Canada Pension Plan or the Quebec Pension Plan (CPP/QPP) for the worker's compensable injury;

   or

b) in the opinion of the Board, be ineligible to receive a CPP/QPP disability pension for the worker's compensable injury only because the worker has made insufficient or no contributions to CPP/QPP.

2. The amount of a supplementary benefit is the amount necessary to increase an applicant's individual annual personal income to an amount equal to one-half of the average industrial wage for Nova Scotia.

3. Eligibility for a supplementary benefit continues until the month after the month in which the WCB pensioner attains the age of sixty-five years. Eligibility for a supplementary benefit is generally reviewed annually by the Board.

Application

This policy replaces Policy 3.8.1R3 issued January 27th, 2003 effective October 1st, 2002. This Policy applies to all decisions made on or after September 10th, 2004.

References

Section 10 D and Section 227 of the Workers' Compensation Act (Chapter 10, Acts of 1994-95) (as amended), and Sections 28-33 of the General Regulations (as amended), and the Chronic Pain Regulations.

Subsection 3.9 - General

- **Policy Number: 3.9.1R - Maximum Insurable/Assessable Earnings**
- **Policy Number: 3.9.2 - Duration of ERB and PIB Benefits**
- **Policy Number: 3.9.3R - Combining of Worker's Compensation Benefits**
- **Policy Number: 3.9.5 - Commutation of PIBs and EERBs**
- **Policy Number: 3.9.6R1 - Implementation of Appeal Board Decisions on Permanent Compensation in the Absence of Measurable Impairment**
- **Policy Number: 3.9.10 - Payment of Interest on Transitional Benefits**
- **Policy Number: 3.9.11R1 - Apportionment of Benefits**
- **Policy Number: 3.9.12 - Inflation-Indexing of benefits**

Policy Number: 3.9.1R

Topic: Maximum Insurable/Assessable Earnings
Section: Short-Term and Long-Term Benefits
Subsection: General

Effective: May 27, 2002
Issued: May 27, 2002
Approved by Board of Directors: March 15, 2002

Policy Statement

For purposes of Section 41(c), "average industrial wage for the Province" is defined as being equal to 'Average weekly earnings, for all employees, industrial aggregate, Nova Scotia,' as reported by Statistics Canada, for the 12-month period ending March 31 of the year prior to the year in which this average will apply, for purposes of calculating maximum earnings.

Application

This Policy applies to all decisions made on or after May 27, 2002. It replaces Policy 3.9.1 issued on December 1, 1995 and effective January 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 38(b)(ii)

Policy Number: 3.9.2

Topic: Duration of ERB and PIB Benefits
Section: Short-Term and Long-Term Benefits
Subsection: General

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: March 1, 1995

Policy Statement

1. Earnings Replacement Benefits (ERB) are payable until the earlier of:

    a) the date the Board determines that the loss of earnings has ended or is no longer the result of the injury; or

    b) the date the worker reached the age of 65.

2. If the worker is 63 years of age or older at the time the loss of earnings commences, the worker will be paid an ERB for up to 24 months after the date the loss of earnings took place (subject to paragraph 1(a)).

3. Permanent Impairment Benefits (PIB) are payable for the lifetime of the worker.

Guidelines

Earnings Replacement Benefits (ERBs) include Temporary Earnings Replacement Benefits (TERBs) and Extended Earnings Replacement Benefits (EERBs).

Application

This Policy applies to all ERBs and PIBs awarded pursuant to the Act.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 34(5), 37(8), 37(9).

Policy Number: 3.9.3R

Topic: Combining of Worker's Compensation Benefits
Section: Short-Term and Long-Term Benefits
Subsection: General

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. The total amount of compensation paid to a worker by the Board shall not exceed:

    a) for the first 26 weeks of compensation, 75% of the *net* maximum assessable earnings in place the year the injury occurred; and,

    b) thereafter, 85% of the *net* maximum assessable earnings in place the year the injury occurred.

2. The calculation of the *net* value of the maximum assessable earnings will be based on the individual worker's tax credits which include TD1 code amount, EI premiums, and CPP premiums.

3. The total amount of compensation includes all Pensions from a predecessor Act, any Permanent Impairment Benefit, Temporary Earnings Replacement Benefits, and Extended Earnings Replacement Benefits. For the purposes of this calculation, Survivor Benefits will not be included, however.

4. If the total benefits received by the worker are in excess of the net maximum assessable earnings as calculated for that worker, the benefits paid will be reduced by the excess. However, the Board will not reduce the benefits below the total of the worker's benefits from a predecessor Act, even if they exceed the net maximum assessable earnings.

Application

This Policy applies to all compensation awards made on or after October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 48.

Policy Number: 3.9.5

Topic: Commutation of PIBs and EERBs
Section: Short-Term and Long-Term Benefits
Subsection: General

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: March 1, 1995

Policy Statement

1. The Board may, at its discretion, commute to a lump sum, any compensation paid as a periodic benefit.

2. The Board will commute, without application, a Permanent Impairment Benefit (PIB) if:

   a) the worker's cumulative permanent medical impairment rating is 30% or less; and

   b) no Extended Earnings Replacement Benefit (EERB) is payable to the worker in connection with the injury.

3. However, the Board may choose not to commute the PIB if the Board determines that the commutation is not to the advantage of the worker.

4. In addition, the Board may, under the following circumstances, commute any periodic benefits (PIB and/or EERB) if:

   a) the commuted benefit is to be used for a purpose approved by the Board (approved purpose is a purpose that is determined by the Board to enhance the worker's vocational rehabilitation beyond that which would normally have been provided by the Board);

   b) there are no other sources of funds that are accessible and appropriate for the approved purpose;

   c) the worker is not dependent on the periodic benefit for the necessities of life nor is expected to be in the future;

   d) the commutation is in the best long-term interests of the worker;

   e) the worker's injury-related condition has stabilized; and

   f) the final scheduled review for an EERB (if applicable) has been completed.

Application

This Policy applies to workers injured on or after March 23, 1990.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 74.

Policy Number: 3.9.6R1

Topic: Implementation of Appeal Board Decisions on Permanent Compensation in the Absence of Measurable Impairment

Section: Short-Term and Long-Term Benefits
Subsection: General

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Preamble

The *Workers' Compensation Act* addresses, through the "Transitional" provisions in Sections 225-228, the general rules for granting permanent benefits to workers who fall within various categories. To deal with certain situations not specifically addressed in the Transitional sections of the Act, the Workers' Compensation Board has adopted the following policy.

Policy Statement

1. Where:

   (a) the Workers' Compensation Appeal Board has determined that a worker has a permanent impairment and/or a permanent disability, but did not assign a specific permanent impairment percentage rating; and

   (b) the Workers' Compensation Board has not yet made an award to the worker for permanent disability; and

   (c) the Workers' Compensation Board has difficulty determining, upon examination, an impairment using the Permanent Impairment Rating Schedule (contained in Policy 3.3.2R4),

   staff may, in order to conform to the appeal ruling, assign the worker a permanent medical impairment rating not to exceed 5%, and make:

   (i) a Permanent Partial Disability award (CRS Award) for injuries before March 23, 1990; or

   (ii) a Permanent Impairment Benefit award for injuries on or after March 23, 1990.

2. Consideration for entitlement to other benefits will be in keeping with the order of the Appeal Board and in keeping with the approved policies of the Workers' Compensation Board with regard to those benefits.

Application

This Policy is effective December 16, 2021. This replaces Policy 3.9.6R that was effective October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 225-228

Policy Number: 3.9.10

Topic: Payment of Interest on Transitional Benefits
Section: Short-Term and Long-Term Benefits
Subsection: General

Effective: January 9, 1997
Issued: May 2, 1997
Approved by Board of Directors: January 9, 1997

Policy Statement

Definitions

1. For purposes of this Policy, a 'Transitional Claim' is defined as a claim that meets *all* of the following criteria:

    1) The client has a permanent medical impairment (PMI) related to the claim in question, and is thus entitled to long-term-disability (LTD) benefits;

        Note: 'long-term-disability benefits' is the standard term used by all WCBs to refer to benefits paid for permanent impairment, permanent disability and extended earnings loss. In the case of the WCB of Nova Scotia, long-term-disability benefits include:

        a) for workers injured on or after 23/3/90: Permanent-Impairment Benefits (PIBs), and possibly also Extended Earnings-Replacement Benefits (EERBs);
        b) for workers injured prior to 23/3/90: permanent-disability pensions

    2) The client's long-term-disability (LTD) benefits are calculated in accordance with the new Workers' Compensation Act (chapter 10, Acts of 1994-95).

    3) Benefits are paid on the claim *after* Feb. 1, 1996, for a period *prior* to Feb. 1, 1996;

    4) The claim was affected by the Board of Directors' November, 1992 decision to suspend new awards of permanent LTD benefits, in order to allow the Board (and, as it turned out, the Legislature) time to develop a new approach to the calculation of LTD benefits. As a result of that decision, the WCB delayed paying many workers' LTD benefits (in whole or on part) -- benefits which eventually were calculated in accordance with the new Act.

2. For purposes of this Policy, a 'Retroactive Transitional Adjustment Payment' is a payment made on a Transitional Claim, where the payment meets all of the following criteria:

    1) The Payment is made on or after February 1, 1996 -- that is, the "date of payment" is on or after February 1, 1996;

    2) The date beginning from which the Payment amount is calculated is prior to February 1, 1996 -- that is, the "effective date" of the Payment is prior to February 1, 1996.

3. For purposes of this Policy, the 'Interest Effective Date' is the effective date from which interest on Retroactive Transitional Adjustment Payments will be calculated. The Interest Effective Date for a given Retroactive Transitional Adjustment Payment is the *later* of the following two dates:

    a) the effective date of the Retroactive Transitional Adjustment Payment;

    b) November 26, 1992.

4. For purposes of this Policy, all Retroactive Transitional Adjustment Payments for a given claim shall be payable for the period:

    a) beginning on the effective date of the Retroactive Transitional Adjustment Payment in question; and

    b) ending on the payment date for the first Retroactive Transitional Adjustment Payment on the claim.

Entitlement to Interest

5. Clients who receive Retroactive Transitional Adjustment Payments are entitled to interest on their Retroactive Transitional Adjustment Payments, in accordance with the calculation method described in section 6 of this Policy.

Calculation of Interest

6. Interest on Retroactive Transitional Adjustment Payments shall be calculated as follows:

    a) For claims where the Retroactive Transitional Adjustment Payments pertain to commuted (lump-sum) awards, the following formula shall be used to calculate the client's interest entitlement:

    Interest amount = (5.50% per annum) * p * n/12

    where

    n = number of months (rounded to the nearest tenth of a month) between Interest Effective Date and payment date of the first Retroactive Transitional Adjustment Payment on the claim

    p = amount of Retroactive Transitional Adjustment Payment

    b) For claims where Retroactive Transitional Adjustment Payments pertain to periodic (monthly) awards, the following formula shall be used to calculate the client's interest entitlement:

    Interest amount = (2.81% per annum) * p * n/12

    where

    n = number of months (rounded to the nearest tenth of a month) between Interest Effective Date and payment date of the first Retroactive Transitional Adjustment Payment on the claim

    p = amount of Retroactive Transitional Adjustment Payment

Application

This Policy applies to all decisions made on or after January 9, 1997.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 74, 226-229.

Policy Number: 3.9.11R1

Topic: Apportionment of Benefits
Section: Short-Term and Long-Term Benefits
Subsection: General

Effective: April 10, 2008
Issued: April 22, 2008
Approved by Board of Directors: April 10, 2008

Preamble

Where a personal injury by accident arising out of and in the course of employment results in loss of earnings or permanent impairment due (a) in part to the injury and in part to causes other than the injury; or (b) to an aggravation, acceleration, or activation of a disease or disability existing prior to the injury, the WCB is directed by Section 10(5) of the *Workers' Compensation Act* ("the Act") to pay compensation for the proportion of the loss of earnings or permanent impairment that may reasonably be attributed to the injury.

The WCB has adopted the following Policy with respect to the effect of Section 10(5) on the amounts of compensation benefits payable.

Definitions

For the purpose of the Policy, the following definitions shall apply:

"**aggravation**", "acceleration", or "activation" means the clinical effect of a compensable injury on a pre-existing disease or disability resulting in a permanent increase in the impairment and/or loss of earnings capacity resulting from the pre-existing disease or disability;

"**cause other than injury**" means any aspect of the physical condition of an individual worker which, due to its nature or severity, could be reasonably expected to have a significant impact on the duration and/or the degree of a worker's loss of earnings or permanent impairment resulting from a compensable injury

"**compensable injury**" means a personal injury by accident arising out of and in the course of employment;

"**degenerative**" means characterized by progressive, often irreversible, deterioration;

"**disability**" means the decreased capacity or loss of ability of an individual to meet personal, social or occupational demands;

"**disease**" means the specific pathophysiologic process involved, which gives rise to the worker's signs and symptoms and their progression;

"**exacerbation**" means the clinical effect of a compensable injury on a pre-existing disease or disability resulting in a temporary increase in the impairment and/or loss of earnings capacity resulting from the pre-existing disease or disability;

"**impairment**" means the loss of, loss of use of, or derangement of any body part, system or function;

"**non-compensable factor**" means any condition unrelated to a compensable injury which may affect recovery and/or the extent of impairment/loss of earnings. A non-compensable factor may exist prior to a compensable injury or it may develop post-injury. This includes causes other than the injury and pre-existing diseases or disabilities;

"**permanent impairment**" means impairment associated with a permanent medical impairment and/or a pain-related impairment;

"**permanent medical impairment**" means any impairment that has become static or stabilized and that is unlikely to improve despite further medical treatment. A permanent medical impairment also accounts for the usual pain that accompanies the type of injury and resulting impairment;

"**pain-related impairment**" means impairment associated with chronic pain.

"**pre-existing disease or disability**" means a non-compensable disease or disability which existed prior to the compensable injury.

Policy Statement

1. **Temporary Earnings Replacement Benefit (TERB)**

    1.1. Where:

    (a) the compensable injury causes an exacerbation or aggravation, acceleration or activation of a pre-existing disease or disability; or

    (b) the loss of earnings is due in part to the compensable injury and in part to a non-compensable factor which developed post-injury,

    the WCB will assume full responsibility for TERB without apportionment as long as there are medical findings to substantiate that the compensable injury is contributing to some degree to the loss of earnings, even if a non-compensable factor(s) is prolonging recovery and/or loss of earnings.

    1.2. Where a worker is unable to commence or continue medical treatment for a compensable injury due to a non-compensable factor, the WCB will apply Policy 1.3.2R (Interruption of Medical Treatment – Circumstances Beyond Worker's Control).

2. **Medical Aid**

    2.1. Medical aid required as a result of the compensable injury will not be subject to apportionment.

3. Vocational Rehabilitation

    3.1. Where the WCB determines that no proportion of a worker's permanent impairment can be attributed to a compensable injury, vocational rehabilitation services will not be offered to the worker.

    3.2. Where:

    (a) the compensable injury causes an aggravation, acceleration or activation of a pre-existing disease or disability; or

    (b) the anticipated permanent impairment is due in part to the compensable injury and in part to a non-compensable factor(s) which developed post-injury,

    and medical evidence indicates that a proportion of the anticipated long-term loss of earnings can be attributed to the compensable injury, vocational rehabilitation services will be provided to the worker in accordance with normal guidelines, without apportionment.

4. **Permanent Impairment**

4.1. Where a non-compensable factor(s) is contributing to the worker's permanent impairment, the permanent impairment may be adjusted to reflect the impact of this non-compensable factor(s). Permanent impairment benefits will only be paid for the permanent impairment resulting from the compensable injury.

4.2. To determine the impact of the non-compensable factor(s) on the permanent impairment:

(a) the WCB will gather evidence which can include, but is not limited to:

- Physician chart notes;
- Specialist reports;
- Diagnostic test results (i.e. x-ray, CT scan, MRI);
- Physiotherapy, chiropractor and occupational therapy reports;
- Accident Report;
- Information from disability insurance providers and/or the employer;
- Employment-related information.

(b) if the non-compensable factor(s) is degenerative in nature, the WCB will gather medical evidence with respect to how the condition would have progressed (up to the point of assessing permanent impairment) in the absence of the compensable injury.

4.3. Where:

(a) the compensable injury causes an aggravation, acceleration or activation of a pre-existing disease or disability; or

(b) the permanent impairment is due in part to the compensable injury and in part to a non-compensable factor(s) which developed post-injury

the WCB will determine the portion of the permanent impairment that is compensable in the following ways:

4.3.1.

(a) Determine the total permanent impairment rating using the applicable permanent impairment rating schedule in accordance with Policy 3.3.2R2 (Permanent Impairment Rating Schedule).

(b) Assign the impairment that results from the non-compensable factor(s) a permanent impairment rating and subtract this from the total permanent impairment rating to determine the portion of permanent impairment that is compensable.

4.3.2.

(a) If it is not possible to apply Policy Statement 4.3.1(b), determine the degree of permanent impairment that results from the non-compensable factor(s) by applying the following definitions:

"**Minor**" refers to an impairment which produced no or minimal limitations on working capacity but required occasional medical care.

"**Moderate**" refers to an impairment which produced some limitations on working capacity and required periodic medical care.

"**Major**" refers to an impairment which produced significant limitations on working capacity requiring ongoing medical care.

"**Severe**" refers to an impairment which produced significant limitations on working capacity, requiring ongoing medical care and would certainly have resulted in total disability independent of the compensable injury.

(b) Determine the portion of permanent impairment that is compensable by multiplying the total permanent impairment rating by the percentage from the table below which corresponds to the applicable definition:

Classification of Non-Compensable Factor(s)	Compensable Percentage of Permanent Impairment
Minor	100% (no apportionment)
Moderate	75%
Major	50%
Severe	25%

5. Extended Earnings Replacement Benefit (EERB)

5.1. Where the worker is experiencing an on-going loss of earnings as a result of the permanent impairment remaining after the compensable injury, the WCB will determine what proportion of the loss of earnings can be attributed to the compensable injury and what proportion can be attributed to a non-compensable factor(s). EERBs will only be paid for the on-going loss of earnings resulting from the compensable injury.

5.2. Where the WCB determines that a non-compensable factor was only a latent weakness or susceptibility and there is no evidence: (a) that it had any impact on the worker's pre-injury earning capacity; or (b) that it would have progressed to produce loss of earning capacity without the occurrence of the compensable injury, it will be considered that the entire extended loss of earnings can be attributed to the compensable injury and EERBs will be paid without apportionment under Section 10(5) of the *Act*.

5.3. The WCB will determine the portion of the extended loss of earnings that is compensable in the following way:

5.3.1. Determine the total extended loss of earnings in accordance with normal guidelines.

5.3.2. Determine the portion of extended loss of earnings that is compensable by multiplying the total extended loss of earnings by the percentage from the table below which corresponds to the applicable definitions for the non-compensable factor:

Classification of Non-Compensable Factor(s)	Compensable Percentage of Extended Loss of Earnings Payable
Minor*	100% (no apportionment)
Moderate*	75%
Major*	50%
Severe*	25%

** As determined in accordance with Section 4.3.2 of this Policy*

6. Death/Survivors' Benefits

6.1. If the WCB determines that a compensable injury was a factor contributing to a worker's death, death and survivors' benefits are payable in the full amounts provided for in the Act, without apportionment, since such benefits are not paid as compensation for loss of earnings or permanent impairment.

Application

This policy replaces Policy 3.9.11R issued on September 13, 2004 and effective September 10, 2004. This Policy applies to all decisions made on or after April 10, 2008.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 10(5)

Policy Number: 3.9.12

Topic: Inflation-Indexing of benefits
Section: Short-Term and Long-Term Benefits
Subsection: General

Effective: January 1, 2000
Issued: December 16, 1999
Approved by Board of Directors: December 3, 1999

Policy Statement

Benefits to be adjusted

1. As of January 1 each year and commencing January 1, 2000, the Board shall adjust, by applying the 'indexing factor' described below, the amount of compensation payable to recipients of the following benefits:

   (a) permanent impairment benefits;

   (b) extended earnings replacement benefits;

   (c) survivor pensions;

   (d) dependent child benefits;

   (e) permanent pensions payable pursuant to a predecessor Act (including benefits payable pursuant to section 10D of the Act as amended); and

   (f) temporary earnings replacement benefits (TERB), where the worker has been receiving TERB for more than twelve continuous months as of January 1 of the year in question.

Indexing factor to be used

2. The indexing factor to be applied each January shall be one-half of the change in the all-items Consumer Price Index for Nova Scotia for the preceding year – i.e. the 12-month period ending December 31 immediately preceding the January in question.

3. To calculate the *change* in the all-items Consumer Price Index (CPI) for Nova Scotia for 1999, the Board shall compare the 'annual average' CPI for 1999 (i.e. the average monthly CPI for the 12-month period ending December 31, 1999) with the 'annual average' CPI for 1998, as published by Statistics Canada (catalogue 62-001). Specifically, the Board shall use the following formula:

   (a) subtract the 'annual average' CPI for 1998 from the annual average CPI for 1999;

   (b) divide the number calculated in step 'a' by the annual average CPI for 1998;

   (c) multiply the number obtained in step 'b' by 100, to obtain the percentage change in the CPI for 1999;

   (d) multiply the number obtained in step 'c' by one-half. This is the indexing factor (expressed as a percentage) to be applied.

4. The number obtained in step '3d' above shall be the indexing factor to be used as of January 1 in the year 2000. The indexing factor to be used in subsequent years shall be calculated in a similar manner, using data for the appropriate years (For example, to calculate the indexing factor to be used as of January 1, 2001, the annual average Nova Scotia all-items CPI for 2000 will be compared to the annual average Nova Scotia all-items CPI for 1999.)

Application

This Policy applies to all decisions made on or after January 1, 2000.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95, as amended), Sections 69,70,74.

Section 4 - Vocational Rehabilitation

OVERVIEW

Note: This Overview is intended to provide a general guide to Board policies and programs. It does not constitute official Board policy.

Vocational Rehabilitation services are designed to assist injured workers in returning to the workforce.

These services are offered to injured workers who experience difficulty following an accident and have suffered, or are likely to suffer, a permanent impairment as a result of their workplace accident.

Rehabilitation Services may consist of appropriate assessments, skills upgrading, on-the-job training, job search preparation, and a variety of other services. The goal of any vocational rehabilitation plan is always to return the worker to work that is suitable and reasonably available.

The worker will be assisted by a Vocational Rehabilitation Counsellor, as part of a Case Management Team, in developing a suitable return-to-work plan.

When a rehabilitation program has been developed and implemented with an injured worker, and as long as they actively participate in the program, they are generally eligible for earnings-replacement benefits.

The policies which surround this process are contained in this section of the manual.

Subsection 4.1 – Entitlement to VR Services

- **Policy Number: 4.1.1R1 - Eligibility for Vocational Rehabilitation**
- **Policy Number: 4.1.2R - Extent of Vocational Rehabilitation Services**
- **Policy Number: 4.1.3 - Goals and Objectives of Individual VR Plans**
- **Policy Number: 4.1.4 - Goals and Objectives of Individual VR Plans**
- **Policy Number: 4.1.5 - Attendance in Training Programs**
- **Policy Number: 4.1.6 - VR – Non-Participation – Circumstances Beyond Worker's Control**

Policy Number: 4.1.1R1

Topic: Eligibility for Vocational Rehabilitation
Section: Vocational Rehabilitation
Subsection: Entitlement to VR Services

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. Vocational Rehabilitation services may be provided to an injured worker who:

   (a) in the opinion of the Board, is likely to suffer a permanent impairment; and

   (b) may experience an earnings loss as a result of the permanent impairment.

2. One of the following circumstances must be evident to suggest a possible earnings loss:

   2.1. A strong likelihood of problems with return to the pre-injury employment due to the compensable injury;

   2.2. Evidence, due to the serious nature of the injury, of an extended recovery period that could jeopardize a return to pre-accident employment. Serious injuries include: head injuries, major amputations, severe back injuries, severe burn injuries, etc.;

   2.3. A serious risk of re-injury or aggravation of the compensable condition given the nature of the pre-injury employment;

   2.4. The worker has lost a job due in part to the compensable injury and requires limited assistance in locating similar employment (i.e. worker is laid off because of their injury status);

   2.5. A psychological condition resulting from the compensable injury impedes a return to employment (e.g. post-traumatic stress resulting from a severe injury);

   2.6. The worker is unable to return to the pre-injury employment due to a combination of the work injury and a condition which existed prior to the work injury. The inability to return to work, however, must be shown to be primarily due to impairment as a result of the compensable injury.

Application

This policy is effective December 21, 2021. This policy replaces Policy 4.1.1R that was effective September 10, 2004.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 112.

Policy Number: 4.1.2R

Topic: Extent of Vocational Rehabilitation Services
Section: Vocational Rehabilitation
Subsection: Vocational Rehabilitation Program Expenses

Effective: February 11, 2010
Issued: February 25, 2010
Approved by Board of Directors: February 11, 2010

Policy Statement

1. The extent of Vocational Rehabilitation (VR) services to be offered will be determined by:

    a) the Hierarchy of Objectives (opportunities for re-employment) – see Policy 4.1.3;

    b) the client's transferable skills;

    c) the client's capacity for employment;

    d) the client's wishes; and

    e) the estimated cost of the VR program.

2. Where appropriate, VR services may consist of a review or assessment by the Service Delivery Departments conducted in an attempt to determine eligibility for, appropriateness, or extent, of further VR intervention.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 112.

Policy Number: 4.1.3

Topic: Goals and Objectives of Individual VR Plans
Section: Vocational Rehabilitation
Subsection: Entitlement to VR Services

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: June 1, 1995

Policy Statement

1. The goal of each individual Vocational Rehabilitation (VR) plan is to assist the injured worker, through various job-specific interventions, to return to work.

2. The following Hierarchy of Objectives will be followed when developing a Vocational Rehabilitation (re-employment) plan:

Hierarchy of Objectives (in descending order)

2.1. Return to the same job with the same employer.

2.2. Return to a similar or comparable job with the same employer.

2.3. Return to a different but suitable job with the same employer.

2.4. Return to work in a similar or comparable job with a different employer.

2.5. Return to work in a different but suitable job with a different employer.

2.6. Retraining for jobs that are suitable and reasonably available.

2.7. Self-employment.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 112.

Policy Number: 4.1.4

Topic: Non-Cooperation by Worker
Section: Vocational Rehabilitation
Subsection: Entitlement to VR Services

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: June 1, 1995

Policy Statement

1. A determination of non-cooperation will be based primarily on the criteria below, but will not be made without consideration of the individual circumstances of the case. This includes consideration of the impact of the worker's non-cooperation on the overall Vocational Rehabilitation (VR) Plan and its goals.

2. A worker will generally be considered "non-cooperative" in the following circumstances.

    2.1. The worker claims an inability to participate with VR efforts in the absence of supporting medical evidence;

    2.2. The worker fails to participate with Board staff in development of an appropriate VR Plan (e.g., will not meet with staff to discuss occupational goals, fails to attend assessments or testing to determine aptitudes and/or abilities), or consistently presents obstacles which, in the Board's opinion, delay commencement or completion of any stage of a VR program;

    2.3. The worker fails to complete any aspect of an agreed upon VR Plan, for reasons not directly related to the compensable condition;

    2.4. The worker fails to meet performance or attendance criteria required by an employer or institution in relation to a VR Plan with which the worker is involved as part of a VR program, for reasons not directly related to the compensable condition;

    2.5. The worker fails to accept an appropriate offer of employment consistent with the Board's Hierarchy of Objectives (see Policy 4.1.3), or fails to actively pursue such employment opportunities, at any stage during a VR program, where, in the opinion of the Board, that employment would equal or surpass the goals of the VR program; or

    2.6. The worker refuses an offer of appropriate light duty or modified work (or similar programs) during a period of temporary disability.

3. Further, wherever in the opinion of the Board, a worker's actions or inactions have jeopardized successful completion of a VR Plan, the worker may be judged as non-cooperative.

4. The Board considers VR "efforts" as any attempt to return the worker to the workplace, including appropriate light duty or modified work, prior to maximum medical recovery, whether this effort is conducted by a VR counsellor or other Board staff member involved with the worker in a similar capacity.

5. The Board considers an offer of light duty or modified work as appropriate only where the duties are consistent with the worker's physical abilities (i.e. in the opinion of the Board and the worker's physician, the work poses no reasonably foreseeable risk to the worker's health).

6. Generally, where a worker has been judged as non-cooperative, provision of further VR assistance may be terminated, pursuant to Section 113 of the Act.

7. Where a worker's inability to cooperate with a VR program is due to non-compensable factors beyond the worker's control, the case will be reviewed (pursuant to Policy 4.1.6, re: "Circumstances Beyond Worker's Control) before a decision to terminate benefits, pursuant to Section 113, will be made.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) Section 113.

Policy Number: 4.1.5

Topic: Attendance in Training Programs
Section: Vocational Rehabilitation
Subsection: Entitlement to VR Services

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: June 1, 1995

Policy Statement

Generally, a client's absence from a training program greater than 10% of the time per month (i.e. 2.5 days per month) may require that the training program be terminated.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 113.

Policy Number: 4.1.6

Topic: VR – Non-Participation – Circumstances Beyond Worker's Control
Section: Vocational Rehabilitation
Subsection: Entitlement to VR Services

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: June 1, 1995

Policy Statement

1. Where a worker is temporarily unable to fulfil the obligations of a Vocational Rehabilitation (VR) program due to circumstances which, in the opinion of the Board, are unrelated to the worker's compensable condition and are genuinely beyond the worker's control, benefits may be continued where:

    a) the interruption is of sufficiently short duration as to not have a significant impact on the VR program; or

    b) the worker is able to undertake other activities consistent with the VR program during the interruption period.

Interrupted Program

2. Where the worker is unable to participate with any appropriate VR efforts during the interruption period, the worker's VR program, and any associated earnings-replacement benefits payable to the worker, will be suspended until the worker is available to resume VR efforts. The worker shall be provided with written notice two weeks prior to benefits being suspended.

3. When the worker is once again available to participate with VR activities, the case will be reviewed as per the following.

    3.1. Where the original VR program can be resumed without significant delay, benefits will be reinstated and the program resumed once the worker is available to continue.

    3.2. Where the worker is available to resume VR activity but the VR program cannot be continued without significant delay (e.g. the worker must wait to be reinstated in the course) the worker's case will be reviewed to determine if:

        a) the worker can begin an alternate VR program within a reasonable period; or

        b) the worker can undertake activities consistent with the original VR goals until the original program can be resumed.

    Benefits to worker will be reinstated while the options above are investigated.

4. It is the intent of Board staff to avoid suspension of VR efforts wherever possible.

5. Where a VR program is interrupted and cannot be resumed without significant delay, Board staff will make every effort with the worker to locate an alternate VR program or to identify appropriate activities to undertake while waiting for the original program to resume, in order to minimize economic hardship to the worker and to ensure a timely resumption of VR efforts once the worker is able to participate.

6. Where a formal educational or training program has been interrupted, the Board will negotiate with the institution to recover any tuition/fees for the unused portion of the program. The Board will generally not require the worker to assume responsibility for any additional tuition/fees incurred as a result of the interruption.

7. Where benefits must be suspended, notice is provided to the worker in order to allow an opportunity to secure coverage through an alternate illness coverage plan (if any) normally available to the worker.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) Section 112.

Subsection 4.2 – VR Program Expenses

- **Policy Number: 4.2.1R1 - Workplace Modifications**
- **Policy Number: 4.2.2 - Tools and Equipment**
- **Policy Number: 4.2.3 - Relocation Assistance**
- **Policy Number: 4.2.4R17 - Workers' Travel Expenses for Vocational Rehabilitation**

Policy Number: 4.2.1R1

Topic: Workplace Modifications
Section: Vocational Rehabilitation
Subsection: VR Program Expenses

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

The Board may assist in the modification of the employer's premises where that modification will permit the worker to gain access to the workplace or to fulfil the requirements of their employment.

Application

This Policy is effective December 16, 2021. This Policy replaces Policy 4.2.1 that was effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 112.

Policy Number: 4.2.2

Topic: Tools and Equipment
Section: Vocational Rehabilitation
Subsection: VR Program Expenses

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: June 1, 1995

Policy Statement

1. The Board may provide financial assistance for the purchasing of tools, equipment, and clothing for employment, assessment or retraining.

2. They will be provided on a one-time-only basis, with repair and replacement being the worker's responsibility.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 112.

Policy Number: 4.2.3

Topic: Relocation Assistance
Section: Vocational Rehabilitation
Subsection: VR Program Expenses

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: June 1, 1995

Policy Statement

In approved cases, relocation assistance will be provided to Vocational Rehabilitation clients who secure employment outside a reasonable commuting distance.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 112.

Policy Number: 4.2.4R17

Topic: Workers' Travel Expenses for Vocational Rehabilitation
Section: Vocational Rehabilitation
Subsection: Vocational Rehabilitation Program Expenses

Effective: April 1, 2022
Issued: April 21, 2022
Approved by Board of Directors: April 21, 2022

Policy Statement

1. **General**

   Where participation in a vocational rehabilitation program or service requires a worker to travel, the Workers' Compensation Board may reimburse the worker for travel expenses in accordance with the provisions of this policy.

   All travel must be pre-authorized by the Case Manager.

   Travel reimbursement for a worker will be based on the costs associated with the most economical and appropriate means of transportation available.

2. **Travel**

   Where participation in a vocational rehabilitation program or service requires a worker to travel, the Workers' Compensation Board may reimburse the worker for mileage in excess of the worker's travel distance to their regular pre-injury workplace.13

   A reimbursement for mileage will be determined by calculating the difference between the distance a worker travelled to their regular pre-injury workplace and the distance they are required to travel to access their vocational rehabilitation program or service.

   A worker may use their own vehicle for transportation purposes to access vocational rehabilitation programs and services, if it is the most economical and reasonable means of transportation and has been pre-authorized by the Board. Authorized vehicle use will be reimbursed at the rate of **57.70 c/km**.

   Where an alternate mode of transport is considered to be more appropriate and economically viable, it will be supported by the Workers' Compensation Board. The worker will be reimbursed in accordance with the method described above except in circumstances where it is more economically practical to pay actual costs based on receipts.

   Future travel rates will be adjusted, on a go-forward basis, following notification from the Director of Human Resources that the rates for Workers' Compensation Board employees have increased; and

   Rates will not be retroactive; and

   Future rates will be effective on the "Effective Date" specified in the revised policy.

3. **Living Allowance**

   A Case Manager may authorize a living allowance if it is determined appropriate, in the discretion of the Board, for a worker to relocate and maintain a second residence for the duration of their vocational rehabilitation program. Specifically, if the worker must maintain a home while being trained and residing

in another location, room and board expenses to a maximum of $1,500/month (reimbursement based on receipts) may be reimbursed by the Workers' Compensation Board. The living allowance is considered to include the costs of rent, basic utilities, meals and travel expenses.

4. **Other Travel Expenses**

   When a Case Manager pre-authorizes use of a personal vehicle, the Workers' Compensation Board will reimburse actual parking, toll bridge and toll highway expenses (based on receipts) incurred during implementation of a Vocational Rehabilitation Plan.

5. **Meal Allowance**

   A meal allowance may be provided to workers who must be away from their home over a meal period in order to attend pre-authorized worker meetings, assessments or physical rehabilitation programs. Coverage of meals must be pre-authorized by the Case Manager. If pre-authorized a per diem amount of $43.00 (including gratuities) may be paid, comprised of:

Breakfast	$8.00
Lunch	$15.00
Dinner	$20.00
Total	$43.00

   Future meal allowance rates will be adjusted, on a go-forward basis, following notification from the Director of Human Resources that the rates for Workers' Compensation Board employees have increased; and

   Rates will not be retroactive; and

   Future rates will be effective on the "Effective Date" specified in the revised policy.

6. **Accommodations – Public and Private**

   When necessary, workers may be provided with overnight accommodations, pre-authorized by the Board. Where possible, costs will be charged directly to the Board, otherwise reimbursements will be based on receipts. In cases where a worker chooses to use private overnight accommodations, the Workers' Compensation Board will reimburse the worker at a rate of $40.00 per night.

   Future private overnight accommodation rates will be adjusted, on a go-forward basis, following notification from the Director of Human Resources that the rates for Workers' Compensation Board employees have increased; and

   Rates will not be retroactive; and

   Future rates will be effective on the "Effective Date" specified in the revised policy.

7. **Employment Incentives Program**

   A worker participating in the Employment Incentives Program is not eligible for travel reimbursement.

Application

This Policy applies to travel on or after April 1, 2022. This policy replaces predecessor Policy 4.2.4R16.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 112

Subsection 4.3 – General

- **Policy Number: 4.3.1 - Eligibility of Clients While on Training and Job Search Programs**

Policy Number: 4.3.1

Topic: Eligibility of Clients While on Training and Job Search Programs
Section: Vocational Rehabilitation
Subsection: General

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: June 1, 1995

Policy Statement

1. A Workers' Compensation Board client, while in training at a training institution or work place (covered or not covered) shall have compensation coverage extended to him/her in case of further accident.

2. While a Workers' Compensation Board client is conducting an active job search, no coverage will be extended.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 112.

Section 5 - Re-Employment

Overview

Note: This Overview is intended to provide a general guide to Board policies and programs. It does not constitute official Board policy.

The re-employment sections of the *Workers' Compensation Act* (Sections 89-101) support returning injured workers to the workplace by setting out a re-employment obligation for certain employers. Re-employment is intended to return the worker to a place in the labour market resembling, as closely as possible, the position held at the time of their injury.

In particular, employers (except those in the construction industry) who regularly employ 20 or more workers are obligated to re-employ an injured worker who has missed time from work due to the work injury if: 1) that injured worker has been employed with them continuously for at least twelve months prior to the work-related injury; and 2) the worker can perform the essential duties of their pre-injury job, or other suitable work.

Typically, the WCB, is not required to invoke the re-employment obligations. Where disputes arise, the WCB will first meet with the employer and injured worker as a part of the case management process in an attempt to identify barriers to re-employment and establish a plan to return the worker to the workforce. Where disputes cannot be resolved, the WCB will take appropriate actions to invoke the re-employment obligations in the *Act*, which may include issuing orders to re-employ or levying penalties.

The following policy provides guidance and interpretation of the re-employment obligations, and other supporting provisions, set out in the *Workers' Compensation Act (the "Act")*.

Subsection 5.6 – General

- **Policy Number: 5.6.1 – Obligation, duties, and penalties**

Policy Number: 5.6.1

Topic: Obligation, Duties, and Penalties
Section: Re-Employment
Subsection: General

Effective: September 28, 2022
Issued: October 14, 2022
Approved by Board of Directors: September 28, 2022

Preamble

The re-employment sections of the *Workers' Compensation Act* (Sections 89-101) support returning injured workers to the workplace by setting out a re-employment obligation for certain employers. Re-employment is intended to return the worker to a place in the labour market resembling, as closely as possible, the position held at the time of their injury.

In particular, employers (except those in the construction industry) who regularly employ 20 or more workers are obligated to re-employ an injured worker who has missed time from work due to the work injury if: 1) that injured worker has been employed with them continuously for at least twelve months prior to the work-related injury; and 2) the worker can perform the essential duties of their pre-injury job, or other suitable work.

Typically, the WCB, is not required to invoke the re-employment obligations. Where disputes arise, the WCB will first meet with the employer and injured worker as a part of the case management process in an attempt to identify barriers to re-employment and establish a plan to return the worker to the workforce. Where disputes cannot be resolved, the WCB will take appropriate actions to invoke the re-employment obligations in the *Act*, which may include issuing orders to re-employ or levying penalties.

This policy provides guidance and interpretation of the re-employment obligations, and other supporting provisions, set out in the *Workers' Compensation Act (the "Act")*.

Policy Statement

1. Re-employment Obligations and Human Rights Legislation

Under human rights law, all employers have a duty to accommodate workers with disabilities. The *Nova Scotia Human Rights Act* and (for federally regulated employers) the *Canadian Human Rights Act* apply in Nova Scotia. In addition, provided certain criteria are met, employers have an obligation under the *Act* to accommodate and re-employ workers injured on the job. The WCB's jurisdiction to deal with issues of accommodation applies only to a workplace accommodation required for the compensable work injury.

In circumstances where the re-employment provisions of the *Act* apply, the WCB is responsible for determining whether an employer has met its obligation to accommodate the worker to the point of undue hardship. If WCB determines that an employer or injured worker has not fulfilled their obligations under the *Act*, the employer or injured worker has the right to appeal a WCB decision.

If the worker also requires accommodation under the *Nova Scotia Human Rights Act* or the *Canadian Human Rights Act*, employers may have additional accommodation requirements that coincide with actions taken as part of the WCB re-employment process. Complaints about accommodation for those other protected

grounds should be made to the Nova Scotia Human Rights Commission or the Canadian Human Rights Commission.

References: Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 91.

2. Employer Coverage and Worker Eligibility

2.1 Employers

a) All employers, except those in the construction industry[3] and those who are determined by the WCB to regularly employ fewer than twenty employees, are obligated to offer re-employment to an eligible injured worker.

b) An employer shall be deemed to have "regularly" employed twenty or more workers if the company actively employed and paid:

i) at least twenty workers per month in eight out of the twelve months preceding the calendar month of the worker's injury; and
ii) an average of twenty workers per month over the twelve months preceding the calendar month of the worker's injury.

2.2 *Workers*

An employer covered by the re-employment sections of the Act is obligated to offer re-employment to a worker following an injury, where the worker's circumstances meet the following conditions:

a) The worker has been unable to perform work for the employer for a period of time, due to the injury. Eligibility for earnings replacement benefits is not a necessary pre-condition to this obligation; and

b) The worker has been employed by the employer for at least twelve continuous months, including eligible pauses, at the time of the injury. Eligible pauses are those that are less than thirty calendar days, or those that are thirty calendar days or more where the pauses:

i. have been authorized by the employer (e.g. leaves of absence, vacations, or suspensions);

ii. are the right of the worker under other legislation (e.g. maternity / paternity leaves; or

iii. notwithstanding Section 2.1, are supported by substantive evidence of a continuing employment relationship (e.g. payment of ongoing employer paid benefits), or a mutual agreement that the worker will return to work for the employer upon recall, subject to applicable seniority provisions.

References: Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 89 and 90.

[3]Employers classified under SIC codes 4011-4499 in the Standard Industrial Classification (SIC) published by Statistics Canada

3. Length of Re-employment Obligation

3.1 Definition of "date of injury"

For the purposes of Sections 89-101 of the *Act* only "date of injury" means the date that time loss commences.

3.2 Length of Obligation

An employer's obligation to re-employ an injured worker continues from the date they receive notice of the injured worker's ability to return to either pre-injury employment or other suitable work until the earlier of:

a) the second anniversary of the date of injury; or
b) the 65th birthday of the worker.

3.3 Re-instatement in last six months

Where the injured worker is re-instated in the last six months of the re-employment period, the obligation is extended for an additional six months beyond the date of re-employment.

3.4 Worker refuses offer of re-employment

An employer is no longer bound by the re-employment provisions of the *Act,* with respect to an injured worker, where that injured worker refuses an offer of re-employment made in accordance with the reemployment provisions of the *Act* and this policy.

3.5 Recurrences

Where a worker, who continues to be employed by the injury employer, suffers a recurrence within the re-employment period, the injury employer continues to be bound by the re-employment provisions for the duration of the re-employment period specified in Section 3.2 Length of Obligation.

References: Workers' Compensation Act (Chapter 10, Acts of 1994-95), 89(2), 92, 92(1)(a), 93, 96(1), 97, 97(1), 99(3)(b)

4. Determining if case appropriate for re-employment

The WCB may delay or determine it is inappropriate to move to enforce the re-employment provisions where:

a) it is not anticipated the worker will be fit to be re-employed;
b) labour / management issues will interfere with the re-employment process; or
c) the WCB has determined there is an established hiring and / or placement practice in the worker's trade or occupation that is reasonable and provides the worker with similar or improved re-employment opportunities.

The WCB may reconsider this determination if the situation changes.

References: Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 91, 95.

5. Obligations of Injured Workers

Injured workers are responsible for mitigating the loss caused by a work-related injury by taking all reasonable steps to reduce or eliminate any impairment and loss of earnings resulting from a work-related injury. This includes accepting bona fide offers of re-employment made by an employer and cooperation with efforts to accommodate the work or the workplace in order to facilitate re-employment.

References: Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 84.

6. Re-employment Obligations of Employers

6.1 Pre-injury circumstances

References to pre-injury circumstances refer to those circumstances which existed when the worker's time loss commenced.

For greater certainty, pre-injury circumstances do not include transitional, modified, or similar duties that are being performed due to the workplace injury for which the re-employment obligations apply.

6.2 Terms and conditions at the time of the injury

The employer's re-employment obligation is generally limited to the duration of the pre-injury contract and / or the nature of the pre-injury employment arrangement.

6.3 Worker able to return to work with pre-injury employer

When the worker is fit for either the essential duties of the pre-injury job or for suitable employment only the WCB will notify the employer and worker, in writing, of the worker's status.

a) Worker able to perform essential duties

i) The employer shall offer to re-instate the worker into the pre-injury employment immediately upon receiving written notice from the WCB that the worker is capable of performing the essential duties associated with the work. Essential duties constitute the core tasks which achieve the usual outcome of the work.

ii) If the employer has satisfied the WCB that it is unable to re-instate the worker to the pre-injury employment, the employer shall offer the injured worker alternative work. Alternative work is considered to be equivalent to the pre-injury employment in its duties, functional demands, obligations, rights, rules, earnings, qualifications, opportunities and any other pertinent aspects which are considered to be relevant. Other pertinent aspects may include, but are not limited to:

- geographic location of the work;
- level of responsibility and supervision of other employees;
- skills, qualifications, and experience required; and
- bargaining unit status.

iii) The following factors may be considered in determining whether the geographic location of the alternative work is comparable to the pre-injury employment:

- travel or assignment to different job sites is the normal practice of the industry;

- travel or assignment to a job site other than the injury job site forms part of the employment contract;
- the worker normally accepts employment assignments in various geographic areas;
- travelling to the alternative employment falls within the normal parameters of travel expected of the worker; and
- the reasonableness of the offer.

If the employer has satisfied the WCB that it cannot offer pre-injury or alternative work, the employer shall offer to provide the injured worker with suitable work.

b) Injured worker able to perform suitable work only

i) Upon receiving written notice that the injured worker is fit to return to suitable work only, an employer shall offer an injured worker the first opportunity to accept suitable work that may become available. Suitable work is work the injured worker has the necessary skills to perform, is medically able to perform and which does not pose a health or safety hazard to the injured worker or any coworkers.

ii) As the injured worker's functional capability continues to increase, the employer shall, for the duration of the re-employment period, continue to offer available work which more closely compares to the pre-injury employment.

c) If there is a dispute about whether an injured worker is medically able to perform the essential duties of the pre-injury job or suitable work only, the WCB will make the final determination. In making it's determination, the WCB and may arrange for a worksite analysis or gather other relevant information.

6.4 Collective Agreements

Where the terms of a collective agreement conflict with the re-employment provisions, whichever provides the injured worker better re-employment opportunities shall prevail, with the exception that seniority provisions set out in the collective agreement always prevail.

6.5 Suitable work with another employer

Where an employer is unable to offer the injured worker re-employment opportunities within the company, but assists the worker is finding suitable work with another employer, the obligation remains with the injury employer until the expiration of the obligation period.

References: Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 89 (2), 89(3), 92, 92(1)(a), 96(1), 97, 97(1)(a), 98, 99(3)(b), 100(1).

7. Accommodation and Undue Hardship

7.1 Duty to Accommodate

The employer shall accommodate the work or workplace to facilitate an injured worker's return to work, providing the injured worker is capable of performing either the essential duties of the pre-injury employment or suitable employment only. The employer is required to accommodate the injured worker to the extent that the accommodation does not cause the employer undue hardship.

The expectations and requirements for accommodation and meeting the undue hardship standard for re-employment in the *Act* are consistent with those required by human rights law. Examples of possible accommodations include, but are not limited to, such things as:

a) supplying or modifying tools or equipment;
b) making the premises accessible;
c) modifying the hours of work or offering flexible work;
d) changing schedules;
e) moving the worker to a different work location;
f) altering aspects of the job, such as job duties; and/or
g) moving the worker to a different job.

While there are potentially many options to accommodate an injured worker, employers are not expected to create an unnecessary job for the injured worker. That is, an employer is not required to create a new permanent position expressly for the injured worker that is comprised of new duties that were previously non-existent that do not add value or provide a benefit to the employer.

7.2 Claiming Undue Hardship

Where the employer claims that an accommodation will cause undue hardship, the onus is on the employer to show adequate evidence of the detrimental impact on productivity, the operation, or the profitability of the business. There are general principles that set out the factors usually considered when assessing undue hardship, but the finding of undue hardship will vary according to the specific circumstances. What is undue hardship for one employer may not be for another. The WCB will consider a number of factors when determining whether the accommodation would pose an undue hardship. These factors may include:

a) employee and customer safety;
b) financial cost and benefits of the accommodation;
c) interchangeability of the workforce and facilities;
d) disruption of services to the public; and
e) the size of the employer's operation.

Where the WCB is satisfied that the accommodation will cause undue hardship, it may assist the employer in overcoming the hardship and/or may assist the worker directly, if the worker is otherwise eligible under the vocational rehabilitation program.

References: Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 91.

8. Failure to re-employ

8.1 Defenses for failure to re-employ

a) The employer may claim that failure re-employ an injured worker is due to:

i) reasons beyond the control of the employer that could not have been foreseen and avoided by the exercise of due diligence; or
ii) other justifiable reasons.

b) Examples of possible reasons for a failure to re-employ include, but are not limited to:

i) The re-employment obligation expires.

ii) The worker refuses an offer of employment.
iii) The employer is unable to offer pre-injury or alternative work. The WCB presumes an employer is able to offer the employment unless there is evidence to the contrary, for example, such as:

- The employer has permanently or temporarily laid off the staff in that function;
- The essential duties of the position have genuinely changed and now exceed the worker's functional ability, skills, and/or ability to obtain skills;
- The worker had been employed on a fixed-term contract which has expired, and for which there is no longer need of the worker's services.
- The employer can only meet their re-employment obligation by violating the Section 71 Labour Standards Code rights of another employee.

iv) Suitable work is unavailable:

- Where an injured worker is fit only for suitable work, the employer is required to offer such employment as it becomes available during the re-employment period.
- Therefore, unavailability of suitable work is a defence to not re-employing an injured worker, but only for the period of time in which the work is unavailable.

8.2 Termination within six months of re-instatement

Where an employer terminates an injured worker's employment within six months of re-instatement, the onus will be on the employer to provide evidence that the termination is for reasons unrelated to the worker's injury and / or claim.

8.3 WCB review

The WCB may on its own initiative, or at the request of the worker, make a determination about whether the employer has fulfilled their re-employment obligations. In making its determination, the WCB may consider evidence from the employer and other appropriate sources, including the worker.

References: Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 94, 95,100(3).

9. Orders and Penalties

9.1 Order and penalty upon finding of non-compliance with re-employment obligation

Upon determining that an employer has failed to meet its re-employment obligations, the WCB shall issue a specific and written order to the employer directing that the employer re-employ the injured worker as prescribed in the order. The order shall specify, at a minimum, that the employer is to re-employ the injured worker within **fourteen business days** of receipt of the order. The order will also notify the employer that the WCB will levy a penalty (amount to be calculated as described below) if the injured worker is not re-employed within the **fourteen business days** stipulated in the order.

The worker will be provided a copy of the order at the time of its issuance.

9.2 Penalty calculation - non-compliance with re-employment obligation

The penalty for non-compliance with an employer's re-employment obligations will be the greater of:

a) the full amount of any compensation payable to the worker and any expenditures made by the WCB in respect of the worker, during the year after the injury, or

b) the amount of the worker's net average earnings for the year preceding the injury;

9.3 Reduction or withdrawal of re-employment obligation penalty

The penalty levied for an employer's non-compliance with their re-employment obligations may, at the discretion of the WCB, be reduced or withdrawn where the WCB is satisfied that:

a) the employer has offered to re-employ the worker as specified in the order, or assists the worker in finding suitable work elsewhere. In these instances, the penalty may be no less than the wages which the worker would have earned during the delay in re-employment.; or

b) the employer has provided a defense for not re-employing the worker that meets the requirements of Section 8 of this policy.

9.4 Penalty for non-compliance with order

a) Where the employer fails to comply with the order to re-employ, the WCB may levy a penalty of two thousand dollars for the first offence. Penalties for subsequent failures to comply with an order to re-employ may be levied at the WCB's discretion to a maximum of ten thousand dollars.

b) In determining whether to apply a penalty in the first instance, or the amount of a penalty for non-compliance with an order to re-employ, the WCB will take into consideration the employer's:

i) history of compliance with re-employment obligations or orders to re-employ; and
ii) overall willingness to co-operate in the re-employment process.

References: Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 99, 99(1)(a), 211.

Application

This Policy applies to workers whose date of injury is on or after September 28, 2022 (see Section 3.1 Definition of Date of Injury).

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 89-101.

Section 6 - Survivor Benefits

Overview

Note: This Overview is intended to provide a general guide to Board policies and programs. It does not constitute official Board policy.

Fortunately, few workplace accidents in Nova Scotia result in death. But if a worker should die due to a workplace accident, the WCB can provide the surviving spouse and dependents financial support.

The benefits may include:

- reimbursement for burial expenses and transportation of the body (Policy 6.1.2 & 6.1.3)
- a lump sum 'death benefit' to the dependent spouse (6.1.1 & 6.1.4)
- a monthly benefit to the dependent spouse (6.2.1R)
- a monthly benefit to the surviving dependent child(ren) (6.2.3)
- discretionary benefits to 'other dependents' if there is no surviving spouse or children (6.2.4)
- an annuity to the spouse after the monthly benefit ceases (6.2.8R)

The policies regarding this benefit package are contained in this section.

Subsection 6.1 – One-Time Benefits

- **Policy Number: 6.1.1 - Death Benefit**
- **Policy Number: 6.1.2 - Burial Expenses**
- **Policy Number: 6.1.3 - Expenses for Transportation of Body**
- **Policy Number: 6.1.4 - Death of a Worker While in Receipt of Compensation**

Policy Number: 6.1.1

Topic: Death Benefit
Section: Survivor Benefits
Subsection: One-Time Benefits

Effective: February 1, 1996
Issued: December 15, 1995
Approved by Board of Directors: March 1, 1995

Policy Statement

1. Where a worker dies as a result of a compensable injury, and the worker has a surviving dependent spouse, the spouse is entitled to a lump-sum death benefit of $15,000 (fifteen thousand dollars).

Application

This Policy applies to compensable deaths occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 59(a) and 60(1)(c).
Survivor Benefit Regulations.

Policy Number: 6.1.2

Topic: Burial Expenses
Section: Survivor Benefits
Subsection: One-Time Benefits

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: June 1, 1995

Policy Statement

1. Where a worker has died as a result of a compensable injury, the Board will pay for the necessary expenses of the burial as follows.

    1.1. The Board will pay for burial expenses up to $4,000 provided that suitable documents to substantiate the expenses are supplied to the Board.

    1.2. The Board will pay for burial expenses above $4,000 and up to $5,000 on the following conditions:

    a) Application has been made to the Canada Pension Plan (CPP) (by the worker's survivors/estate) for a CPP death benefit;

    b) CPP has made or refused payment of a death benefit;

    c) The amount of expenses that the Board would pay for above $4,000 would be the *lesser* of:

    i) $1,000; or

    ii) the amount by which the burial cost beyond $4,000 exceeds the CPP death benefit; and

    d) Suitable documents to substantiate the expenses are supplied to the Board.

2. In all cases, the Board covers only expenses actually incurred.

Application

This Policy applies to compensable deaths occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 60(1)(a). Survivor Benefit Regulations.

Policy Number: 6.1.3

Topic: Expenses for Transportation of Body
Section: Survivor Benefits
Subsection: One-Time Benefits

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: March 1, 1995

Policy Statement

1. Where a worker dies as a result of a compensable injury, the Board will pay for expenses for transportation of the body of the worker as follows.

    1.1. Where the place of death is **within** Nova Scotia, the Board will pay up to $500 for transportation of the body from the place of death to the worker's usual place of residence.

    1.2. Where the place of death is **outside** Nova Scotia, the Board will pay the actual expenses for transportation of the body from the place of death to the worker's usual place of residence.

2. In all cases, the Board covers only expenses actually incurred.

3. In all cases, the Board only pays for expenses that are not already being paid for by another agency (e.g. Canada Pension Plan).

Application

This Policy applies to compensable deaths occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 60(1)(b). Survivor Benefit Regulations.

Policy Number: 6.1.4

Topic: Death of a Worker While in Receipt of Compensation
Section: Survivor Benefits
Subsection: One-Time Benefits

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: March 1, 1995

Policy Statement

1. Where a worker dies while in receipt of compensation, the dependent spouse or dependent children of the worker will receive three times the monthly amount which would have been payable to the worker if not for the worker's death.

2. Further, where the worker was receiving compensation with respect to a 100% permanent impairment rating (pursuant to Section 34), an additional nine times the monthly benefit otherwise payable to the worker will be paid to the dependent spouse or dependent children of the worker.

Application

This Policy applies to compensable deaths occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 60(7), 60(8).

Subsection 6.2 – Periodic Benefits

- **Policy Number: 6.2.1R - Survivor Pension**
- **Policy Number: 6.2.2 - Survivor Pension – More Than One Spouse Qualifies**
- **Policy Number: 6.2.3 - Dependent-Child Benefit**
- **Policy Number: 6.2.4R - Discretionary Benefits to Surviving Dependants**
- **Policy Number: 6.2.5 - Benefits to Person Standing in Place of Parent**
- **Policy Number: 6.2.6 - Recalculation of Benefits When One Dependant Ceases to Qualify**
- **Policy Number: 6.2.7R - Duration of Payments to Dependants**
- **Policy Number: 6.2.8R - Annuity**

Policy Number: 6.2.1R

Topic: Survivor Pension
Section: Survivor Benefits
Subsection: Periodic Benefits

Effective: February 1, 1996
Issued: May 17, 1999
Approved by Board of Directors: May 14, 1999

Policy Statement

1. Where a worker dies as a result of a compensable injury and is survived by a dependent spouse, the spouse shall receive a Survivor Pension equivalent to 85% of the worker's net average earnings before the accident.

2.

   a) If the date of the worker's injury was on or after February 1, 1996, the benefit will be paid monthly until either:

      i) the spouse reaches 65 years of age; or

      ii) the worker would have reached 65 years of age,

      whichever is later.

   b) Once the Survivor Pension ceases to be payable, an annuity will be provided to the spouse.

3. If the date of the worker's injury was prior to February 1, 1996 the benefits will be paid monthly for the life of the spouse, and no annuity is payable.

Application

This Policy applies to compensable deaths occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 59(c), 60(1)(c), 60(3).

An Act to Amend Chapter 10 of the Acts of 1994-1995, *the Workers' Compensation Act* (Chapter 1, Acts of 1999), Clause 6.

Policy Number: 6.2.2

Topic: Survivor Pension – More Than One Spouse Qualifies
Section: Survivor Benefits
Subsection: Periodic Benefits

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: March 1, 1995

Policy Statement

1. Where a worker dies as a result of a compensable injury and is survived by more than one spouse who qualifies for a Survivor Pension, the Survivor Pension may be apportioned between the surviving spouses. Apportionment of the Survivor Pension shall be based primarily on each spouse's demonstrated level of financial dependence on the worker before the accident.

2. The total of the Survivor Pension payments to all qualifying surviving spouses will equal 85% of the worker's net average earnings before the accident.

3. Where a Survivor Pension is apportioned among more than one surviving spouse, the annuity contributions for each spouse will be based on whatever portion of the Survivor Pension is payable to that spouse.

Application

This Policy applies to compensable deaths occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 63, 66.

Policy Number: 6.2.3

Topic: Dependent-Child Benefit
Section: Survivor Benefits
Subsection: Periodic Benefits

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: March 1, 1995

Policy Statement

1. Where a worker dies as a result of a compensable injury and is survived by a dependent child or children (pursuant to Section 64), the dependent child(ren) will receive a Dependent Child Benefit of $196 per month. The benefit is payable until the month in which the child turns 18 years of age, or the end of the school year in which the child attains 25 years of age, if attending an approved educational facility.

Guidelines

1. Where a child qualifies as a dependant at the time of the worker's death and both of the child's parents are deceased, the child may (subject to maximum allowable benefit provisions) qualify for an increase in the Dependent Child Benefit (see Policy 6.2.4R).

Application

This Policy applies to compensable deaths occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 59(b), 60(1)(d), 64.
Survivor Benefit Regulations.

Policy Number: 6.2.4R

Topic: Discretionary Benefits to Surviving Dependants
Section: Survivor Benefits
Subsection: Periodic Benefits

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

Other Recognized Dependants [s.60(4)]

1. Where the worker is not survived by a spouse or dependent children any amount awarded to 'other recognized dependants' [pursuant to s.60(4)] shall be based primarily on that person's demonstrated level of financial dependence on the worker before the accident.

Dependent Children - Both Parents Deceased [s.62]

2. Where both parents of a child are deceased, and the child qualifies as a dependant (pursuant to s.64) at the time of the worker's death, any further amount in addition to the dependent child benefit [see policy 6.2.3] shall be based on the child's level of financial dependence on the worker before the accident, as well as any extraordinary financial hardship imposed on the child as a result of the worker's death.

3. Any further amount awarded (as per the preceding paragraph) may be payable only for so long as the child continues to qualify as a dependant (as defined in Section 64 of the *Act*).

General

4. The total of all periodic benefits payable with respect to "other recognized dependants" of the worker, or the total of any further amount(s) contemplated under s.62, may not exceed 85% of the worker's net average earnings before the accident [s.60(5) and 62(2)]

Application

This Policy applies to compensable deaths occurring on or after October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 60(4), 60(5), 62, 64.

Policy Number: 6.2.5

Topic: Benefits to Person Standing in Place of Parent
Section: Survivor Benefits
Subsection: Periodic Benefits

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: March 1, 1995

Policy Statement

1. When a discretionary benefit is awarded to a person standing in the place of a parent and maintaining the worker's household, the benefit will be payable to the person until either:

   a) the worker's child(ren) ceases to qualify as a dependant; or

   b) the month in which the child(ren) ceases to live with the person on a full-time basis,

   whichever is earlier.

2. Further, the amount of benefit awarded will be primarily based on the level of financial hardship imposed on that person as a result of maintenance of the worker's household.

3. A person standing in place of a parent will generally be considered to be maintaining the worker's household so long as:

   a) the person resides with the child(ren), of the worker; or

   b) the person assumes a significant financial burden in order to allow the dependent child(ren), to reside in their own home.

4. The total of any benefit payable pursuant to this Policy, and any other periodic benefit payable with respect to the death of the worker, shall not exceed 85% of the worker's net average earnings before the accident.

Application

This Policy applies to compensable deaths occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 61.

Policy Number: 6.2.6

Topic: Recalculation of Benefits When One Dependant Ceases to Qualify
Section: Survivor Benefits
Subsection: Periodic Benefits

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: March 1, 1995

Policy Statement

1. When benefits are payable to more than one dependant with respect to the death of a worker, and one of the dependants subsequently ceases to qualify for benefits, payment to that dependant will cease. Benefits payable to the remaining dependant, or dependants, will be recalculated (where appropriate) to reflect the compensation which would have otherwise been payable had they been the only dependant, or dependants, at the time of the worker's death.

2. The recalculation will result in a higher award to the remaining dependants only where individual benefits were originally limited by the number of qualifying dependants, such as in the case of "other recognized dependants" of the worker [no spouse or child; pursuant to subsection 60(4)], or where a discretionary increase has been granted to a child under 18 where both parents are deceased (pursuant to s.62).

Application

This Policy applies to compensable deaths occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 65.

Policy Number: 6.2.7R

Topic: Duration of Payments to Dependants
Section: Survivor Benefits
Subsection: Periodic Benefits

Effective: February 1, 1996
Issued: May 17, 1999
Approved by Board of Directors: May 14, 1999

Policy Statement

Dependent Spouse

1. a) A dependent spouse of a worker whose injury date was on or after February 1, 1996 will receive a Survivor Pension until either:

    i) the month in which the spouse reaches age 65, or

    ii) the month in which the worker would have reached age 65,

    whichever is later.

    b) A dependent spouse of a worker whose injury date was prior to February 1, 1996 will receive a survivor pension for life.

Dependent Child

2. A Dependent Child Benefit is payable until the month in which the child reaches 18 years of age.

Dependent Child Attending Approved Educational Facility

3. If the child is attending an approved educational facility beyond the age of 18, then the benefit may be payable until the end of the school year in which the child turns 25 years of age. In any case, this benefit will continue only for so long as the worker would have reasonably been expected to continue to support the child.

Child Incapable of Earning

4. Where a child is physically or mentally incapable of earning, the dependant child benefit may be payable until the child:

    a) is capable of earning, or

    b) dies,

    whichever is earlier.

Other Recognized Dependents

5. Where benefits are granted to other dependents of the worker [pursuant to Section 60(4)], the benefit will continue:

a) only so long as the worker's support would have been expected to continue, or

b) for five years,

whichever is earlier.

Application

This Policy applies to compensable deaths occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 60 and 64.

An Act to Amend Chapter 10 of the Acts of 1994-1995, *the Workers' Compensation Act* (Chapter 1, Acts of 1999), Clause 6.

Policy Number: 6.2.8R

Topic: Annuity
Section: Survivor Benefits
Subsection: Periodic Benefits

Effective: February 1, 1996
Issued: May 17, 1999
Approved by Board of Directors: May 14, 1999

Policy Statement

1. Wherever a Survivor Pension is payable to the spouse of a worker whose injury date was on or after February 1, 1996, an amount equal to 5% of the value of the Survivor Pension will be set aside to provide an annuity to the recipient once the Survivor Pension is no longer payable.

2. Annuity contributions made with respect to a surviving spouse will be in accordance with the Board's annuity policies (see Subsection 3.6 of this Policy Manual).

3. Where a Survivor Pension is apportioned among more than one surviving spouse, the annuity contributions for each spouse will be based on whatever portion of the Survivor Pension is payable to that spouse.

Application

This Policy applies to compensable deaths occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 66.

An Act to Amend Chapter 10 of the Acts of 1994-1995, *the Workers' Compensation Act* (Chapter 1, Acts of 1999), Clause 6.

Subsection 6.3 – General

- **Policy Number: 6.3.1R - Death Prior to February 1, 1996**

Policy Number: 6.3.1R

Topic: Death Prior to February 1, 1996
Section: Survivor Benefits
Subsection: General

Effective: April 28, 1999
Issued: May 17, 1999
Approved by Board of Directors: may 14, 1999

Policy Statement

1. Any person receiving, or entitled to receive compensation pursuant to Section 22 of the former Act (i.e. Survivors' Benefits) as of February 1, 1996, will continue to receive compensation pursuant to the former Act, although indexing of these benefits will be pursuant to Section 70 of the 1995 Act.

2. Any person whose survivor benefits are reinstated pursuant to An Act to Amend Chapter 10 of the Acts of 1994-95, the *Workers' Compensation Act*' will have their reinstated benefits indexed pursuant to the former Act and the 1995 Act, as appropriate.

Guidelines

1. The "1995 Act" is the Workers' Compensation Act, Chapter 10, Acts of 1994-95.

2. The "former Act" is the Workers' Compensation Act, Chapter 508, Revised Statutes of Nova Scotia, 1989.

Application

This Policy applies to all compensable deaths prior to February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 230

An Act to Amend Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act*, Clause 7.

Section 7 - Specialized Adjudication

Overview

Note: This Overview is intended to provide a general guide to Board policies and programs. It does not constitute official Board policy.

Transitional Benefits (subsections 7.1 and 7.2)

With the coming into effect of the new *Workers' Compensation Act* on February 1, 1996, the rules for short- and long-term compensation changed, moving the Board and its clients to a system based on earnings replacement as well as physical impairment. Since the new rules applied to all injuries on or after March 23, 1990, some claims already paid benefits in accordance with the former Act had to be recalculated and the benefits adjusted in accordance with the new Act. This process was essentially completed in 1996. The rules with respect to which claims were recalculated and how the benefits were adjusted are contained in the Transitional Benefit Policies.

Amended Interim Earnings Loss (subsection 7.3)

The Board adopted the Amended Earnings Loss Policies on November 24, 1993. The policies were intended to ensure that an interim earnings loss benefit would be provided to those workers most in need (ie. those with a permanent physical impairment and a loss of earnings related to their injury).

Benefits paid were generally one-half of the earnings loss reported by the worker and continued (in most cases) until the adoption of final earnings loss policies. These "final" policies were adopted pursuant to the new Act and are contained in this manual. Recalculation of these interim benefits were carried out as part of the transitional benefit recalculations referred to above. Effective April 28, 1999, Bill 90 reinstated AIEL benefits to workers with injury dates prior to March 23, 1990.

Recalculation under s. 228 (subsection 7.4)

On August 11, 1998 the Court of Appeal released a decision (the *Richard* decision) that ruled the current *Workers' Compensation Act* and policies apply to requests for permanent benefits for workers' injured during the 'window period' of March 23, 1990 and January 31, 1996. In other words, the calculation for permanent benefits during the window period is to be based on the formula in the current Act (i.e. 85% of net).

Compensation for Chronic Pain for Injuries March 23, 1990-Jan. 31, 1996 (subsection 7.5)

Effective April 28, 1999, sections 10A and 10E of Bill 90 came into force. Section 10A states that no compensation is payable for chronic pain, other than that specified under the Functional Restoration Program Regulations (for post-February 1, 1996 injuries) and Section 10A of Bill 90 (for injuries after March 23, 1990 and February 1, 1996).

Section 10E provides certain workers in the appeal system, or on temporary benefits, as of November 25, 1998, with Permanent Impairment Benefits and Extended Earnings Replacement Benefits, where appropriate.

Subsection 7.1 – Transitional Claims: Temporary Disability

- **Policy Number: 7.1.1 - Benefits on or After February 1, 1996 for Injuries Before February 1, 1996**

Policy Number: 7.1.1

Topic: Benefits on or After February 1, 1996 for Injuries Before February 1, 1996
Section: Specialized Adjudication
Subsection: Transitional Claims – Temporary Disability

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: March 1, 1995

Policy Statement

1. Where a worker:

   a) suffered an injury prior to February 1, 1996; and

   b) on February 1, 1996 was receiving, or was entitled to receive, compensation for temporary disability pursuant to Chapter 508 of the Revised Statutes, 1989 as amended (i.e. the "former Act" - the Workers' Compensation Act in force prior to February 1, 1996) the worker will continue, on and after February 1, 1996, to receive compensation calculated in accordance with the former Act.

2. The Board shall recalculate the amount of compensation payable to such a worker in accordance with the Workers' Compensation Act, Chapter 10, Acts of 1994-95.

3. Payment of the recalculated amount will commence August 1, 1996.

Guidelines

1. For injuries occurring prior to June 1, 1995, the rate of compensation for temporary total disability under the former Act was 75% of the worker's average weekly gross earnings prior to the injury.

2. For injuries occurring June 1, 1995-January 31, 1996 inclusive, the rate of compensation for temporary total disability under the former Act was 75% of the worker's average weekly net earnings for the first 26 weeks of compensation and 85% thereafter.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 229.

Subsection 7.2 – Transitional Claims: Permanent Disability

- **Policy Number: 7.2.1 - Recalculation of Awards Where Injury Occurred On or After March 23, 1990**

Policy Number: 7.2.1

Topic: Recalculation of Awards Where Injury Occurred On or After March 23, 1990
Section: Specialized Adjudication
Subsection: Transitional Claims: Permanent Disability

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: March 1, 1995

Policy Statement

1. Where a worker's injury occurred on or after March 23, 1990, and the worker is entitled to receive compensation for either permanent partial or permanent total disability when the Act comes into force, then the worker's compensation will be recalculated in accordance with section 228 of the Act. The recalculation shall be carried out as per the requirements outlined in Sections 34 to 58 in the Act and will include:

    a) calculation of a permanent impairment benefit;

    b) calculation of an earnings replacement benefit, where such a benefit is payable; and

    c) calculation of annuity contributions for the recalculated period, where appropriate.

2. If the recalculation results in a lesser award, the Board shall begin paying the recalculated amount effective the date of recalculation. No overpayment with respect to the previously paid period will be collected.

3. If the recalculation results in a greater award, the Board shall begin paying the recalculated amount effective:

    a) the date on which the Board first determines that the worker has suffered a permanent physical impairment (pursuant to this Act, or any previous Act);

    b) the date on which the worker completes a Vocational Rehabilitation (VR) program (if the worker is involved in VR, or if VR is indicated for the worker); or

    c) November 26, 1992,

    whichever is later.

Application

This Policy applies to workers injured on or after March 23, 1990.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 228.

Subsection 7.3 – Amended Interim Earnings Loss

- **Policy Number: 7.3.1 - Statement of Principles**
- **Policy Number: 7.3.2 - Eligibility for Award**
- **Policy Number: 7.3.4 - Effective Date of Awards**
- **Policy Number: 7.3.5 - Calculation of Award**
- **Policy Number: 7.3.6R - Pre-Accident Earnings**
- **Policy Number: 7.3.7 - Indexing of Pre-Accident Earnings**
- **Policy Number: 7.3.8R - Post-Accident Earnings - Documentation**
- **Policy Number: 7.3.9 - Post-Accident Earnings – Canada Pension Plan (CPP) Disability Benefits**
- **Policy Number: 7.3.10 - Post-Accident Earnings – Permanent Partial Disability Awards**
- **Policy Number: 7.3.11 - Duration of Benefits**
- **Policy Number: 7.3.12 - Workers Reaching Normal Retirement Age**
- **Policy Number: 7.3.13 - Commutation of Awards**
- **Policy Number: 7.3.14 - Reinstated AIEL benefit for pre-March 23, 1990 injuries**

Policy Number: 7.3.1

Topic: Statement of Principles
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. On November 24, 1993, the Board of Directors amended the interim earnings-loss policy that it had approved on November 25, 1992.

2. The amendment is intended to be a transitional step toward implementation of final earnings-loss policies.

3. The intention of this amendment is to provide one-half the maximum potential benefit to which a worker may be entitled under final earnings-loss policies.

4. The amendment is primarily intended to ensure that an earnings-loss benefit is paid to those most in need (i.e. having the greatest difference between pre- and post-accident earnings as a result of the compensable injury). Consequently, the Board will give priority to those workers who will benefit most from this policy.

5. In all other respects not covered by this amendment, the Board's interim policy dated November 25, 1992, continues in effect.

6. (Details of the amended interim earnings-loss policies are outlined in the policy statements which follow (7.3.2 - 7.3.13). All policies with respect to amended interim earnings-loss are prefaced with the code 7.3.)

Guidelines

1. The Amended Interim Earnings Loss set of policies (7.3.1 - 7.3.13) was originally passed by the Board of Directors on November 24, 1993. The Policies will remain in use until all relevant claims involving permanent disability have been adjudicated pursuant to the 'transitional' provisions of the Act. [See Policies 7.2.1, 7.2.2]. The transitional provisions of the Act are the "final earnings-loss policies" referred to in this Policy Statement.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1).

Policy Number: 7.3.2

Topic: Eligibility for Award
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. To be eligible for consideration under the Amended Interim Earnings Loss policies, a worker must:

   a) have been granted an initial award for permanent disability on, or after, March 23, 1990; or

   b) be in receipt of an award granted under the interim earnings-loss policy (which became effective on November 26, 1992) with respect to an initial award for permanent disability granted on, or after, March 23, 1990.

2. Further, the Board will examine evidence presented to it to determine whether the worker has a loss of earnings on, or after, November 24, 1993, that is a result of the compensable injury.

3. The amended interim earnings-loss policies do not apply to workers who have reached "normal retirement age" (See Policy 7.3.11) before November 24, 1993.

4. An award is considered an "initial award" for the purposes of the Amended Interim Earnings Loss policies when:

   a) an adjudicator signs and dates a Form 51P (or equivalent documentation) stating that the worker has a permanent medical impairment; or

   b) an appeal committee, appeal officer or member of the Board of Commissioners releases a decision reversing a denial of a permanent-disability award; or

   c) the Appeal Board releases a valid decision reversing a denial of a PPD award, unless the Notice of Appeal was filed on or after November 23, 1993, and was in respect of a denial of a permanent-disability award made before March 23, 1990;

   or

   d) the Nova Scotia Court of Appeal (or Nova Scotia Supreme Court Appeal Division) releases a decision reversing a denial of a PPD award,

   whichever is most recent.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1). Policies 7.3.1, 7.3.3, 7.3.11.

Policy Number: 7.3.4

Topic: Effective Date of Awards
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. Where a worker is eligible for an award under the Amended Interim Earnings Loss policies, the Board shall calculate and begin paying that award effective either:

   a) November 24, 1993; or

   b) the date the worker's reported loss of earnings began,

   whichever is more recent.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1). Policy 7.3.1.

Policy Number: 7.3.5

Topic: Calculation of Award
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. Where a worker is eligible for an award under the Amended Interim Earnings Loss policies, the award shall be one-half of 75% of the difference between:

    a) what the worker was earning before the accident (subject to an appropriate indexing factor and the maximum assessable salary for the year(s) being reviewed; and

    b) the worker's documented earnings following the accident.

2. The Board may, under exceptional circumstances, award a higher wage loss benefit than that described above, particularly where the worker has a permanent medical impairment of 60% or higher.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1).
Policies 7.3.1, 7.3.6R, 7.3.7, 7.3.8R, 7.3.9, 7.3.10.

Policy Number: 7.3.6R

Topic: Pre-Accident Earnings
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. Pre-accident earnings shall be based on earnings over the 52 week period prior to the accident, and shall generally be taken to be those already indicated on the worker's claim file.

2. However, where Employment Insurance (EI) benefits have formed a part of the worker's earnings profile over the three years prior to the accident, EI benefits over the 52 weeks prior to the accident may be included in the calculation of pre-accident earnings.

Application

This Policy applies to all decisions made on or after October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1).
Policy 7.3.1.

Policy Number: 7.3.7

Topic: Indexing of Pre-Accident Earnings
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. When comparing pre-accident earnings to post-accident earnings for the purposes of calculating an award under the Amended Interim Earnings Loss policies, an indexing factor shall be applied to pre-accident earnings to ensure a valid comparison.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1).
Policy 7.3.1.

Policy Number: 7.3.8R

Topic: Post-Accident Earnings - Documentation
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. When determining the worker's post-accident earnings, the Board shall require the worker to provide a certified copy of the worker's Statement of Income and Deductions from the Canada Revenue Agency and/or such other documentation as the Board feels appropriate for the year(s) being reviewed.

Application

This Policy applies to all decisions made on or after October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1).
Policy 7.3.1.

Policy Number: 7.3.9

Topic: Post-Accident Earnings – Canada Pension Plan (CPP) Disability Benefits
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. For the purpose of determining a worker's post-accident earnings, the Board shall include 50% of any Canada Pension Plan (CPP) Disability Benefits the worker is receiving.

Guidelines

1. The Board does not consider any portion of a CPP Disability payable, with respect to the worker's dependants, as post-accident earnings.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1).
Policy 7.3.1

Policy Number: 7.3.10

Topic: Post-Accident Earnings – Permanent Partial Disability Awards
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. For the purpose of determining a worker's post-accident earnings, the Board shall not include the amount of any permanent disability award(s) the worker is receiving from the Board which are not being reviewed with respect to the Amended Interim Earnings Loss policies.

2. However, where the amount of the award under the Amended Interim Earnings Loss policies in combination with the value of previous PPD awards exceeds 75% of the worker's pre-accident earnings for the claim being reviewed, then the award granted under the Amended Interim Earnings Loss policies shall generally be reduced by the excess amount.

Guidelines

1. PPD awards not being reviewed with respect to the Amended Interim Earnings Loss policies are generally those first awarded prior to March 23, 1990.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1).
Policy 7.3.1.

Policy Number: 7.3.11

Topic: Duration of Benefits
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. Where a worker is eligible for an award under the Amended Interim Earnings Loss policies, the award shall be paid until either:

    a) the worker returns to employment at a level of earnings equal to, or greater than, pre-accident earnings; or

    b) the worker reaches normal retirement age, at which time the award shall be reviewed and replaced by a benefit intended to replace lost retirement income (see Policy 7.3.12).

2. "**Normal retirement age**" shall generally be taken by the Board to be 65 years of age unless the worker can, to the satisfaction of the Board, demonstrate otherwise.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1).
Policy 7.3.1, 7.3.12.

Policy Number: 7.3.12

Topic: Workers Reaching Normal Retirement Age
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. Where a worker in receipt of an award under the Amended Interim Earnings Loss policies reaches normal retirement age, the worker shall receive either:

   a) a continuance of the award granted under the amended interim earnings-loss policies; or

   b) an amount equivalent to an award for permanent medical impairment (under the Clinical Rating Schedule) with respect to the compensable injury which was reviewed under the Amended Interim Earnings Loss policies,

   whichever is less, pending review pursuant to final earnings-loss policies, once implemented.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1).
Policy 7.3.1.

Policy Number: 7.3.13

Topic: Commutation of Awards
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective:
Issued:
Approved by Board of Directors:

Policy Statement

1. Any award to which the Amended Interim Earnings Loss policies apply will not be eligible for commutation unless an offer of commutation was made prior to December 1, 1993.

Guidelines

1. Commutation of earnings-loss benefits may be considered after final earnings-loss policies are implemented.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 37(1).
Policy 7.3.1.

Policy Number: 7.3.14

Topic: Reinstated AIEL benefit for pre-March 23, 1990 injuries
Section: Specialized Adjudication
Subsection: Amended Interim Earnings Loss

Effective: April 28, 1999
Issued: May 17, 1999
Approved by Board of Directors: May 14, 1999

Preamble

Section 10D of the *Workers' Compensation Act* outlines criteria for reinstating Amended Interim Earnings Loss (AIEL) benefit for pre-March 23, 1990 injuries.

Policy Statement

Eligibility

1. To be eligible for benefits under section 10D, a worker must:

   (a) have been injured before March 23, 1990;

   (b) have been granted a permanent partial disability or a permanent total disability benefit under Section 43 or 45 of the former *Act* (Chapter 508 of the Revised Statutes, 1989, as amended); and

   (c) have been granted an amended interim earnings loss benefit pursuant to the Amended Interim Earnings Loss Policy adopted by the Board on November 24, 1993, pursuant to the former *Act*, and the worker's benefit was reduced on or before the coming into force of the current Act (Chapter 10 of the Acts of 1994-95, the *Workers' Compensation Act*).

Benefits

2. The Board shall pay an eligible worker the benefit the worker was receiving pursuant to the AIEL Policy adopted by the Board on November 24, 1993.

3. For greater certainty, effective the date of payment, an eligible worker will be paid the greater of:

   i) the reinstated AIEL benefit payable under this Policy; or

   ii) the amount of the worker's permanent partial disability or permanent total disability benefit the worker was receiving with respect to the claim on which the AIEL benefit was paid.

4. The benefit referred to under section #2 of the Policy is paid until the worker reaches the age of 65 years. After the age of 65 the worker will be reinstated to a permanent partial disability or permanent total disability benefit paid under section 43 or 45 of the former Act, which will continue for life.

Benefits

5. Benefits are paid retroactive to January 1, 1999.

Status of Appeals

6. A worker eligible for a benefit under this Policy who has, as of April 28, 1999, an appeal pending before the Workers' Compensation Appeals Tribunal (WCAT), on an issue other than medical aid, can either choose this benefit and forgo their appeal, or choose to continue with the appeal and forgo this benefit.

Application

This Policy applies to decisions made on or after April 28, 1999, for workers injured prior to March 23, 1990.

References

An Act to Amend Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act* (Chapter 1, Acts of 1999), Section 10D

Subsection 7.5 – Compensation for chronic pain for injuries on or after March 23, 1990 and before February 1, 1996

- **Policy Number: 7.5.6R1 - Criteria for Compensation for chronic pain**

Policy Number: 7.5.6R1

Topic: Criteria for Compensation for chronic pain
Section: Specialized Adjudication
Subsection: Compensation for chronic pain for injuries on or after March 23, 1990 and before February 1, 1996

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Preamble

Section 10E, the *Workers' Compensation Act*, outlines criteria for compensation for chronic pain for workers who were injured on or after March 23, 1990 and before February 1, 1996.

Policy Statement

Eligibility

1. To be eligible for the benefits outlined under section 10E, a worker must:

   (a) have been injured on or after March 23, 1990, and before February 1, 1996;

   (b) have chronic pain that commenced following the injury referred to in (a);

   (c) as of November 25, 1998, have been in receipt of temporary earnings-replacement benefits; or

   (d) as of November 25, 1998, had a claim under appeal

      (i) for reconsideration,

      (ii) to a hearing officer,

      (iii) to the Workers' Compensation Appeals Tribunal, or

      (iv) to the Nova Scotia Court of Appeal,

   or whose appeal period with respect to an appeal referred to in subsection (i) to (iv) had not expired.

Definition

2. "**Chronic Pain**," as defined in section 10A, means pain:

   (a) continuing beyond the normal recovery time for the type of personal injury that precipitated, triggered or otherwise predated the pain, or

   (b) disproportionate to the type of personal injury that precipitated, triggered, or otherwise predated the pain;

   and includes chronic pain syndrome, fibromyalgia, myofascial pain syndrome, and all other like or related conditions, but does not include pain supported by significant, objective, physical findings at the site of the injury which indicate the injury has not healed.

Benefits

3. The Board shall pay eligible workers a Permanent Impairment Benefit based upon a Permanent Medical Impairment (PMI) rating of 12.5%.

4. The PMI rating referred to in section #3 of this Policy is in addition to any PMI rating a worker may have been awarded under Policy 3.3.2R4, *Guidelines for Assessment of Permanent Medical Impairment*, or under Policy 3.9.6R1.

5. For greater certainty, a worker may not receive greater than a 100% PMI in accordance with this Policy, the *Guidelines for Assessment of Permanent Medical Impairment*, and Policy 3.9.6R1, combined.

6. Eligible workers will be considered for an Extended Earnings Replacement Benefit, if payable pursuant to sections 37-48 of Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act*.

7. In accordance with Clause 10E(d), eligible workers will be entitled to receive 50% of an Extended Earnings Replacement Benefit, if payable pursuant to sections 37-48 of the *Act*.

Retroactivity

8. Benefits paid under section 10E are retroactive to January 1, 1999.

Status of Appeals

9. For workers eligible for benefits under section 10E, any appeals referred to in section 1(d) of this Policy are null and void, regardless of the issue or issues on appeal.

Application

This Policy is effective December 16, 2021. This Policy replaces Policy 7.5.6R that was effective October 27, 2016, for workers injured on or after March 23, 1990 and before February 1, 1996, who have chronic pain that commenced following their work-related injury.

References

An Act to Amend Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act* (Chapter 1, Acts of 1999), Sections 10A, 10E, 10I.

Section 8 - Internal Appeals

Overview

Note: This Overview is intended to provide a general guide to Board policies and programs. It does not constitute official Board policy.

General

Both workers and employers can appeal decisions concerning the payment of compensation, including decisions with respect to the acceptance of claims, the payment of earnings loss compensation or health care benefits, the provision of vocational rehabilitation services or the payment of permanent impairment benefits. Employers can also appeal decisions concerning their WCB assessment.

Internal Appeal

A worker or an employer may, within 30 days of being notified of the final decision on a claim, appeal that decision to a Hearing Officer. Hearing Officers have the authority to make enquiries, receive evidence and render a final written decision concerning the issues on appeal. A Hearing Officer will either conduct a paper review of the file or hold an oral hearing. The Hearing Officer's decision is the final decision of the Board. The Hearing Officer is legally required to issue decisions within 60 days of the oral hearing or paper review, although the accepted corporate standard is 30 days.

It is important to note that it is not always necessary to file a an appeal to have a decision reviewed by a WCB staff member. If new information about a claim or assessment becomes available after a decision has been made, it should be sent directly to the staff member who made the original decision. The staff member can then review their decision, based on the new information provided, without the file having to go through the formal internal appeals process. However, where the decision for which a review is being requested is a final decision of the Board, the new information must be truly new evidence (eg. not a reiteration of evidence already on file or a new argument based on the same evidence) and evidence which could not have been presented by the worker or the employer at the time the final decision was made.

'External' Appeal

After receiving a Hearing Officer's decision, a worker or an employer may file an appeal with the Workers' Compensation Appeals Tribunal (WCAT) within 30 days of being notified of the Hearing Officer's decision. The WCAT is an independent agency that is administratively separate from the Workers' Compensation Board (WCB). Accordingly, the WCB's Board of Directors does not have jurisdiction to pass policies concerning the process used to conduct 'external' appeals, and no such policies are included in this manual.

Subsection 8.1 – Internal Appeals Process

- **Policy Number: 8.1.3R3 – Internal Appeals**
- **Policy Number: 8.1.4R - Participants in an Appeal**
- **Policy Number: 8.1.6 - Referrals to Medical Review Commission**
- **Policy Number: 8.1.7R2 - Reconsiderations Pursuant to s. 185(2) Where a Final Decision of the Board Addressing an Issue Has Been Rendered**
- **Policy Number: 8.1.8 - Requests for Reconsideration pursuant to former s.196 of Chapter 10 of the Acts of 1994-95**

Policy Number: 8.1.3R3

Topic: Internal Appeals
Section: Internal Appeals
Subsection: Internal Appeals Process

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Definitions

a) "**appellant**" means the participant who has filed the Notice of Appeal;

b) "**decision**" means a decision that would, if not reconsidered or appealed, have effect as a final decision of the Workers' Compensation Board;

c) "**new evidence**" includes documents, reports and oral evidence;

d) "**participant** means

i) in the case of a decision respecting compensation, the Worker and the Worker's employer; or

in respect of an assessment or a collection decision, the Employer

e) **"regular mail**" includes courier delivery;

f) "**staff member**" means a member of the staff of the Service Delivery departments of the Workers' Compensation Board, or any person exercising the authority of a member of those departments.

Policy Statement

1.

1.1. Any participant may appeal a decision made pursuant to section 185 to a Hearing Officer. For the purposes of an appeal before a Hearing Officer, the participants are those defined in Section 197(4) of the Act, and Policy 8.1.4R.

1.2. All participants shall be deemed to have been notified of a decision made pursuant to section 185

a) on the day the participant is actually notified in writing; or

b) five business days after the Workers' Compensation Board has posted, by regular mail, notice of the decision to the participant,

whichever is sooner.

1.3.

(a) A participant intending to appeal a decision of the Workers' Compensation Board shall submit a fully completed Notice of Appeal no later than 30 days after the date referred to in paragraph 1.2, the proof of which shall rest with the participant.

(b) In order to satisfy the requirement for submitting a Notice of Appeal within the time limit prescribed in subsection (a) above, the Notice must contain all of the following information:

1. The name of the appellant;

2. The address of the appellant;
3. The claim number of the appellant;
4. The name and address of the appellant's employer at the time of the accident;
5. The date of the reconsideration decision, and the name of the staff member who conducted the reconsideration rendered the decision;
6. An identification and discussion of the error alleged to have been made in the reconsideration decision;
7. Copies of any new evidence which supports the appeal, including a written explanation of how each piece of new evidence supports the appellant's argument;
8. Any written argument the appellant wishes the Board to consider;
9. Where the appellant wishes to have witnesses present evidence at an oral hearing, a list of the witnesses and a brief summary of the evidence they will be presenting; and
10. Where applicable, an application for an oral hearing.

(c) Where written submissions or evidence are forwarded by the requester after the 30-day time limit has expired, the Hearing Officer may consider the reasons for the late filing of the information and may, based on the reasons given, make a decision on whether the information will be considered in the appeal.

(d) Where appropriate, where the Board has not received the information required by subsection (b) within the 30 day time limit, the appeal shall not be carried out, and the staff member's decision shall be the final decision of the Board.

2.

2.1. On receipt of the complete Notice of Appeal, the WCB shall notify appeal participants of the appeal and send them a copy of the Notice of Appeal.

2.2. Any participant other than the appellant may make a submission to the Workers' Compensation Board within 10 days of the participant receiving, or being deemed to receive, the notification of appeal.

2.3. The notification of appeal shall be deemed to have been received by every participant

(a) on the day the participant is actually notified in writing; or

(b) five business days after the Workers' Compensation Board has posted, by regular mail, notice of the notification of appeal to the participant,

whichever is sooner.

3.

3.1. Where an application is made for an oral hearing, the Hearing Officer has the discretion to determine when an oral hearing is appropriate.

3.2. Where a Hearing Officer decides to hold an oral hearing, the Workers' Compensation Board shall send notification of the time and place of the hearing to every participant.

4. Where a Hearing Officer decides to conduct an appeal by way of oral hearing, and all participants agree to a hearing date, any cancellation or adjournment may result in the appeal proceeding by way of paper review on the date originally scheduled for the oral hearing.

5.

5.1. The decision of a Hearing Officer shall be rendered within 30 days of the oral hearing or paper review date, as the case may be.

5.2. If a Hearing Officer requires clarification of evidence presented at the oral hearing or paper review from an internal resource, the time limit for rendering decisions may be extended to a maximum of 40 days from the oral hearing or paper review date.

5.3. If a Hearing Officer requires clarification of evidence presented at the oral hearing or paper review from an external resource, the Chief Hearing Officer may extend the time limit prescribed by Section 197(8) where an injustice would otherwise result.

5.4. Where a Hearing Officer seeks clarification pursuant to subsection 5.2 or 5.3, the Hearing Officer shall provide to the participants a copy of the question(s) to be clarified, and the responses from the resource.

5.5. Where copies of the response are provided to the participants pursuant to subsection 5.4, the participants may make written submissions related to the response to the Hearing Officer within seven (7) days of the participant receiving, or being deemed to receive, the copy of the response.

6. A Hearing Officer may render any decision that could have been rendered by a staff member.

7.

7.1. The decision of a Hearing Officer does not require the approval of the Board of Directors.

7.2. The decision of a Hearing Officer shall be the final decision of the Workers' Compensation Board

8. An appeal to a Hearing Officer does not operate as a stay of proceedings in respect of the decision that is being appealed.

Application

This Policy applies to any decision by a staff member dated on or after October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 190 and Sections 197-202.

An Act to Amend Chapter 10 of the Acts of 1994-95, the Workers' Compensation Act (Chapter 1, Acts of 1999), Clause 26.

Policy Number: 8.1.4R

Topic: Participants in an Appeal
Section: Internal Appeals
Subsection: Internal Appeals Process

Effective: March 1, 1997
Issued: February 3, 1997
Approved by Board of Directors: November 8, 1996

Policy Statement

1. A participant in an appeal pursuant to Section 197(4)(c) will have demonstrated that he or she will present evidence and make submissions directly relevant to the appeal before the Hearing Officer.

2. Any question as to whether a person is a participant as defined by Section 197(4)(c), or as to the nature of such a participant's role in the oral hearing, is at the sole discretion of the Hearing Officer.

3. The Hearing Officer will consider all implications flowing from the decision that any given person is a participant pursuant to Section 197(4)(c), including the confidential nature of any information being presented at the hearing, and the impact of any delay caused by the inclusion of the participant.

Application

This Policy applies to any decision by a staff member dated on or after March 1, 1997.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 197(4)(c).

Policy Number: 8.1.6

Topic: Referrals to Medical Review Commission
Section: Internal Appeals
Subsection: Internal Appeals Process

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 5, 1995

Policy Statement

1. The decision to refer an issue to the Medical Review Commission is solely and completely at the discretion of the Workers' Compensation Board on its own motion, and is to be initiated to seek advice on an issue that the Workers' Compensation Board deems to be significant.

2. A medical opinion may be sought from the Medical Review Commission on a significant medical issue.

3. The medical opinions of the Medical Review Commission are not binding on the Workers' Compensation Board, and shall be considered by the appropriate decision-maker, in conjunction with all other information relevant to the matter under consideration, before a decision is rendered.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 204(1).

Policy Number: 8.1.7R2

Topic: Reconsiderations Pursuant to s. 185(2) Where a Final Decision of the Board Addressing an Issue Has Been Rendered

Section: Internal Appeals
Subsection: Internal Appeals Process

Effective: February 11, 2010
Issued: February 25, 2010
Approved by Board of Directors: February 11, 2010

Definitions

Final decision of the Board" means

(a) a decision of a staff member if a Notice of Appeal is not filed with the Workers' Compensation Board within the prescribed time limits; or

(b) a decision of a Hearing Officer.

Policy Statement

1.

1.1. Subject to the review rules set out in Sections 71-73 of the Act, Service Delivery Departments (as appropriate) may reconsider any final decision of the Board when a Worker or Employer provides the Workers' Compensation Board with new evidence in support of the request for a reconsideration pursuant to Section 185(2).

1.2. In order to conduct a s. 185(2) reconsideration the new evidence must satisfy the following two criteria:

i) It must truly be new evidence. It must not be a reiteration of the evidence already on file, or a new argument based on the same evidence, or evidence which is inconsequential and therefore, even if accepted, would not impact on the Workers' Compensation Board's final decision; and

ii) the evidence could not have been presented by the worker or employer at the time the final decision was made.

2. When a request is made to reconsider a matter that is already the subject of a final decision of the Workers' Compensation Board, the Workers' Compensation Board shall determine the following issue(s) only:

a) whether the evidence presented satisfies the criteria for new evidence set out in subsection 1.2 above; and, if so,

b) whether the new evidence presented to the Workers' Compensation Board is sufficient to persuade it to alter the final decision.

3. If these two issues are satisfied in the appellant's favour, the final decision on this issue is set aside, and the Workers' Compensation Board will implement the new decision of the Service Delivery Department.

4. An appeal of a Section 185(2) reconsideration decision shall be specifically limited to the two issues set out in paragraph 2.

5. The discretion of the Board to reconsider a decision, order or ruling made by it, pursuant to Section 185(2), is subject to the limitation on the Board's discretion to review compensation payable as a Permanent-Impairment Benefit, a Temporary Earnings-Replacement Benefit and an Extended Earnings-Replacement Benefit as set out in Sections 71-73 of the Act.

Application

This Policy applies to any decision by a staff member dated on or after April 16, 1999.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 185(2), 71-73.
An Act to Amend Chapter 10 of the Acts of 1994-95, the Workers' Compensation Act (Chapter 1, Acts of 1999), Clause 25.

Policy Number: 8.1.8

Topic: Requests for Reconsideration pursuant to former s.196 of Chapter 10 of the Acts of 1994-95
Section: Internal Appeals
Subsection: Internal Appeals Process

Effective: April 16, 1999
Issued: May 17, 1999
Approved by Board of Directors: May 14, 1999

Policy Statement

1. Where a Request for Reconsideration pursuant to the former s.196 of Chapter 10 of the Acts of 1994-95 is received by the Board prior to April 16, 1999, and the reconsideration has not been completed as of that date, the staff member conducting the reconsideration shall refer the matter directly to a Hearing Officer for a decision.

Application

This Policy applies to requests for reconsideration filed prior to April 16, 1999 with no decision rendered by April 16, 1999.

References

An Act to Amend Chapter 10 of the Acts of 1994-95, *the Workers' Compensation Act*, Clause 25.

Subsection 8.2 – Referrals to the Chair

- **Policy Number: 8.2.1 - Adjournment and Referral of Appeal by Hearing Officer to Chair of Board of Directors**
- **Policy Number: 8.2.2R1 - Interim Awards During Adjournment**

Policy Number: 8.2.1

Topic: Adjournment and Referral of Appeal by Hearing Officer to Chair of Board of Directors
Section: Internal Appeals
Subsection: Referrals to the Chair

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 5, 1995

Policy Statement

1. At any time in the appeal, and before a written decision is rendered by a Hearing Officer on an appeal, the appeal may be adjourned and referred to the Chair of the Board of Directors if, in the Hearing Officer's opinion, the appeal raises either

   a) an issue of law and general policy that should be reviewed by the Board of Directors; or

   b) important or novel questions or issues of general significance that should be decided by the Workers' Compensation Appeals Tribunal.

2. The Chair of the Board of Directors who receives the reference from the Hearing Officer has 30 calendar days from the date of receipt of the file to direct in writing that the appeal be

   a) reviewed by the Board of Directors pursuant to Section 183 of the Act;

   b) heard and decided by the Appeals Tribunal pursuant to Part II; or

   c) returned to the Hearing Officer.

3. If the Chair of the Board of Directors returns the appeal to the Hearing Officer, the merits of the appeal shall be determined by the Hearing Officer pursuant to Sections 197 and 198.

4. A reference by a Hearing Officer to the Chair of the Board of Directors pursuant to Sections 197(7) and 199 is not a final decision of the Workers' Compensation Board, and therefore is not the subject of an appeal to the Workers' Compensation Appeals Tribunal pursuant to Section 243(1).

5. **Chair's referral to Board of Directors**

   5.1. **Purpose**: These provisions are intended to provide the Board of Directors with a vehicle for review of significant issues for which the existing policy is insufficient, or where there is no policy and the matter must be dealt with expeditiously. This process is not intended to replace the ongoing policy development function of the Workers' Compensation Board, and will be exercised only in exceptional cases.

   5.2. For the purposes of the application of Sections 183, 199(1)(a), 200(1)(a), 201 and 248, issues of "... law and general policy that should be reviewed by the Board of Directors..." include those for which

   (a) there is no written Policy and the issue is of broad significance;

   or

   (b) there is a written Policy relevant to the issue on appeal and, in the opinion of the Hearing Officer or the Chair of the Board of Directors, the Policy needs to be reconsidered to reflect the original intent of the Board of Directors; the written Policy is inconsistent with the Act, decision(s) of WCAT or decision(s) of the Supreme Court of Nova Scotia; or to reflect changed circumstances not anticipated by the Board of Directors when the Policy was originally passed.

6. Chair's referral to Workers' Compensation Appeals Tribunal

6.1. Purpose: These provisions are intended to provide the Chair of the Board of Directors with a vehicle to refer an issue to the Workers' Compensation Appeals Tribunal for review. This referral is intended to take place only in exceptional cases where there is a significant issue as to the interpretation of the legislation and the issue is most appropriately dealt with by the WCAT.

6.2. For the purposes of the application of Sections 199(1)(b) and 200(1)(b), appeals that raise "...important or novel questions or issues of general significance that should be decided by the Appeals Tribunal..." include, for example, appeals where the potential to set a precedent for a large number of stakeholders exists.

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 197(7), 199(1), 200(1), 201, 248.

Policy Number: 8.2.2R1

Topic: Interim Awards During Adjournment
Section: Internal Appeals
Subsection: Referrals to the Chair

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. **Purpose**:

   The purpose of an interim award is to prevent the adjournment or postponement pursuant to Section 199 from prolonging the worker's functional recovery from a work-related injury. This award should not be made for purely economic reasons. Therefore, without fettering the discretion of the Hearing Officer, the interim award should focus on provision of medical aid and/or vocational rehabilitation assistance.

2. The Hearing Officer shall only exercise their discretion to award an interim award where there is a preponderance of evidence that the interim award will

   a) prevent the development of a permanent medical impairment (PMI) or the increase of an existing PMI;

   b) aid the worker in recovering from their work-related injury; or

   c) prevent an increase in the worker's earnings loss that can be directly attributed to the work-related injury,

   and there is no reasonable alternative to remedy the worker's situation.

3. An interim award made pursuant to Section 199(4) is not a final decision of the Workers' Compensation Board, and in light of the fact that it is interim or temporary in nature, is not a decision which is appealable pursuant to Sections 196, 197 or Part II of the Act.

4. An interim award made pursuant to Section 199(4) may be amended at the Hearing Officer's discretion. An interim award made pursuant to Section 199(4) shall be made without prejudice to any further decisions of the Board relating to the same issue(s) on appeal.

5. Any payments made through an interim award pursuant to Section 199(4) will be considered a non-recoverable overpayment (pursuant to Policy 10.2.1R1) if the appeal is ultimately unsuccessful.

Application

This Policy is effective December 16, 2021. This Policy replaces Policy 8.2.2 that was effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 199(4).

Section 9 - Assessments and Collections

Overview

Note: This Overview is intended to provide a general guide to Board policies and programs. It does not constitute official Board policy.

Scope of Coverage

The *Workers' Compensation Act* requires firms which employ three or more workers, and which operate in industries designated by regulation as subject to mandatory registration, to register for coverage. The term 'workers' includes full-time, part-time, and casual workers as well as sub-contractors. Those businesses that are not subject to mandatory registration under the Act -- e.g. financial institutions, professional services and farms -- may apply to obtain workers' compensation coverage on a voluntary basis.

Special protection coverage is an optional insurance plan for self-employed proprietors, partners, and family members of an employer living in the employer's household. The applicant chooses the desired level of coverage, ranging from a minimum to a maximum, and benefits are based on the lesser of the actual wages or the amount of coverage purchased.

Registration

If a firm is required to register mandatorily under the scope of the Act, it must do so within 10 business days of becoming an employer. If an employer fails to register with the WCB they may be subject to penalties.

Classification and Rate Setting

The funds needed to cover WCB benefits and services are collected from registered employers in the form of assessments. To calculate rates, employers are first grouped by the type of business they operate, and are given a *Standard Industrial Classification* (SIC) code. Industry groups with similar WCB claim-cost patterns are then put into the same rate groups. Each rate group is assigned an assessment rate based on the cost experience for the rate group.

Experience Rating

Under *experience rating*, an individual employer's claim-cost experience is compared to the average experience for their rate group as a whole. Any adjustment to the employer's rate will be based in part on this comparison. Employers with a better than average accident experience will pay lower assessment rates than those with a higher than average accident experience.

One of the strengths of this program is that it extends the role of insurance-based principles in the setting of premium rates, thereby making the system far more equitable. Employers have the power to positively affect their assessment rates through increased attention to workplace safety and return-to-work programs.

Prevention

In 2005, the WCB implemented a Safety Incentive Program aimed at motivating employers to implement effective health and safety systems and processes in their workplaces. The Safety Incentive Program is comprised of three components. These include:

1. Applying a surcharge to companies that are consistently worse than their rate group (i.e. have a claims cost to payroll ratio at least 200% greater than their rate group for four consecutive years). The goal is to encourage more businesses to improve and implement health and safety best practices.

2. Doubling the impact of serious injuries and fatalities when calculating an employer's Experience Rating.

3. Applying weighting factors to Rate Setting and Experience Rating costs to ensure that recent trends are better reflected in assessment rates. This way, employers who have taken recent steps to improve their safety performance will see a reduction in their Experience Rating sooner. Similarly, employers whose safety performance gets worse will see their rates increase quicker.

The details surrounding the rate-setting process (including experience rating), the Prevention Incentives Program as well as employer classification and penalties can be found in this section.

Subsection 9.1 – Scope of Coverage

- **Policy Number: 9.1.1R - Continuous coverage when the numbers of workers drops below three**
- **Policy Number: 9.1.2R - Special Protection Coverage**
- **Policy Number: 9.1.3R - Coverage for contractors and subcontractors which employ less than three workers**

Policy Number: 9.1.1R

Topic: Continuous coverage when the numbers of workers drops below three
Section: Assessments and Collections
Subsection: Scope of Coverage

Effective: January 1, 2000
Issued: December 1, 1999
Approved by Board of Directors: October 7, 1999

Policy Statement

1. If an employer registers under compulsory coverage regulations (i.e. employs three or more workers) and temporarily reduces the workforce to less than three workers, it is the Board's policy to continue coverage. A temporary reduction is one where the employer reduces the workforce to fewer than three workers for a period of less than 12 consecutive months.

2. Employers who temporarily reduce the workforce to less than three, and do not expect to have any workers employed (i.e. the employer will report no assessable earnings) may notify the Board indicating those facts and the date that the employer expects to have assessable wages once again.

3. Employers who temporarily reduce the workforce to less than three, but who have at least one employee, must report and make payment to the Board for the remaining worker(s).

Permanent Reduction: Cancellation of Coverage

4. If an employer permanently reduces the workforce to less than three workers, the employer may request in writing to the Board to cancel their coverage.

5. A permanent reduction in the number of workers is one where the employer will have less than three workers for a period of 12 consecutive months or more. Cancellation of coverage requires the approval of the Board. The Board will examine historical payroll information to determine the employer's coverage status. The Board will not allow cancellation of coverage for seasonal employers whose work force fluctuates because of the nature of the business.

6. If the request for cancellation is accepted by the Board, cancellation is to be effective the date the Board is advised and the employer must pay premiums up to that date. The account may be audited to ensure the accuracy of the employer's statements.

7. If an employer cancels coverage it is the employer's responsibility to inform workers that they are no longer covered. If an employer increases the workforce to three workers subsequent to cancellation, coverage is effective from the date three workers were employed. It is the employer's responsibility to re-register with the Board.

General

8. In counting the number of workers for purposes of section 15 of the Workers' Compensation General Regulations (the 'Regulations'), "worker" includes a person counted to be a worker pursuant to section 17 of the Regulations (an active officer not carried on the payroll of the business and family members living in the same household). Pursuant to section 18 of the Regulations this is made solely for purposes of counting the number of workers and does not entitle a person defined under section 17 of the Regulation to compensation.

Application

This Policy applies to decisions rendered on or after January 1, 2000.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) (as amended), Section 3.
Workers' Compensation General Regulations, Section 15, 17, and 18.

Policy Number: 9.1.2R

Topic: Special Protection Coverage
Section: Assessments and Collections
Subsection: Scope of Coverage

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. When an employer or partner applies for special protection under the Act, coverage is made effective the date the application and full payment of the assessment is received.

2. The assessment premium will be based on the total annual amount elected by the applicant and prorated quarterly.

3. The Board may require the applicant to have a medical examination prior to approval of the application.

4. Employers and partners must also renew their coverage annually and if this is not done it will automatically be cancelled.

Application

This Policy applies to all decisions made on or after October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 4.
Policy 3.1.1R4.

Policy Number: 9.1.3R

Topic: Coverage for contractors and subcontractors which employ less than three workers
Section: Assessments and Collections
Subsection: Scope of Coverage

Effective: January 1, 2014
Issued: January 23, 2014
Approved by Board of Directors: December 18th, 2013

Preamble

1. The *Workers' Compensation Act* requires employers which employ three or more workers, and which operate in industries designated by Regulation as subject to mandatory registration, to register for coverage. Employers within the scope of mandatory coverage under the *Act* are referred to as covered employers.

2. A covered employer which hires contractors is considered a principal. A covered employer who is a contractor may hire subcontractors. Contractor and subcontractor have the same meaning as in *Policy 9.5.4R1-Late Reporting of Year – End*.

Policy Statement

Deemed Workers

3. Where a contractor with less than 3 workers is hired by a principal, the workers of the contractor are deemed to be the workers of the principal if the following criteria are met:

   a) Both the principal and the contractor operate in an industry designated under the *Workers' Compensation General Regulations* as subject to mandatory coverage;

   b) The contractor has not purchased voluntary compensation coverage;

   c) The principal has three or more workers.

4. Workers of subcontractors with less than three workers hired by a covered contractor are deemed to be the workers of the contractor where both operate in an industry designated under the *Workers' Compensation General Regulations* as subject to mandatory coverage, and the remaining criteria in Section 3 of this policy are met.

Determination of contractor's assessable earnings

5. To determine the contractor's (or subcontractor's) assessable earnings the principal (or contractor) must calculate the labour portion of the work or services performed. The labour component is determined by subtracting the value of materials and equipment from the gross amount of work or services performed. The amount remaining is the labour portion of the work or services.

6. Where the exact value of materials and equipment is not known, a proxy amount specified in the table below must be used.

Type of work/service	Proxy
Labour and Materials	50%
Logging (chain saw):	75%
Courier Service	50%
Trucking and Leased Equipment	25%
Labour only	100%

Example:

Type	Total value of work or services performed	Proxy	Value of labour
Logging (chain saw)	$500	75%	$375

Application

This Policy applies to all decisions made on or after January 1, 2014.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), (as amended) Sections 9, 125.

Workers' Compensation General Regulations, Section 15.

Subsection 9.2 – Classification of Firms

- **Policy Number: 9.2.1 - Multiple Classification – Eligibility**
- **Policy Number: 9.2.2R - Classification of Firms not Eligible for Multiple Classification**

Policy Number: 9.2.1

Topic: Multiple Classification – Eligibility
Section: Assessments and Collections
Subsection: Classification of Firms

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: Sept. 14, 1995

Policy Statement

1. In order for a single firm to qualify for two industry classifications, each operation must be able to stand on its own. The second classification cannot be incidental to the first.

2. "Incidental" can be defined as an operation, regardless of whether separated by a location or payroll, that exists to service the prime industry of the firm or if it exists as an inescapable, supportive or ancillary part of the firm's main business.

3. Once it has been determined that an activity within the firm appears to stand on its own, the following guidelines are applied and all conditions must be met to qualify as a separate industry classification.

    3.1. Payroll for the firm must be at least $10,200.

    3.2. The firm must maintain a separate payroll for each classification.

    3.3. The industry activities must be performed by specific personnel as their sole function.

    3.4. The product or service provided must be offered to the public at large with the intent of producing revenue from sales to non-affiliated firms. As a rule 50% of the activity should be with non-affiliated firms[1].

    3.5. At least 25% of the firm's associated payroll must be applicable to the second industry (large firms, generally those with total payroll in excess of $500,000 need not meet this rule since payroll of less than 25% may still provide a significant presence in an industry).

[1] Guideline #3.4 will not apply to a sales and installation firm if they maintain a stock of goods for sale. Two classifications will be applied if all other tests are satisfied.

Examples

1. A machine shop which operates within a shipbuilding firm and provides a service to the shipbuilding firm only, will not be classified as a machine shop.

2. A manufacturing firm which maintains a sales division or sales outlet to sell its own product is not granted a separate sales category. Sales are considered an inescapable part of the firm's primary activity of manufacturing.

3. A logging company operates a nursery to grow seedlings. If more than 50% of the firm's seedling production is sold to non-affiliated companies, a separate classification will be allowed; otherwise it will be considered supportive of the firm's main industry and the logging classification will apply.

Application

This Policy applies to 1996 assessment rates onward.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 120(3)(4).

Policy Number: 9.2.2R

Topic: Classification of Firms not Eligible for Multiple Classification
Section: Assessments and Collections
Subsection: Classification of Firms

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. If a firm with multiple operations does not meet the eligibility criteria for separate classifications (see Policy 9.2.1: Multiple Classification - Eligibility), all payroll will be assessed at one rate.

2. Classification will then be based on the industry classification with the highest assessment rate for the operations undertaken, providing the highest-rated category represents as least 25% of the firm's operations. If this is not the case, the next highest classification will be assigned.

Application

This Policy applies to 1996 assessment rates onward.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 120(3)(4).

Subsection 9.3 – Rate Setting

- **Policy Number: 9.3.1R2 - Classification, Rate Setting and Experience Rating Process**
- **Policy Number: 9.3.2R2 - Transition**
- **Policy Number: 9.3.3R1 - Data Used in Rate Setting at Rate Group Level**
- **Policy Number: 9.3.4R - Costs Used for Fatal Claims for Rate Setting**
- **Policy Number: 9.3.5R - Claims Costs Which are Excluded From Rate Setting**

Policy Number: 9.3.1R3

Topic: Classification, Rate Setting and Experience Rating Process
Section: Assessments and Collections
Subsection: Rate Setting

Effective: November 23, 2017
Issued: December 19, 2017
Approved by Board of Directors: November 23, 2017

1. Preamble

The WCB uses a rate-setting and experience rating process that incorporates both collective, and individual, employer liability to set assessment rates for employers.

Collective liability is a risk sharing arrangement where the cost of compensation is spread among a pool of employers who are jointly responsible for the costs of the compensation system. Alternatively, under a system of individual employer liability (e.g. self-insured employers), an employer would pay the full amount of the costs it incurs and therefore be exposed to financial costs that might impact its ability to stay in business.

The purpose of this policy is to provide an overview and outline the steps in the rate-setting and experience rating process.

2. Goals of Rate Setting and Experience Rating Process

The goals of the WCB Rate Setting and Experience Rating Process are:

- Financial sustainability. This process produces, as required by Section 115 of the *Workers' Compensation Act* of Nova Scotia, enough funds to cover the estimated total revenue requirements for the upcoming year.

- Balance collective liability with individual employer accountability. While all registered employers in an industry are jointly responsible for the costs of claims, the process provides financial incentives and disincentives to individual employers for their injury prevention and return-to-work performance through experience rating.

- Achieve a balance between rate stability and rate responsiveness. The use of a collective liability model, statistical analysis, and actuarial advice prevents extreme rate variations (increases or decreases) year over year. The WCB's annual monitoring of the process and employers' ability to affect their rate through injury prevention and return to work ensures rates respond to changes in accident experience.

3. Definitions

"accident experience" means historical WCB claims cost data on workplace injuries. The data may be reported at the employer, Industry Group, or Rate Group level. A greater weight will be applied to the most recent year of costs and a lower weight to the most distant year. The weighting factors used will be based on actuarial valuations as determined by the WCB. Accident experience is expressed as a cost ratio for rate setting and experience rating purposes.

"annual cost ratio" is calculated:

- for the purposes of Industry Group or Rate Group formation, by dividing costs for claims with accident dates in the previous consecutive 5 year period by payroll from the same 5 year period.
- for experience rating purposes, the annual cost ratio is calculated by dividing the costs for claims with accident dates in the previous consecutive 3 year period by payroll from the same 3 year period.

"cost ratio" is cash payments on new claims in a defined period divided by assessable payroll for the same period.

"credible" in relation to an Industry or Rate Group, means the group has a sufficient volume of claims accident experience data to allow for confidence in the prediction of future claims experience.

"year" means calendar year.

4. Policy Statement

Introduction

The WCB Rate-setting and Experience Rating process has 7 Steps. Steps 1 through 5 reflect the principle of collective liability. In these steps assessed employers are classified and grouped to enable the WCB to assign baseline assessment rates that are statistically valid. Steps 6 and 7 provide individual employers the ability to directly impact their assessment rates through injury prevention and return-to-work.

Step 1 - Classifying Employers by Standard Industrial Classification (SIC)

Each employer is classified based on the principal activity of the business. The framework used to classify employers is the SIC system published by Statistics Canada.

Some firms may qualify for multiple classifications. See policies *9.2.1 - Multiple Classification – Eligibility* and *9.2.2R - Classification of Firms not Eligible for Multiple Classification*.

Step 2 - Industry Group Formation

Industry groups are determined by combining SIC's which have similar business activities.

Step 3 - Rate Group Formation, Monitoring, and Adjustment

Formation

The objective of Rate Group formation is to enable the WCB to calculate assessment rates (carried out in Step 4) that are an appropriate reflection of the underlying risk characteristics of a Rate Group when compared to other Rate Groups.

To ensure credibility, Rate Groups are formed by combining Industry Groups with similar accident experience. A Rate Group is considered to be made up of Industry Groups with similar accident experience when there is no more than a 20% difference, on average, between the annual cost ratio for each Industry Group and the Rate Group's annual cost ratio over the previous 5 consecutive years.

A Rate Group may consist of a single Industry Group if the group, on its own, has a sufficient volume of claims accident experience data to form a credible Rate Group.

Monitoring and Adjustment

As part of the annual review of Rate Groups the WCB will identify Industry Groups that no longer have accident experience similar to their current Rate Group. Those identified may be moved to another Rate Group.

An Industry Group no longer has accident experience similar to its current Rate Group when there is more than a 20% difference, on average, between the Industry Group's annual cost ratio and the Rate Group's annual cost ratio calculated over the previous 5 consecutive years.

Example: When setting rates for 2017 (carried out in 2016), Industry Group annual cost ratios for 2011 to 2015 inclusive are considered when forming and adjusting Rate Groups. Given that each cost annual ratio is calculated using the previous 5 years of payroll and cost data – a total of 9 years of data (2007 – 2015) are ultimately considered.

The WCB may move an Industry Group from its current Rate Group based on a period of less than 5 consecutive years. In making this decision, the WCB will consider (among other factors) the:

- amount of difference between the Industry Group and the Rate Group's annual cost ratios in the period; and
- the Industry Group's relative impact on the cost experience of the Rate Group.

Changes to Rate Groups may also be made if they are no longer credible.

<u>Step 4 – Calculating the Baseline Assessment Rate for Rate Groups</u>

Baseline assessment rates are calculated for each Rate Group based on the Rate Group's five-year accident experience. *Policy 9.3.3R2–Data Used in Calculating the Baseline Assessment Rate for Rate Groups* is applied when calculating the baseline assessment rate for a Rate Group.

For greater certainty, baseline assessment rates are not calculated for individual employers. They are calculated at the Rate Group level.

<u>Step 5 - Calculating Basic Assessment Rates by Employer</u>

Each employer's basic assessment rate (prior to experience rating) is determined by moving the current rate toward the Rate Group baseline rate over a transition period. The WCB applies policy *9.3.2R1 Transition* when moving the employer's basic assessment rate toward the Rate Group baseline rate.

<u>Step 6 - Experience Rating</u>

Experience Rating is a program, designed to be revenue neutral, which adjusts employer rates on the basis of the comparison of their accident experience (cost ratio) to the average accident experience of the Rate Group over a period of three years. Employers with better than average accident experience may receive merits (rate decreases), while employers with worse than average accident experience receive demerits (rate increases). (See *Policy 9.4.2R4*, re: Maximum Merit/Demerit and Surcharge). In the calculation of the average accident experience, the WCB excludes claim costs for any employers at the maximum demerit which are beyond the level required to put them at this maximum, as they form a portion of the collective liability of the

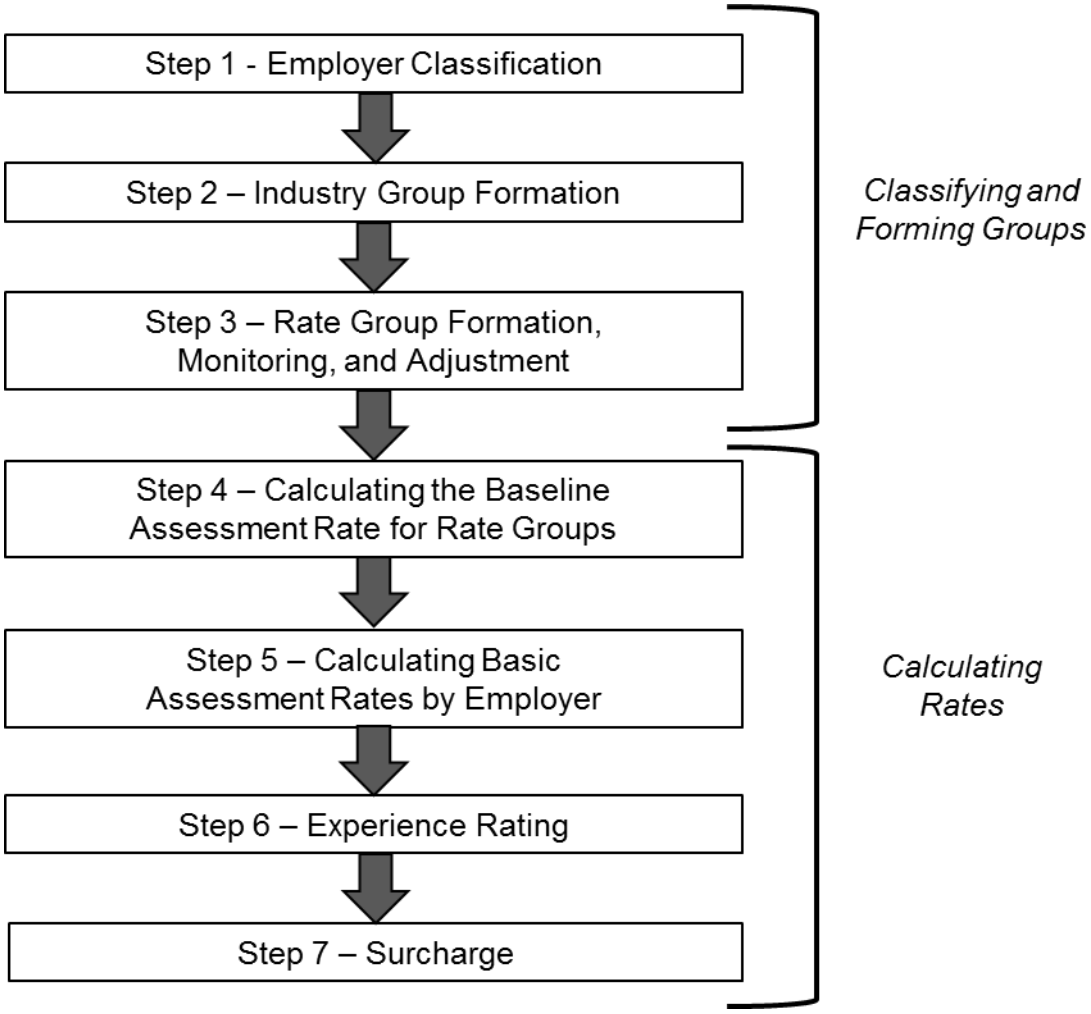
Rate Group. However, the average cost ratio used cannot be less than half (50%) of the cost ratio for the Rate Group including these collective liability costs.

Step 7 – Surcharge

A surcharge will be applied to an employer's basic rate if the criteria outlined in *Policy 9.4.2R4 Experience Rating – Maximum Merit or Demerit Surcharge* are satisfied.

5. Guidelines

Classification, Rate Setting and Experience Rating Process



Application

This Policy applies to all decisions made on or after February 1, 1996, but does not apply to any decisions made where as of November 23, 2017 there exists an active appeal, in that case Policy 9.3.1R2 will continue to apply.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), (as amended),
Sections 120(1), 121(1)(2)(3)(7), 125(1).

Policy Number: 9.3.2R1

Topic: Transition
Section: Assessments and Collections
Subsection: Rate Setting

Effective: January 1, 2001
Issued: August 3, 2000
Approved by Board of Directors: June 30, 2000

Policy Statement

1. The maximum change in an employer's basic rate, prior to the application of Experience Rating, is limited to 20% in any given year.

2. Notwithstanding paragraph 1., prior to Experience Rating:

   a) no firm's basic rate shall exceed 1.20 times (120% of) the rate group's baseline rate;

   b) there shall be a minimum increase of 60 cents for employers in upward transition.

Guidelines

1. The "**baseline rate**" is the rate where all employers in the rate group are headed, based on the rate group's cost experience.

2. The "**basic rate**" is the individual employer's assessment rate, without considering Experience Rating.

Application

This Policy applies to the 2001 assessment year onwards.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), (as amended), Section 121(1).

Policy Number: 9.3.3R2

Topic: Data Used in Rate Setting at Rate Group Level
Section: Assessments and Collections
Subsection: Experience Rating

Effective: November 23, 2017
Issued: December 19, 2017
Approved by Board of Directors: November 23, 2017

1. Preamble

This policy is applied during Step 4 – Calculating the Baseline Assessment Rate for Rate Groups in *Policy 9.3.1R3 – Rate Setting and Experience Rating Process Policy*, after Rate Groups have been formed.

2. Definitions

"annual cost ratio" is calculated:

- for the purposes of Industry Group or Rate Group formation, by dividing costs for claims with accident dates in the previous consecutive 5 year period by payroll from the same 5 year period.
- for experience rating purposes, the annual cost ratio is calculated by dividing the costs for claims with accident dates in the previous consecutive 3 year period by payroll from the same 3 year period.

"cost ratio" is cash payments on new claims in a defined period divided by assessable payroll for the same period.

"year" means calendar year.

3. Policy Statement

1. The data used to calculate the baseline rate for a Rate Group for a particular year consists of the claims costs and assessable payroll for the Rate Group over a period of five consecutive years for all claims with accident dates during that period. The costs that are included and excluded from rate setting are outlined in policies *9.3.4R Costs Used for Fatal Claims for Rate Setting*, and *9.3.5R Claims Costs Which are Excluded From Rate Setting*.

2. Where the benefit is a commuted Permanent Impairment Benefit, the claims costs used will be equivalent to three and one-half annual Permanent Impairment Benefit payments that would have been made had the benefit not been commuted.

3. The payroll used in the calculation will be the total assessable payroll on which the assessments are based for the same five years.

4. The WCB will calculate the cost ratio for the Rate Group by assigning a weighting to each of the five years. A greater weight will be applied to the most recent year of costs and a lower weight to the most distant year. The weighting factors used will be based on actuarial valuations as determined by the WCB. The WCB compares the Rate Group's annual cost ratio to the annual cost ratio for the province in calculating the baseline rate.

Example

To calculate the 2006 baseline rate for a Rate Group the cost and payroll data used will be for the years 2000, 2001, 2002, 2003 and 2004.

Application

This Policy applies to all decisions made on or after February 1, 1996, but does not apply to any decisions where as of November 23, 2017 there exists an active appeal, in that case Policy 9.3.3R1 will continue to apply.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 121(1).

Policy Number: 9.3.4R

Topic: Costs Used for Fatal Claims for Rate Setting
Section: Assessments and Collections
Subsection: Rate Setting

Effective: May 27, 2002
Issued: May 27, 2002
Approved by Board of Directors: March 15, 2002

Policy Statement

For the purposes of rate setting, the costs used for fatal claims over five years will be twice the maximum assessable earnings for the year of the accident, rather than the actual cost of the accident.

Application

This Policy applies to 1996 assessment rates onward. It replaces Policy 9.3.4, issued on December 1, 1995 and effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 121(1)(4), 125(1).

Policy Number: 9.3.5R

Topic: Claims Costs Which are Excluded From Rate Setting
Section: Assessments and Collections
Subsection: Rate Setting

Effective: January 9, 1997
Issued: May 2, 1997
Approved by Board of Directors: January 9, 1997

Policy Statement

1. The following are claims costs which are excluded from consideration for Rate Setting Purposes.

    1.1. Costs recovered by way of a third party action

    1.2. Compensation costs paid out prior to the disallowing of a claim.

    1.3. Costs transferred to another employer fund.

    1.4. Occupational disease claims which on average require exposure for two or more years before manifestation into a disability.

    1.5. Costs for a specific claim which are beyond twice the maximum assessable earnings for the year of the accident.

    1.6. Capitalization costs for claims which qualify for long term disability.

    1.7. Disasters.

    1.8. Costs associated with accounts that were defunct at the end of the year 1994.

    1.9. Costs associated with payment of interest pursuant to Policy 3.9.10.

Application

This Policy applies to 1996 assessment rates onward.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 121(1), 125(1).

Subsection 9.4 – Experience Rating

- **Policy Number: 9.4.1R1 - Experience Rating Participation**
- **Policy Number: 9.4.2R4 - Experience Rating – Maximum Merit or Demerit Surcharge**
- **Policy Number: 9.4.3R1 - Data Used in Experience Rating**
- **Policy Number: 9.4.4R2 - Claims Costs Which are Excluded from Experience Rating**
- **Policy Number: 9.4.5R2 - Costs Used for Fatal Claims for Experience Rating**

Policy Number: 9.4.1R1

Topic: Experience Rating Participation
Section: Assessments and Collections
Subsection: Experience Rating

Effective: January 1, 2001
Issued: August 3, 2000
Approved by Board of Directors: June 8, 2000

Policy Statement

1. Participation in the Experience Rating Program varies according to the employer account's average annual assessment during the historical period considered for Experience Rating and the number of years the employer account was active in that period.

1.1. Calculated Participation Rate

The level of participation is calculated by multiplying:

a) a factor for years of activity during the historical period;

1 year of activity = 25%

2 years of activity = 50%

3 years of activity = 100%

(Note: New firms to the system, with no payroll experience, will not participate in Experience Rating.)

and

b) a factor for average annual assessment during the historical period:

i) effective 2001 assessment year, 33.33% for average assessments from $0 - $5000, plus 1 percentage point for each additional $200, to a maximum of 100%.

Example

Consider an employer account with an average annual assessment of $10,000 which was active for two years in the historical period. The participation level is determined as follows:

Factors for years of activity = 50% (2 years of activity)

Factor for average annual assessment = 58.33%, calculated at 33.33% for the first $5000 average, plus 25% for the remaining $5000 ($5000/$200 = 25%).

Participation level = 50% x 58.33% = 29%

Application

This Policy applies to 2001 assessment rates onward.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), (as amended) Section 121.

Policy Number: 9.4.2R4

Topic: Experience Rating – Maximum Merit or Demerit Surcharge
Section: Assessments and Collections
Subsection: Experience Rating

Effective: March 15, 2012
Issued: March 28, 2012
Approved by Board of Directors: March 15, 2012

Policy Statement

1. The maximum merit (decrease) in an employer's basic rate as a result of Experience Rating is 30%.

2. The maximum demerit (increase) in an employer's basic rate as a result of Experience Rating is 60%.

3. Notwithstanding paragraph 2, where an employer's claims costs to payroll ratio as calculated for experience rating is at least 200% greater than the overall rate group ratio:

   a. for four consecutive experience rating assessment statements a surcharge will be applied in the fourth year if the employer participates fully in experience rating;

   b. for five consecutive experience rating assessment statements a surcharge will be applied in the fifth year if an employer's participation in experience rating, as outlined in Policy 9.4.1R1, ranges from 50% to 99%; and

   c. for six consecutive experience rating assessment statements a surcharge will be applied in the sixth year if the employer's participation in experience rating, as outlined in Policy 9.4.1R1, is less than 50%.

   The surcharge amount will be calculated based on an employer's experience rating participation level in the surcharge year.

4. Notwithstanding paragraph 3, an employer must be issued two successive surcharge warning notices by the WCB prior to a surcharge being applied to its rate.

5. Notwithstanding paragraph 4, surcharge warning notices will not be issued where a previously surcharged employer is out of surcharge position for less than three years.

6. For initial implementation of the surcharge program, the Board will use Experience Rating Statements from 2005 and onward for fully participating employers. For employers whose participation in experience rating ranges from 50% to 99% the Board will use Experience Rating Statements from 2004 onward. For those employers who participate less than 50% in experience rating, the Board will use Experience Rating Statements from 2003 onward.

7. The experience rating surcharge will be equal to annual increments not greater than 20% of the Rate Group's basic rate. Further, the maximum surcharge a firm will receive is an amount equal to its cost experience percentage above 200% of the rate group ratio of claims costs experience for the assessment year. Where a previously surcharged employer returns to a surcharge position, surcharge amount will re-commence at an annual increment not greater than 20% of the Rate Group's basic rate.

8. The amount of the surcharge will be added to the demerit to determine the overall experience rating adjustment.

Application

This Policy applies to 2013 assessment rates onward. It replaces Policy 9.4.2R3, issued on February 12, 2008 and effective January 24, 2008.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), (as amended) Section 121. Policy 9.4.1R1.

Policy Number: 9.4.3R1

Topic: Data Used in Experience Rating
Section: Assessments and Collections
Subsection: Experience Rating

Effective: April 12, 2005
Issued: May 2, 2005
Approved by Board of Directors: April 12, 2005

Policy Statement

1. The data used for experience rating consists of the claims costs and the assessable payroll of a firm over a period of three consecutive calendar years.

2. Claims costs used will be the cash costs (actual cash payments on benefits) for the three-year period for all claims with accident dates during that period. Where the benefit is a commuted Permanent Impairment Benefit, the claims costs used will be equivalent to two annual Permanent Impairment Benefit payments that would have been made had the benefit not been commuted.

3. The payroll used in the calculation will be the total assessable payroll on which the assessments are based for the same three years.

4. The Board will calculate the claims costs to assessable payroll ratio by assigning a weighting to each of the three years. A greater weight will be applied to the most recent year of costs and a lower weight to the most distant year. The weighting factors used will be based on actuarial valuations as determined by the Board.

Example

For the year 2006, the cost and payroll data used will be for the years 2002, 2003 and 2004.

Application

This Policy applies to 2006 assessment rates onward. It replaces Policy 9.4.3R issued on July 19, 1996 and effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 121(1).

Policy Number: 9.4.4R2

Topic: Claims Costs Which are Excluded from Experience Rating
Section: Assessments and Collections
Subsection: Experience Rating

Effective: March 15, 2012
Issued: March 28, 2012
Approved by Board of Directors: March 15, 2012

Policy Statement

1. The following are claims costs which are excluded from consideration for calculating a firm's experience rate.

    1.1. Costs recovered by way of a third party action.

    1.2. Compensation costs paid out prior to the disallowing of a claim.

    1.3. Costs transferred to another employer or fund.

    1.4. Occupational disease claims which on average require exposure for two or more years before manifestation into a disability.

    1.5. Prior to the application of the weighting factors, the costs for a specific claim that are beyond twice the maximum assessable earnings level for the year of the accident. This does not apply to fatal claims.

    1.6. Capitalization costs for claims which qualify for long term disability.

    1.7. Disasters.

    1.8. Costs associated with payment of interest pursuant to Policy 3.9.10.

Application

This Policy applies to 2006 assessment rates onward. It replaces Policy 9.4.4R1, issued on May 2, 2005 and effective April 12, 2005.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 121(1)(2)(3). Policy 9.4.3R1.

Policy Number: 9.4.5R2

Topic: Costs Used for Fatal Claims for Experience Rating
Section: Assessments and Collections
Subsection: Experience Rating

Effective: March 15, 2012
Issued: March 28, 2012
Approved by Board of Directors: March 15, 2012

Policy Statement

For the purposes of Experience Rating, the costs used for fatal claims for the three-year period will be five times the maximum assessable earnings level for the year of the accident, rather than the actual cost of the accident.

Application

This Policy applies to 2013 assessment rates onward. It replaces Policy 9.4.5R1, issued on May 2, 2005 and effective April 12, 2005.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 121(1)(4).

Subsection 9.5 – Penalties

- **Policy Number: 9.5.1R2 - Charge for Late Reporting of Payroll Statement**
- **Policy Number: 9.5.2R - Charge for Unpaid/Overdue Assessments**
- **Policy Number: 9.5.3R1 - Non-registered employers**
- **Policy Number: 9.5.4R1 - Late Reporting of Year-end Contractor and Subcontractor Report**

Policy Number: 9.5.1R2

Topic: Charge for Late Reporting of Payroll Statement
Section: Assessments and Collections
Subsection: Penalties

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. An employer who fails to furnish reports of their payroll, as required by Section 127 and 125(3), of the Workers' Compensation Act, shall pay a Late Reporting Charge in the amount of ten percent (10%) of the assessment premium for the reporting period.

2. Notwithstanding the 10% charge, if an employer has an offense more than once in a 12 month period, or willfully misreports information to the WCB, the maximum penalty may increase to twenty percent (20%) of the assessment premium for the reporting period.

3. For greater certainty, if no report of payroll is remitted by the employer when a remittance is required, the penalty may be based on the weighted average of assessment premiums for the employer during the previous 12 months. Months with no payroll will not be included in the average.

Application

This Policy applies to all decisions made on or after October 27, 2016. It replaces Policy 9.5.1R1, issued May 27, 2002 and effective May 27, 2002.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) (as amended), Sections 125(3), 127, and 128.
Workers' Compensation General Regulations, Section 37.

Policy Number: 9.5.2R

Topic: Charge for Unpaid/Overdue Assessments
Section: Assessments and Collections
Subsection: Penalties

Effective: January 1, 2000
Issued: January 31, 2000
Approved by Board of Directors: January 20, 2000

Policy Statement

1. If an employer fails to pay an assessment by the required due date interest will be charged on any outstanding balance.

2. Interest will be calculated in accordance with the rate prescribed by the Canada Customs and Revenue Canada (CCRA) as per sections 4301 and 4302 of the Income Tax Regulations (Canada).

Application

This Policy applies to all decisions made on or after January 1, 2000. It replaces Policy 9.5.2, approved by the Board on September 14, 1995 and effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) (as amended), Section 145.
Workers' Compensation General Regulations, section 38.

Policy Number: 9.5.3R1

Topic: Non-registered employers
Section: Assessments and Collections
Subsection: General

Effective: May 27, 2002
Issued: May 27, 2002
Approved by Board of Directors: March 15, 2002

Policy Statement

1. Any employer deemed to fall under the regulations as a mandatorily covered employer is required to report their operations to the Board within 10 business days of becoming an employer.

2. If an employer fails to report their operations to the Board the employer's coverage will be backdated and a penalty will be applied as follows:

   2.1. The assessment is backdated either to:

   a) the first date three workers or more were employed; or

   b) three years from January 1 of the current year

   whichever is more recent.

   2.2. The employer must pay a penalty on the outstanding assessment equal to 10% of the assessment owed to the Board.

3. If the Board accepts a claim from a worker employed by a non-registered employer the cash cost of the claim may be charged to the employer. Such claims costs will be in addition to the retroactive assessment and penalty outlined under statement #2.

4. If a non-registered employer voluntarily registers with the Board before a compensable injury occurs to a worker employed by the employer, the employer's coverage will be backdated and a penalty will be applied as follows:

   4.1. The assessment is backdated either to:

   a) the first date three workers or more were employed; or

   b) one year from January 1 of the current year

   whichever is more recent.

   4.2. The employer must pay a penalty on the outstanding assessment equal to 10% of the assessment owed to the Board.

Application

This Policy applies to all decisions made on or after May 27, 2002. It replaces Policy 9.5.3R, issued on July 2, 1997 and effective May 8, 1997.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 127, 137, 216, 217

Policy Number: 9.5.4R1

Topic: Late Reporting of Year-end Contractor and Subcontractor Report
Section: Assessments and Collections
Subsection: Penalties

Effective: January 1, 2014
Issued: January 23, 2014
Approved by Board of Directors: December 18th, 2013

Policy Statement

1. Where a covered employer has hired contractors or subcontractors during the year, a listing of all contractors or subcontractors hired by the employer must be submitted to the WCB by the last day of March following the assessment year.

2. Employers who fail to report contractor or subcontractor information to the Workers' Compensation Board by the last day of March following the assessment year, shall be levied a $50 charge.

Definitions

"**contractor**" means a person hired by a principal to perform work or services that

i) include a labour component;

ii) are carried out at the principal's premises or worksite, or at a location determined by the principal; and

iii) are for the purposes of the principal's trade or business, including those that are integral or incidental to the operation of the principal's business;

but does not include those

iv) whose sole function is to deliver goods or equipment to, or pick them up from, the principal's premises or worksite; or

v) who perform all of the work or services at their own worksite.

"**subcontractor**" has the same meaning as contractor where the person or firm is hired by a covered employer who is a contractor.

Application

This Policy applies to contractor or subcontractor reporting for the year January 1, 2014 onward.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), (as amended), Section 129, 208, *Policy 9.1.3R*.

Subsection 9.6 – Apportionment of Claims Costs

- **Policy Number: 9.6.1 - Effective Date for Apportionment**
- **Policy Number: 9.6.2 - Apportionment of Claims Costs Under Concurrent Employment**
- **Policy Number: 9.6.3 - Apportionment of Claims Costs Under a Rehabilitation Program**
- **Policy Number: 9.6.4 - Apportionment of Claims Costs for Learners**
- **Policy Number: 9.6.5 - Apportionment of Claims Costs for Workers Under 30**
- **Policy Number: 9.6.6 - Employer Cost Relief for Overpayment**

Policy Number: 9.6.1

Topic: Effective Date for Apportionment
Section: Assessments and Collections
Subsection: Apportionment of Claims Costs

Effective: January 1, 2014
Issued: January 23, 2014
Approved by Board of Directors: December 18th, 2013

Policy Statement

Any apportionment of claim costs that the Board undertakes will only apply to costs associated with injuries occurring on or after February 1, 1996 - the date of proclamation of the Workers' Compensation Act (Chapter 10, Acts of 1994-95).

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 18, 44, 45, 46, 47.

Policy Number: 9.6.2

Topic: Apportionment of Claims Costs Under Concurrent Employment
Section: Assessments and Collections
Subsection: Apportionment of Claims Costs

Effective: February 1, 1996
Issued: December 15, 1995
Approved by Board of Directors: Nov. 10, 1995

Policy Statement

1. If a worker is employed with two or more assessed employers and suffers an injury at one employer, the accident employer will only be charged with the portion of the claim cost for which they are directly responsible (the percentage of costs based on earnings at the accident employer). The remaining cost of the claim will be charged to an internal account, which forms part of the overall collective liability.

Definitions

Concurrent Employment: Having two or more employers at the same time

Apportionment of claims costs: Charging less than the full cost of the claim to the accident employer.

Accident Employer: The employer where the worker was working at the time of the injury.

Example

A worker earns $10,000 at employer A and $15,000 at employer B, for a total earnings of $25,000. If the worker is injured at employer A, the loss of earnings will be calculated based on what the worker was earning from employer A and B, provided that both employers had WCB coverage.

Under apportionment, employer A will only be charged with costs associated with 2/5ths, or 40%, of the total cost [$10,000 / ($10,000 + $15,000)]. All costs above this will be charged an internal account, which forms part of the overall collective liability.

Application

This Policy applies to costs associated with injuries occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 44 and 47.

Policy Number: 9.6.3

Topic: Apportionment of Claims Costs Under a Rehabilitation Program
Section: Assessments and Collections
Subsection: Apportionment of Claims Costs

Effective: February 1, 1996
Issued: December 15, 1995
Approved by Board of Directors: Nov. 10, 1995

Policy Statement

1. If a worker, as a result of a compensable injury, is participating in a Board-sponsored Vocational Rehabilitation program (e.g. On-the-Job Training, Employer Incentive Program, work hardening, vocational assessment) and suffers a new injury, the costs associated with the claim will not be charged to the original employer, Institute or Service Provider. Instead, the costs will be charged to an internal account, which forms part of the overall collective liability.

2. If a worker is participating in a VR program and suffers a recurrence of an on old injury, the costs are to be the responsibility of the original employer, as long it is considered to be the same claim.

Definitions

Recurrence - Applies to a worker who has previously suffered a loss of earnings and returns to work and suffers a subsequent loss of earnings from the same injury.

Original Employer - The employer where the worker was working at the time of the original accident.

Example

1. A worker with a compensable neck injury is participating in a Board-sponsored Rehabilitation Program. During the program the worker sustains a new injury (fractured arm) and the program is delayed for two weeks. Benefits paid to the worker during those two weeks, including associated medical costs, are paid by the Board. The costs are then charged to an internal account.

2. A worker with a compensable hip injury is participating in a Board-sponsored Rehabilitation Program. During the program the worker re-injures their hip. The costs associated with the injury (i.e TERB and medical) would be considered a recurrence and therefore are charged to the original employer.

Application

This Policy applies to costs associated with injuries occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 125.

Policy Number: 9.6.4

Topic: Apportionment of Claims Costs for Learners
Section: Assessments and Collections
Subsection: Apportionment of Claims Costs

Effective: February 1, 1996
Issued: December 15, 1995
Approved by Board of Directors: Nov. 10, 1995

Policy Statement

1. If a learner is injured and the Board deems the earnings of the learner to be an amount which is greater than their actual earnings, the employer will only be charged with the portion of the claims cost which is based on the learner's actual earnings. Any claims costs above this amount will be charged to an internal account, which forms part of the overall collective liability.

Application

This Policy applies to costs associated with injuries occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 2(q), 45, 47.

Policy Number: 9.6.5

Topic: Apportionment of Claims Costs for Workers Under 30
Section: Assessments and Collections
Subsection: Apportionment of Claims Costs

Effective: February 1, 1996
Issued: December 15, 1995
Approved by Board of Directors: Nov. 10, 1995

Policy Statement

1. If a worker under thirty is injured and the Board deems the earnings of the worker to be an amount which is greater than their actual earnings, the employer will only be charged with the portion of the claims cost which is based on the worker's actual earnings. Any claims costs above this amount will be charged to an internal account, which forms part of the overall collective liability.

Application

This Policy applies to costs associated with injuries occurring on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 46, 47.

Policy Number: 9.6.6

Topic: Employer Cost Relief for Overpayment
Section: Assessments and Collections
Subsection: Apportionment of Claims Costs

Effective: February 1, 1996
Issued: December 15, 1995
Approved by Board of Directors: June 25, 1994

Policy Statement

1. Once an overpayment has been identified by the Board, the cost associated with the overpayment will be removed from the claim experience of the employer.

Application

This Policy applies to costs associated with injuries occurring at classified employers on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 220.

Subsection 9.8 – General

- **Policy Number: 9.8.2R2 - Under Reporting of Payroll**
- **Policy Number: 9.8.4R - Holdback of Assessment Premium From Contractors and Subcontractors**
- **Policy Number: 9.8.5R - Definition of Assessable Earnings**

Policy Number: 9.8.2R2

Topic: Under Reporting of Payroll
Section: Assessments and Collections
Subsection: General

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. Where an employer under reports payroll information the employer will be responsible to pay a penalty of 10% of the difference between the actual assessment required and the assessment as originally calculated.

2. Interest will also be applied retroactively on the difference between the actual assessment required and the assessment as originally calculated. Interest will be calculated in accordance with the rate published quarterly by the Canada Revenue Agency as per sections 4301 and 4302 of the Income Tax Regulations (Canada).

Application

This Policy applies to payroll submitted for the 2000 assessment year onwards. It replaces Policy 9.8.2R1, approved by the Board on January 31, 2000 and effective January 1, 2000.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), (as amended), Section 128;
Workers' Compensation General Regulations, section 39.

Policy Number: 9.8.4R

Topic: Holdback of Assessment Premium From Contractors and Subcontractors
Section: Assessments and Collections
Subsection: General

Effective: January 1, 2014
Issued: January 23, 2014
Approved by Board of Directors: December 18th, 2013

Preamble

1. The *Workers' Compensation Act* required employers which employ three or more workers, and which operates in industries designated by Regulation as subject to mandatory registration, to register for coverage. Employers within the scope of mandatory coverage under the *Act* are referred to as covered employers.

2. A covered employer which hires contractors is considered a principal. A covered employer who is a contractor may hire subcontractors. Contractor and subcontractor have the same meaning as in *Policy 9.5.4R1-Late Reporting of Year – End*.

3. Section 143 of the *Workers' Compensation Act* allows principals to retain the applicable assessment premium as a 'holdback' from some of their contractors to safeguard against liability which may arise if the contractor has failed to maintain an account in good standing with the WCB (similarly, contractors can hold back from subcontractors). This protects the party from potential liability if assessments have not been paid to the Workers' Compensation Board (WCB).

Policy Statement

4. A hold-back is allowed under section 143 if

   a) The contractor or subcontractor is within the mandatory scope of the *Workers' Compensation Act* (has three or more workers and is in a mandatory industry); or

   b) The contractor is admitted under the *Act* through voluntary coverage pursuant to section 4.

5. Principals are not authorized to hold back from contractors who are 'deemed to be workers' of the principal as per *Policy 9.1.3R*.

Application

This Policy applies to all decisions made on or after January 1, 2014.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), (as amended), Sections 4, 143.

Policy Number: 9.8.5R

Topic: Definition of Assessable Earnings
Section: Assessments and Collections
Subsection: General

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. Assessable earnings includes all employment earnings reportable to the Canada Revenue Agency (CRA) in Box 14 of T4 slips, "*Employment Income*" or "*Gross Earnings*," less the following exceptions:

   a) earnings in excess of the maximum assessable earnings per individual (as per Policy 3.9.1);

   b) earnings of classes of workers excluded from the scope of the Act.

   c) employer-funded short and long-term disability benefits;

   d) employer funded top-up of Workers' Compensation benefits, wage-loss replacement plans, maternity and paternity benefits; or

   e) an amount included in Box 14 of a T4 slip which is an allowance for equipment used at the employees expense, as per section 8(1)(i)(iii) of the *Income Tax Act (Canada)*. Policy 9.1.3, #6, provides the earnings percentage to be applied for assessment purposes.

Application

This Policy applies to all decisions made on or after October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), (as amended), section 125 and 127; Section 1A of the *Workers' Compensation General Regulations*

Section 10 - General Policies

Overview

Note: This Overview is intended to provide a general guide to Board policies and programs. It does not constitute official Board policy.

The policies in this section deal with a number of topics not covered by previous sections of the manual. These include reporting of accidents, access to information in claim files, fraud and misrepresentation, and retroactivity of policy changes.

Subsection 10.1 – Reporting of Accidents

- **Policy Number: 10.1.1R - Accident Reporting – Duties of Employers**
- **Policy Number: 10.1.2R - Accident Reporting – Penalties**

Policy Number: 10.1.1R

Topic: Accident Reporting – Duties of Employers
Section: General Policies
Subsection: Reporting of Accidents

Effective: April 3, 1997
Issued: May 2, 1997
Approved by Board of Directors: April 3, 1997

Policy Statement

1. In every case, where an employer or an official of the employer's company is first made aware of an accident (including occupational diseases and other injuries occurring gradually over time) which may require a worker to lose time from work or seek medical attention, the employer must notify the Board of the accident.

2. Notice of the accident must be submitted to the Board within five business days of the employer becoming aware of the occurrence of the accident and must be received at the Board's offices within eight business days of the employer becoming aware of the occurrence of the accident. "Business days" are defined as Monday to Friday, with the exception of statutory holidays.

3. To report the accident, the employer shall complete, sign and submit the Report of Accident form (Form 67) or an approved facsimile thereof.

4. Failure to report an accident within these parameters may result in a penalty levied against the employer pursuant to Section 207 of the Act.

Application

This Policy applies to accidents occurring on or after February 1, 1996. It replaces Policy 10.1.1 issued on December 1, 1995 and effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 86.

Policy Number: 10.1.2R

Topic: Accident Reporting – Penalties
Section: General Policies
Subsection: Reporting of Accidents

Effective: October 27, 2016
Issued: April 13, 2007
Approved by Board of Directors: October 27, 2016

Policy Statement

1. For accidents occurring on or after October 1, 1996, employers found to be in violation of their accident reporting obligations as prescribed in Section 86 and its associated policy (#10.1.1) shall be subject to an initial penalty of $100. Employers whose reports are received more than one day late, shall be subject to an additional penalty of $25 for each day late, to a maximum of $500.

2. All claims which are reportable to the Board shall be subject to these penalties.

Application

This Policy applies to accidents occurring on or after October 27, 2016

References

1. *Workers' Compensation Act* (Chapter 10, Acts of 1994-95), Section 86, Sections 86, 201.

2. Policy 10.1.1R

Subsection 10.2 – Benefit Overpayments

- **Policy Number: 10.2.1R1 - Recovery of an Overpayment**
- **Policy Number: 10.2.2R - Appealing an Overpayment**

Policy Number: 10.2.1R1

Topic: Recovery of an Overpayment
Section: General Policies
Subsection: Benefit Overpayments

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. An overpayment occurs when the worker is paid benefits exceeding their entitlement according to the Act, policies or procedures. Once an overpayment is identified, a decision will be made about whether or not the overpayment will be recovered.

2. The following criteria will be used by the Board when determining whether or not the overpayment will be recovered.

    a) **Legal** - The overpayment recovery must be in accordance with the law.

    b) **Reasonableness** - If, in the opinion of the Board, the workers should have reasonably known that the payment was in excess of what was owed to him/her, the overpayment should be recovered.

    c) **Time** - If, in the opinion of the Board, the discovery of the overpayment exceeds a reasonable time, the overpayment should not be recovered. For the purposes of this Policy, a reasonable time is defined as three years.

    d) **Cost** - If the amount of the overpayment is less than $50.00, the overpayment should not be recovered.

    e) **Fraud** - If it is determined by the Board that the overpayment resulted from fraud or misrepresentation, the overpayment will be recovered not withstanding any other provisions.

3. The Board will consider the financial impact of the recovery on the worker when determining the means of collection. Once the Board has decided to recover an overpayment, the Board may, in its discretion, use whatever means it deems appropriate to recover the overpayment.

Guidelines

This Policy is subject to transitional benefit recalculation rules pursuant to Section 228.

Application

This Policy is effective December 16, 2021. It replaces Policy 10.2.1R that was effective April 3, 1997.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 220.

Policy Number: 10.2.2R

Topic: Appealing an Overpayment
Section: General Policies
Subsection: Benefit Overpayments

Effective: May 27, 2002
Issued: May 27, 2002
Approved by Board of Directors: March 15, 2002

Policy Statement

1. The declaration by the Board of a recoverable overpayment is appealable. Any appeal must be made pursuant to the Policies on Internal Appeals (see Section 8 of this Manual).

2. Recovery of the overpayment will generally cease until the final decision of the Board is made.

3. A special exception will be made when, in the opinion of the Board, the possibility of collection will deteriorate.

Guidelines

This Policy applies to all decisions made on or after May 27, 2002. It replaces Policy 10.2.2, issued December 1, 1995 and effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 197.

Subsection 10.3 – Administration

- **Policy Number: 10.3.1R1 - Quality of Service Delivery**
- **Policy Number: 10.3.2R - Retroactivity of Policy Changes**
- **Policy Number: 10.3.4R1 - Photocopying of Clients' Files**
- **Policy Number: 10.3.5R1 - Access by Employers to Information Contained in Clients' Claim Files**
- **Policy Number: 10.3.6 - Provision of Information to Canada Pension Plan**
- **Policy Number: 10.3.7R2 - Fraud and Misrepresentation**
- **Policy Number: 10.3.8R - Investment Policy**
- **Policy Number: 10.3.9R - Procurement Policy**
- **Policy Number: 10.3.10R1 - Corporate Information protection Policy**
- **Policy Number: 10.3.11 - Policy Consultation**

Policy Number: 10.3.1R1

Topic: Quality of Service Delivery
Section: General Policies
Subsection: Administration

Effective: December 16, 2021
Issued: January 24, 2022
Approved: December 16, 2021

Definitions

The three categories of communication regarding the quality of service are compliments, complaints and suggestions. For the purpose of this policy, the following definitions will apply:

- **Compliment** – An expression of praise for an individual, a team, a department or the organization.
- **Complaint** – A formal expression of dissatisfaction provided to the organization about a product, advice or service offered or provided coupled with a request to remedy the problem.

  Disagreement with a decision issued by WCB is not considered a complaint. The appeal process is the mechanism provided for under the Workers' Compensation Act to ensure all decisions are correct according to the Workers' Compensation Act and the policies of the Board.
- **Suggestions** – Comments and recommendations made by external parties on how process and service can be improved or service delivered more effectively.
- **Client Relations Officer** – Position designated to review and investigate complaints filed with the WCB regarding the quality of service delivery and process issues. The Officer or designate will determine whether the complaint is unsubstantiated or substantiated and respond to the complainant.
- **Complainant** – A person filing a complaint with the WCB regarding service delivery or process.
- Complaint – **Unsubstantiated** – The findings of a review or investigation by the Client Relations Officer or designate do not support the allegation(s) made by the complainant.
- Complaint – **Substantiated** – The findings of a review or investigation by the Client Relations Officer support the allegation(s) made by the complainant.

Policy Statement

The WCB strives to provide quality service to all external stakeholders, including workers, employers, service providers and members of the public. To support this goal, every communication received from a stakeholder or a member of the public is viewed as either an opportunity to recognize service excellence or as an opportunity to consider service improvements.

1. **Compliments**:

   Compliments received regarding individual employee performance and team performance will be sent to the employee's Manager, who will inform the employee and/or the team. Compliments on department performance will be sent to the CEO and Vice President of the department. Compliments on the organization will be sent to the CEO and Chair of the Board.

2. **Complaints**:

   A formal complaint can be filed with the Client Relations Officer about service delivery or the conduct or behaviour of a Board employee. Contact will be made promptly with the complainant by the Client Relations Officer or designate.

   Once a complaint is filed, it will be investigated by the Client Relations Officer or designate. A determination will be made as to whether the complaint is substantiated or unsubstantiated. Following completion of the investigation, the complainant will be contacted and informed of the outcome of the investigation.

   The fact that a complaint has been made shall not prejudice any decision made in relation to present or future claims or assessment matters related to the complainant.

   When a complaint is substantiated, it will be handled through the WCB internal human resources process. No complaint information will be used for any inappropriate purpose.

   Normally the WCB will not investigate anonymous complaints about service delivery; however, the Client Relations Officer can refer a matter to the Investigation Unit.

3. **Suggestions**:

   Suggestions received through this process regarding service improvements will be forwarded to the Vice President of the operational department for consideration and response.

   All other suggestions will be responded to by the Communications Department.

Application

This policy applies effective December 16, 2021 and replaces Policy 10.3.1R issued on January 1, 2003 and effective January 1, 2003.

Policy Number: 10.3.2R

Topic: Retroactivity of Policy Changes
Section: General Policies
Subsection: Administration

Effective: February 1, 2000
Issued: January 31, 2000
Approved by Board of Directors: January 20, 2000

Policy Statement

1. If the Board of Directors:

   a) adopts a policy because the Board on its own initiative forms the view that a policy is necessary; or

   b) revises a policy because the Board on its own initiative forms the view that an otherwise lawful existing policy is inadequate,

   there is a presumption that the change will not apply before the date on which the new policy comes into force. The date the Policy comes into force is in the discretion of the Board of Directors.

2. If the Board of Directors adopts or revises a policy as a direct result of an amendment to the *Workers' Compensation Act* or other legislation, there is a presumption that the change will not apply before the date on which the statute comes into force. The presumption may be rebutted by express words in the statute or by necessary implication from the words of the statute.

3. If the Board of Directors revises a policy because a court decides or the Board forms the view that existing policy is contrary to law, there is a presumption that the application of the revision will be determined in accordance with principles of good public administration.

4. Good public administration involves a balance between fairness, finality, financing, and administrative practicality.

5. Good public administration will normally require that the new policy apply to any specific case which led to the decision to make the change. If that case was advanced as a test case, good public administration will normally require that the policy apply to all cases pending at the time, or arising since, the test case process began.

6. Good public administration will normally require that the new policy apply to all decisions made after the effective date.

7. Good public administration will normally require that the effective date take into account whether the Board should have changed its policy earlier. The proper question here is whether the Board's failure to act at some point in the past represented a marked departure from a reasonable standard of public administration. The proper question is *not* when, in retrospect, it can be seen that sufficient evidence to justify a change was available.

8. In claims matters, good public administration requires that regard be had to the effect on workers in terms of benefits lost or received under the old policy that would have been awarded or denied under the new policy. Regard must also be had to the effect on employers in term of possibly having to pay increased assessments or fund benefits which should not have been paid. A policy of the Board of Directors may only be made retroactive where the policy benefits a worker.

9. In assessment matters, good public administration requires that regard be had to the effect on employers in terms of assessments under the old policy that would be an over-or-under-assessment under the new policy.

10. Good public administration requires that the decision on retroactivity must be one which the Board is capable of properly administering without unduly increasing costs or affecting its general operations.

11. Every Policy Statement or revision approved by the Board should include a statement, in keeping with this policy, on the effective date of the policy.

12. This Policy shall apply to any policy adopted on or after the date this Policy is approved by the Board of Directors.

Application

This Policy applies to all decisions made on or after April 16, 1999. It replaces Policy 10.3.2, approved by the Board on October 4, 1995.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) (as amended), Section 183.

Policy Number: 10.3.4R1

Topic: Photocopying of Clients' Files
Section: General Policies
Subsection: Administration

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. A file will be copied once and provided free of charge to the client or the client's representative. A client can make a written request or a verbal request to Board staff to receive a copy of their file. If a verbal request is made by the client, Board staff will add the request as a note on the client's file. A client's representative may only make a request for a copy of a client's file in writing, and the written request will be added to the client's file. Subsequent information in the same file(s) will be copied, if requested.

2. There will be a charge applied in an amount determined by the Board for second and subsequent copies of file material previously copied at the request of the client or the client's representative. It is the responsibility of the person requesting the information to make sure that the copied file(s) is/are transferred when and if the client chooses a new representative.

Application

This Policy applies to all decisions made on or after December 16, 2021, and replaces Policy 10.3.4R that was effective October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 193(5)(6).

Policy Number: 10.3.5R1

Topic: Access by Employers to Information Contained in Clients' Claim Files
Section: General Policies
Subsection: Administration

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. A worker's employer is entitled to request access to information in the worker's claim file after an appealable decision has been made.

2. Only the information in the worker's claim file which is relevant to the appealable decision may be released to the worker's employer. Board staff will have the responsibility of reviewing claim files to determine which information is relevant.

3. Information from a claim file will only be released if the employer submits a written request for access to such information and states a reason for requesting access. The reason should make reference to concerns with material either contained in or which the employer has reason to believe was omitted from, the appealable decision.

4. The worker will be advised whenever information is being released to the employer.

5. The employer will be charged a fee related to the cost of staff salaries for reviewing files.

Guidelines

1. A worker who has received a decision on a claim from the Board is entitled, upon written request, to receive a copy of all the information in their file.

2. A worker's employer has the right to participate after an appealable decision has been made. The employer can:

   a) file an internal appeal of the decision; and/or

   b) submit written arguments and/or oral evidence regarding an appeal launched either by itself (the employer) or the worker.

3. The Board, in developing its policy on access by employers to claim file information, has sought to strike an equitable balance between (a) protecting workers' privacy; and (b) providing employers with access to the information the Board used in making its decision(s) regarding claims.

   In so doing, the Board has tried to make its appeal processes fair to all concerned.

Application

This Policy is effective December 16, 2021. This replaces Policy 10.3.5 that was effective February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 193.

Policy Number: 10.3.6

Topic: Provision of Information to Canada Pension Plan
Section: General Policies
Subsection: Administration

Effective: February 1, 1996
Issued: December 1, 1995
Approved by Board of Directors: October 4, 1995

Policy Statement

1. The Board can provide information regarding clients to the Canada Pension Plan authorities as per the guidelines listed below.

    a) Any such requests from the Canada Pension Plan authorities for medical information should be under the signature of the applicant.

    b) The Canada Pension Plan authorities should be advised in each case that any medical information, etc., is furnished as privileged information under the Act and, therefore, is only furnished to them on a confidential basis.

    c) Canada Pension Plan authorities should be advised that any medical information furnished is done so on a reciprocal agreement basis (i.e. the Board may request medical information from the Canada Pension Plan authorities on a specific client).

Application

This Policy applies to all decisions made on or after February 1, 1996.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 192.

Policy Number: 10.3.7R2

Topic: Fraud and Misrepresentation
Section: General Policies
Subsection: Administration

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

Policy Statement

1. Persons engaging in fraud will be vigorously pursued and brought to criminal prosecution regardless of the amount involved.

2. The Board will take vigorous action to recover overpayments where the overpayment results from misrepresentation.

3. The Board will take vigorous action to recover under-assessments where the under-assessment results from misrepresentation.

4. The primary goal of this Policy is deterrence.

Principles

5. This Policy is to be interpreted and applied in light of the following principles.

    a) The Policy applies equally to employers, workers, employees of the Board and suppliers of goods and services.

    b) The burden of proof rests with the Board, the police and the prosecutors.

    c) Where the Board has reason to believe that a fraud has been or is being committed, the matter will be referred to the police.

    d) An investigation unit has been set up to conduct and coordinate the Board's activities in this area and to ensure accountability, the Chief Executive Officer should report periodically to the Board of Directors on the activities of the unit.

    e) The investigative procedures used by the Board will at all times be in keeping with the law, including:

        a) the Charter of Rights;

        b) the Workers' Compensation Act; and

        c) the Freedom of Information Act;

    f) Details with respect to the manner in which internal fraud will be dealt with will be set out in a separate but complementary administrative policy.

Definitions

6. A "misrepresentation" is the misstatement of a relevant fact or the failure to disclose a relevant fact.

7. A "fraud" is a misrepresentation made with *knowledge* that the fact is false (where the fact is stated) or relevant (where the fact is not disclosed) and made with an *intent* to deceive the Board into acting to its detriment.

8. An "overpayment" is a compensation payment or payment for goods or services that results in a person receiving an amount greater than the person's legal entitlement. The Board's policy and procedures on overpayments are separate from this Policy (see Policies 10.2.1R1, 10.2.2R).

9. An "under-assessment" is an assessment that is smaller than the employer's legal obligation. The Board's policy and procedures on under-assessments are separate from this Policy.

Who This Policy Applies To

10. This Policy applies to a misrepresentation made by a person who seeks some advantage, whether for that person or another person, from the Board.

General

11. Process

    a) If a misrepresentation is suspected, staff will refer the matter to their immediate supervisor for review.

    b) If the supervisor is satisfied that there was no misrepresentation, no further action will be taken.

    c) If the supervisor is satisfied that any misrepresentation was non-fraudulent, she/he will ensure that the matter is dealt with in accordance with the Board's policy on overpayments or under-assessments.

    d) If the supervisor has reason to believe that a fraud has occurred or is occurring, or believes that more investigation is required, she/he will refer the matter to the Board's investigation unit.

    e) The Board's investigation unit will review the file and conduct any necessary investigation in accordance with its procedures. In assessment matters, the investigation unit will coordinate the investigation with its field representatives.

    f) The investigation unit's procedures will ensure that investigation techniques are at all times in accordance with the law.

    g) When the investigation is complete, the investigation unit will forward its file, with a recommendation for action, to the Board's legal counsel for review.

    h) If legal counsel, the supervisor of the investigation unit and management of the division concerned are satisfied that a fraud may have occurred or may be occurring, legal counsel will refer the matter to the police.

    i) If, after consultation with legal counsel, management of the division concerned is satisfied that a non-fraudulent misrepresentation has occurred, action may be taken in accordance with the Board's policy on overpayments or under-assessments.

12. Handling Information

    a) Anonymous information tending to show that a misrepresentation has occurred will not be placed in a claimant's or employer's file, or on an employee's personnel file, nor will it be acted upon in making a decision on compensation or, assessment, employee discipline, evaluation or promotion until it is corroborated by credible evidence.

    b) Where the anonymous information is not corroborated, the file, including the investigator's summary report, will be retained for one year at which point it will be destroyed. During that year, the person who was the subject of the investigation may, on written request, receive a copy of the report.

    c) The investigation unit will maintain its own files, separate from claims, assessment or other Board files.

13. Access to Investigation Information

    a) If the matter is referred for criminal investigation or prosecution, the Board will release the investigation file to the police or prosecutor. The Board will not release any part of the investigation file to the person being investigated unless directed or authorized to do so by the police or prosecutor.

    b) If the Board proposes to make a decision on entitlement, assessment or employee discipline, evaluation or promotion based on information in the investigation file, the person being investigated must be given access to all relevant information.

    c) Information that would identify or tend to identify a person who does not wish to be identified may be withheld.

14. Correcting Misinformation

    a) When the Board is satisfied that a misrepresentation has occurred, any facts entered in a file as a result of the misrepresentation will be immediately corrected. Compensation or assessment will be adjusted accordingly.

    b) If the adjustment shows an overpayment has been made, action will be taken in accordance with the Board's policy and procedures on overpayments.

    c) If the adjustment shows an under-assessment has occurred, action will be taken in accordance with the Board's policy and procedures on under-assessment.

Application

This Policy is effective December 16, 2021. This Policy replaces Policy 10.3.7R1 that was effective October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Sections 84, 130.

Policy Number: 10.3.8R

Topic: Investment Policy
Section: General Policies
Subsection: Administration

Effective: October 27, 2016
Issued: April 13, 2017
Approved by Board of Directors: October 27, 2016

Policy Statement

1. The Workers' Compensation Board (WCB) has an Investment Policy which defines the policies, standards, and procedures used to invest funds pursuant to Section 172 of the *Workers' Compensation Act*. This document is available on the Nova Scotia WCB's Website at www.wcb.ns.ca or by contacting the WCB.

Application

This Policy applies to decisions made on or after October 27, 2016.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95) (as amended), Section 172.

Policy Number: 10.3.9R

Topic: Procurement Policy
Section: General Policies
Subsection: Administration

Effective: February 11, 2010
Issued: February 25, 2010
Approved by Board of Directors: February 11, 2010

Policy Statement

1. The Workers' Compensation Board (WCB) has a full procurement policy which defines the policies and procedures used to determine the method for procuring goods and services required at the WCB. The WCB's Procurement Policy follows the Province of Nova Scotia Policy on Government Procurement, dated September 1, 2005, except in areas where terminology is different due to the nature of the organizational structure of the WCB.

    - A quarterly report will be presented to the Audit & Risk Oversight Committee outlining all procurement for the previous quarter, including copies of any Alternative Procurement Practices Approval forms.
    - Reference to the following positions and Departments in the Provincial Policy should be replaced with those listed below:

      Province

      1. Deputy Minister
      2. Procurement Services of the Department of Economic Development
      3. Province's Corporate Financial Management System
      4. (A) Minister of Economic Development

         (B) Executive Council

      WCB

      1. Chief Executive Officer
      2. Administration Department of the Workers' Compensation Board of NS
      3. In the WCB's Administrative records
      4. (A) Audit & Risk Oversight Committee of the Workers' Compensation Board of NS

         (B) Finance & Investment Committee of the Workers' Compensation Board of NS

2. A copy of the Provincial Procurement Policy is attached.

Application

This Policy applies to all decisions made on or after October 12, 2001.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95, as amended), sections 151(1), 169 and 183(2).

Policy Number: 10.3.10R1

Topic: Corporate Information protection Policy
Section: General Policies
Subsection: Administration

Effective: December 16, 2021
Issued: January 24, 2022
Approved by Board of Directors: December 16, 2021

General

In fulfilling its legislative obligations, the Workers' Compensation Board of Nova Scotia must obtain and create information to support its business objectives. The Workers' Compensation Board of Nova Scotia recognizes that information is a corporate resource and that the public has a right to certain information it holds and to know personal information is protected. As a public body, the Workers' Compensation Board of Nova Scotia must endorse its accountability to the public to adhere to applicable legislation.

Definitions

Definitions as contained in the Freedom of Information and Protection of Privacy Act of Nova Scotia:

(a) "**background information**" means

- (i) any factual material,
- (ii) a public opinion poll,
- (iii) a statistical survey,
- (iv) an appraisal,
- (v) an economic forecast,
- (vi) an environmental-impact statement,
- (vii) a final report or final audit on performance or efficiency of a public body or on any of its programs or policies,
- (viii) a feasibility or technical study, including a cost estimate, relating to a policy or project of a public body,
- (ix) a report on the results of field research undertaken before a policy is formulated,
- (x) a report of an external task force, advisory board or similar body that has been established to consider any matter and make reports or recommendations to a public body, or
- (xi) a plan or proposal to establish a new program or to change a program, if the plan or proposal has been approved or rejected by the head of the public body.

(b) "**personal information**" means recorded information about an identifiable individual, including

- (i) the individual's name, address and telephone number,
- (ii) the individual's race, national or ethnic origin, colour, or religious or political beliefs or associations,
- (iii) the individual's age, sex, sexual orientation, marital status or family status,
- (iv) an identifying number, symbol or other particular assigned to the individual,

(v) the individual's fingerprints, blood type or inheritable characteristics,

(vi) information about the individual's health care history, including a physical or mental disability,

(vii) information about the individual's education, financial, criminal or employment history,

(viii) anyone else's opinions about the individual, and

(ix) the individual's personal views or opinions, except if they are about someone else.

(c) "**public body**" means

(i) a Government department or a board, commission, foundation, agency, tribunal, association or other body of person, whether incorporated or unincorporated, all the members of which or all the members of the board of management of board of directors of which

(a) are appointed by order of the Governor in Council, or

(b) if not so appointed, in the discharge of their duties are public officers or servants of the Crown.

(d) "**record**" includes books, documents, maps, drawings, photographs, letters, vouchers, papers and any other thing on which information is recorded or stored by graphic, electronic, mechanical or other means, but does not include a computer program or any other mechanism that produces records.

(e) "**third party**", in relation to a request for access to a record or for correction of personal information, means any person, group of persons or organization other than

(i) the person who made the request, or

(ii) a public body.

Policy Statement

1. The Board will adopt the following principles to ensure the protection of personal information, as contained in the Model Code for the Protection of Personal Information (attached).

1.1. Accountability
1.2. Identifying Purposes
1.3. Consent
1.4. Limiting Collection
1.5. Limiting Use, Disclosure and Retention
1.6. Accuracy
1.7. Safeguards
1.8. Openness
1.9. Individual Access
1.10. Challenging Compliance

2. The Workers' Compensation Board of Nova Scotia will ensure the protection of personal information and background information by ensuring appropriate:

2.1. Confidentiality of the information;
2.2. Availability of the information; and
2.3. Integrity of the information.

References

Worker's Compensation Act (Chapter 10, Acts of 1994 – 95) Sections 192 -195

Freedom of Information and Protection of Privacy (Chapter 5, Acts of 1993)

Model Code for the Protection of Personal Information (Approved as a National Standard of Canada by the Standards Council of Canada)

Principles set out in the National Standard of Canada entitled "Model Code for the Protection of Personal Information"

Principle 1 - Accountability

An organization is responsible for personal information under its control and shall designate an individual or individuals who are accountable for the organization's compliance with the following principles.

Principle 2 - Identifying Purposes

The purposes for which personal information is collected shall be identified by the organization at or before the time the information is collected.

Principle 3 - Consent

The knowledge and consent of the individual are required for the collection, use, or disclosure of personal information, except where inappropriate.

Note: In certain circumstances personal information can be collected, used, or disclosed without the knowledge and consent of the individual. For example, legal, medical, or security reasons may make it impossible or impractical to seek consent. When information is being collected for the detection and prevention of fraud or for law enforcement, seeking the consent of the individual might defeat the purpose of collecting the information. Seeking consent may be impossible or inappropriate when the individual is a minor, seriously ill, or mentally incapacitated. In addition, organizations that do not have a direct relationship with the individual may not always be able to seek consent. For example, seeking consent may be impractical for a charity or a direct-marketing firm that wishes to acquire a mailing list from another organization. In such cases, the organization providing the list would be expected to obtain consent before disclosing personal information.

Principle 4 - Limiting Collection

The collection of personal information shall be limited to that which is necessary for the purposes identified by the organization. Information shall be collected by fair and lawful means.

Principle 5 - Limiting Use, Disclosure, and Retention

Personal information shall not be used or disclosed for purposes other than those for which it was collected, except with the consent of the individual or as required by law. Personal information shall be retained only as long as necessary for the fulfilment of those purposes.

Principle 6 - Accuracy

Personal information shall be as accurate, complete, and up-to-date as is necessary for the purposes for which it is to be used.

Principle 7 - Safeguards

Personal information shall be protected by security safeguards appropriate to the sensitivity of the information.

Principle 8 - Openness

An organization shall make readily available to individuals specific information about its policies and practices relating to the management of personal information.

Principle 9 - Individual Access

Upon request, an individual shall be informed of the existence, use, and disclosure of their personal information and shall be given access to that information. An individual shall be able to challenge the accuracy and completeness of the information and have it amended as appropriate.

Note: In certain situations, an organization may not be able to provide access to all the personal information it holds about an individual. Exceptions to the access requirement should be limited and specific. The reasons for denying access should be provided to the individual upon request. Exceptions may include information that is prohibitively costly to provide, information that contains references to other individuals, information that cannot be disclosed for legal, security, or commercial proprietary reasons, and information that is subject to solicitor-client or litigation privilege.

Principle 10 - Challenging Compliance

An individual shall be able to address a challenge concerning compliance with the above principles to the designated individual or individuals accountable for the organization's compliance.

Policy Number: 10.3.11

Topic: Policy Consultation
Section: General Policies
Subsection: Administration

Effective: January 1, 2004
Issued: November 18, 2004
Approved by Board of Directors: November 9, 2004

Policy Statement

The Workers' Compensation Board, a stakeholder representative Board, is committed to a policy development framework that provides for appropriate consultation with stakeholders. The Board of Directors will consider all relevant information including stakeholder input to arrive at a final policy decision.

To seek input from stakeholders, the Workers' Compensation Board may use a variety of consultation tools including electronic consultation, small group discussions, focus groups, surveys, public meetings etc.

At a minimum, the Workers' Compensation Board will post a draft policy and related background information on the Workers' Compensation Board Web site for 30 days to allow for stakeholder input.

In addition, the Workers' Compensation Board will maintain a list of key stakeholders who will be notified that policy consultation is in progress. Upon request, any stakeholder can be added to this list. These key stakeholders will be mailed a copy of related background information and a draft policy for review and comment.

Application

This policy applies to policies developed on or after January 1, 2004.

References

Workers' Compensation Act (Chapter 10 of the Acts of 1994-95), (as amended), Section 183.

Section 11 - Prevention

Subsection 11.1 – Priority Employer Program

- **Policy Number: 11.1.3 - Practice Incentive Rebate Program for Construction and Trucking Industry**
- **Policy Number: 11.1.4 - Conditional Surcharge Refund Program**

Policy Number: 11.1.3

Topic: Practice Incentive Rebate Program for Construction and Trucking Industry
Section: Prevention
Subsection: Practice Incentive Rebate Program

Effective: June 27, 2012
Issued: July 5, 2012
Approved by Board of Directors: June 27, 2012

Preamble

The WCB's focus on injury prevention and safe and timely return to work recognizes that societal and cultural change is essential for creating a culture of health and safety in the workplace. The WCB encourages employers to implement effective health and safety management systems as an important step towards reducing the risk of workplace injuries and illnesses. The Practice Incentive Rebate Program gives an added incentive to employers classified in the construction or trucking industry to attain health and safety certification, to strengthen their commitment to safe work, to continue expanding worker knowledge of safe work practices through training and awareness, and to improve safety performance overall.

The Practice Incentive Rebate Program will apply to construction and trucking firms that meet the criteria established by the WCB and receive or maintain certification for effective health and safety management systems (i.e. Certificate of Recognition (COR)).

Employers with appropriate certification will be eligible for a practice incentive rebate in accordance with this policy.

Definitions

"**assessment year**" is the period from January 1 to December 31.

"**qualifying year**" is the assessment year preceding the year in which the practice incentive rebate for an employer may be awarded.

Policy Statement

1. **Program Eligibility Criteria**

   To qualify for the practice incentive rebate, an employer must meet the following requirements:

   - Employer must operate in the construction or trucking industry, as defined and classified by the WCB;
   - Employer must have a health and safety management system in place that has successfully passed a certification audit by a WCB-approved audit provider using a WCB-approved audit instrument;
   - Employer must pass the certification audit and receive certification prior to December 31st of the qualifying year;
   - Employer must be in good standing with WCB of NS at the time the rebate is issued. This means the employer:
     - Has WCB coverage;
     - Has met all payroll reporting requirements; and

- Has paid all premiums to date.

- Employer must have no compensable fatal claims during the qualifying year and up to the date the rebate is issued.
- For surcharged employers, if they do not show a minimum of 25% improvement in their cost experience ratio three years following the initial practice incentive rebate received once surcharged, they will not be eligible for further rebates from this point forward until they can show this minimum improvement or until they are no longer in a surcharge position.

An employer who does not meet the criteria established by the WCB will not receive the practice incentive rebate until the criteria are met, as determined by the WCB.

2. **Practice Incentive Rebate**

   An employer who obtains health and safety management system certification (i.e. COR) and who has met the criteria outlined in this policy will receive the following rebate:

   - A 5 per cent rebate of assessment premiums paid in the qualifying year for employers with premiums of $10,000 and above; or
   - A 10 per cent rebate of assessment premiums paid in the qualifying year for employers with premiums of $5,000 or less; or
   - A $500 rebate for employers with premiums between $5,001 and $9,999.

An employer is eligible for a practice incentive rebate each assessment year. To be eligible for subsequent practice incentive rebates an employer must maintain health and safety management certification (i.e. COR) and meet the eligibility criteria outlined above in section 1.

Application

This program policy applies to employers in the construction or trucking industry, as defined and classified by the WCB for 2013 onward.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 121(5).

Policy Number: 11.1.4

Topic: Conditional Surcharge Refund Program
Section: Prevention
Subsection: Conditional Surcharge Refund Program

Effective: March 15, 2012
Issued: March 28, 2012
Approved by Board of Directors: March 15, 2012

Preamble

In 2005, the WCB introduced the Surcharge Program to encourage employers with consistently poor safety and return to work records to improve safety and return to work outcomes in the workplace. Under the Surcharge Program, employers whose accident costs are significantly and consistently worse than their rate group may receive surcharges. Policy 9.4.2R4 *Experience Rating - Maximum Merit or Demerit Surcharge* describes when a surcharge is applied.

The Conditional Surcharge Refund Program provides employers an opportunity to be refunded the money they have paid in surcharges where they have made investments in safety. The purpose of this program policy is to describe the criteria WCB registered employers must meet to be eligible for the Conditional Surcharge Refund Program and to provide details of how the refund is payable.

Definitions

"**cost experience ratio**" is an employer's weighted 3-year experience rating costs relative to the employer's 3-year assessable payroll.

Policy Statement

Eligibility Criteria

To be eligible for the Conditional Surcharge Refund Program in a given calendar year, an employer must meet the following criteria:

- Employer must be in good standing.
- Employer must have paid surcharge premiums in the previous calendar year.
- Employer must have no compensable fatal claims with date of injury during the previous calendar year and up to the date the refund is issued.
- Employer must make investment(s) in safety in the previous calendar year, which fall under the following categories:
    - Safety training for managers/supervisors and/or employees;
    - Third party safety audit of employer worksite;
    - Health & Safety programming, such as specific prevention programs;
    - New equipment purchase or upgrade to existing equipment to prevent injury;
    - Hire or contract dedicated Occupational Health & Safety personnel.

- The investment(s) in safety must benefits workers working in Nova Scotia.
- Employer must be able to show proof of the investment(s) in safety, through either an invoice or confirmation of monies paid to hired or contracted Occupational Health & Safety personnel.

Refund

If an employer meets the above criteria they will be eligible to receive a conditional surcharge refund, payable as follows:

- Refund is equal to the amount invested in safety in the previous calendar year up to a maximum equal to the employer's surcharge premium paid in the previous calendar year.
- Proof of the investment(s) in safety is required before a refund will be issued.
- Refund will be forfeited if more than 12 months has elapsed since the end of the year the surcharge was applied. For example, employers that pay surcharge premiums in 2013 and make an investment in safety in 2013 will be able to receive a refund in 2014. If a refund is not requested by the end of 2014, the money is forfeited.
- If an employer does not show a minimum of 25% improvement in their cost experience ratio three years following the initial conditional surcharge refund, they will not be eligible for further refunds from this point forward until they can show this minimum improvement.

Application

This Program Policy applies to 2013 assessment rates onward.

References

Workers' Compensation Act (Chapter 10, Acts of 1994-95), Section 121(5).

Rescinded Policy

Section 1 - Entitlement

1.2 Occupational Disease:

Policy Number 1.2.2 – Fee Schedule Assessment: Automatic Assumption Claims

1.4 Decision Making:

Policy Number 1.4.1 – Use of Textbooks or Similar Resources as Evidence
Policy Number 1.4.2 – Hearsay Evidence

1.3 General:

Policy Number: 1.3.6 - Compensability of Stress as an Injury Arising out of and In the Course of Employment – Government Employees Compensation Act (GECA)

Section 2 - Health Care

2.1 Workers' Expenses:

Policy Number 2.1.2R – Workers' Use of Taxi to Rehabilitation Centre
Policy Number 2.13R – Travel Expenses for Rehabilitation or Treatment
Policy Number 2.1.4R – Accommodation and Expenses in Halifax

2.2 Services/ Treatments:

Policy Number 2.2.2 – Fee Schedule – Second Opinion Spinal Surgery

2.4 Functional Restoration Program:

Policy Number 2.4.1R - Pain Target Services
Policy Number 2.4.2 – Phase II – Multi-Faceted Pain Services: Criteria
Policy Number 2.4.3 – Program Costs of Phase II
Policy Number 2.4.4 – Consideration of Workers who are beyond 12 Months of the Date of their Injury
Policy Number 2.4.5 – Date of Injury
Policy Number 2.4.6R – Functional Restoration Program

Section 3 - Short-Term and Long-Term Benefits

3.9 General:

Policy Number 3.9.4 – Collateral Benefits
Policy Number 3.9.7 – Payment Considered to be Collateral benefits
Policy Number 3.9.8 – Calculation of Allowable Collateral benefits
Policy Number 3.9.9 – Reduction of EERB due to Section 49

Section 5 - Re-Employment

5.1 Eligibility & Coverage:

Policy Number: 5.1.1R1 - Employer Coverage
Policy Number: 5.1.2R - Worker Eligibility

Policy Number: 5.1.3 - Case Appropriate for Re-Employment

5.2 Nature of Re-Employment Obligation:
Policy Number: 5.2.1R - Determination of Date of Injury for Purposes of Re-Employment
Policy Number: 5.2.2 - Employer's Obligations Within the Re-Employment Period
Policy Number: 5.2.3 - Termination Within the Re-Employment Period
Policy Number: 5.2.4 - Worker Able to Perform Essential Duties of Pre-Injury Employment
Policy Number: 5.2.5 - Worker Able to Perform Suitable Work
Policy Number: 5.2.6 – Accommodation

5.3 Defenses and Exceptions:
Policy Number: 5.3.1 - Employer Defenses
Policy Number: 5.3.2 - Collective Agreements
Policy Number: 5.3.3 - Established Hiring Practices in Worker's Trade or Occupation
Policy Number: 5.3.4 - Section 71 of Labour Standards Code

5.4 Enforcement of Obligation:
Policy Number: 5.4.1 - Order to Re-Employ
Policy Number: 5.4.2 - Penalties Under Section 99 for Breach of Re-Employment Obligations

5.5 Appeals:
Policy Number: 5.5.1 - Re-employment Appeals

Section 7 - Specialized Adjudication

7.3 Amended Interim Earnings Loss:
Policy Number 7.3.3 – Eligibility for Award Revision

7.4 Recalculation of Long-Term Benefits Pursuant to Section 228:
Policy Number 7.4.0 – Principles for recalculation of benefits under section 228
Policy Number 7.4.1 – Earnings to be included in pre-accident earnings
Policy Number 7.4.2 – Earnings to be included in post-accident earnings
Policy Number 7.4.3 – Determination of suitable employment
Policy Number 7.4.4 – Duration of Benefits
Policy Number 7.4.5 – Indexing Benefits
Policy Number 7.4.6 – Amount set aside as an Annuity
Policy Number 7.4.7 – Combining permanent benefits

7.5 Compensation for chronic pain for injuries on or after March 23, 1990 and up to January 31, 1996:
Policy Number 7.5.1 – Guidelines for Marked Life Disruption Assessment (MLDA)
Policy Number 7.5.2 – Chronic Pain: Permanent Medical Impairment (PMI) rating
Policy Number 7.5.3R – Calculation of Permanent Impairment Benefit
Policy Number 7.5.4R – Calculation of Extended Earnings Replacement Benefits
Policy Number 7.5.5 – Apportionment of Benefits for Chronic Pain

Section 8 - Internal Appeals

8.1 Internal Appeals Process:

Policy Number 8.1.1 - Definitions
Policy Number 8.1.2R – Reconsideration pursuant to s.196
Policy Number 8.1.5 – Form of Written Request for an Appeal

Section 9 - Assessments and Collections

9.3 Rate Setting

Policy 9.3.2A – Temporary Transition

9.7 Collections:

Policy Number 9.7.1R1 – Write-off Uncollectable Accounts

9.8 General:

Policy Number 9.8.1R – Backdating Coverage
Policy Number 9.8.3 – Credit for Overestimating Payroll

Section 10 - General Policies

10.3 Administration:

Policy Number 10.3.3R – Guidelines for Claims Adjudication – Processing Medical Aid Only

Section 11 - Prevention

11.1 Priority Employer Program:

Policy Number: 11.1.1 - Selection Criteria for Priority Employer Program
Policy Number: 11.1.2 - Termination of Priority Employer Program Coaching Services

Glossary

The terms below are defined based on their accepted interpretation and use within the Board with respect to the new *Workers' Compensation Act* (Chapter 10, Acts of 1994-95). Where appropriate, reference is made to the Act, as well as other related terms within these definitions. Items in *italics* can be found as separate entries within the glossary. This Glossary has not been formally approved by the Board of Directors and, as such, does not constitute official Board policy. The definitions are general in scope and are not intended to replace or supersede existing legislative or policy definitions.

- A -

AWCBC - Association of Workers' Compensation Boards of Canada.

Accepted (Claim) - A claim for which entitlement under the *Act* has been recognized.

Accident - [*Act*, Sec. 2(a)] An event or circumstance(s) causing or leading to an injury, arising out of and in the course of employment. Also includes *occupational disease*. Generally, does not include stress, other than an acute reaction to a traumatic event.

Accident Date - see *Date of Injury***.**

Accident Employer - The *employer* with whom the *worker* was employed at the *date of injury.*

Accident Employer Training (AET) - A *vocational rehabilitation* program which gives *injured workers* an opportunity to learn marketable skills and obtain experience at an alternate job with the *accident employer. Workers* continue to receive *vocational rehabilitation benefits* for the duration of an AET program and the *employer* may, but is not obligated to, offer employment at the end of the program. An AET program differs from an *On-the-Job Training (OJT)* program in that the accident employer is responsible for the *claims costs* associated with any new injury or *recurrence* during the AET program.

Accident Fund - [*Act*, s. 2(b)] The fund into which *assessment* revenues collected from *employers* and other revenues received by the *Board* are deposited and from which any payments of *compensation* and related expenditures are made.

Accident Reporting Penalty - [*Act*, ss. 86 and 207; *Policy* 10.1.2R] A penalty levied against the *accident employer* for failing to notify the *Board* of the occurrence of an *accident* within the time and in the manner specified in the *Act.*

Accommodation (*Re-employment*) - [*Act,* s.91] Refers to an *employer's* duty to alter work or workplace to facilitate an injured worker's return to work, providing the injured worker is capable of performing either the essential duties of the pre-injury employment or suitable employment only. The duty to accommodate only applies to the extent that the accommodation does not cause the employer *undue* hardship. Where accommodation of the work or workplace is necessary to enable the worker to perform the *essential duties* of the *pre-injury work* or *suitable work*, the *Board* may financially assist the employer.

Act - The Nova Scotia Workers' Compensation Act (Chapter 10, Acts of 1994-95).

Adjudication - The process of determining a *worker's* initial eligibility for and on-going entitlement to *compensation* in accordance with the *Act.*

Adjustment Payment - (i) A payment to a *worker* or an *employer* for a period for which *compensation* has previously been paid but at a different rate or amount; or (ii) a payment to a *worker* or an *employer* issued to cover a period for which retroactive benefits are owed to the worker.

Allowed (Claim) - see *Accepted (Claim)*

Alternative Employment *(Re-employment)* - [*Act,* s 89(3)] Employment that is comparable to the worker's *pre-injury work* in its' nature, earnings, qualifications, opportunities and other relevant aspects (e.g., duties, functional demands, obligations, rights, rules). The employer must satisfy the Board that the employer is unable to offer a return to pre-injury employment before the option of offering the worker alternative employment will be accepted. (see *also: Normal Rate of Productivity*)

Amended Interim Earnings Loss (AIEL) Policies - [*Policies* 7.3.1 to 7.3.13, inclusive] A set of *policies* adopted by the *Board of Directors* which allowed payment of one-half the earnings loss suffered by workers who also experienced a permanent physical disability as a result of a *compensable injury.* The AIEL Policies superseded the *Interim Earnings Loss Policies* and took effect on November 24, 1993. With the coming into force of the *Act* on February 1, 1996, benefits payable pursuant to these policies were recalculated in accordance with the *Tnansitional Benefit Provisions.*

Annuity - [*Act*, ss.50-58; *Policies* 3.6.1 to 3.6.9R1, inclusive] An accumulating benefit created by reserving 5% of the *Extended Earnings Replacement Benefi*t *(EERB)* and the *Permanent Impairment Benefit (PIB)* payable to a *worker*, or 5% of any *survivor pension* payable to a surviving *spouse,* plus any interest accumulated on the amounts reserved. An annuity generally becomes payable at age 65 and may be payable as a *lump sum* if the amount payable is less than an amount prescribed by *regulation*.

Appealable Decision - Any decision of a staff member of the *Board,* a *Hearing Officer* or the *Appeals Tribunal* which may be appealed in accordance with the provisions of the *Act.*

Appeal Board, **Workers' Compensation** - A government-appointed external appeal body which preceded the *Appeals Tribunal.*

Appeals Tribunal, Workers' Compensation - [*Act,* ss.238 - 258] The external body appointed by the government to hear appeals of final decisions of the *Board* after all *internal appeal* mechanisms have been exhausted. The Tribunal is bound by *Board policy*.

Apportionment (*Claims Cost*) - [*Policies* 9.6.1 to 9.6.6, inclusive] Generally refers to situations where more than one *employer* is responsible for the costs of a *worker*'s claim (e.g., diseases arising over time).

Apportionment (Benefits) - [*Act,* s.10(5); *Policy* 3.9.11R1] Refers to situations where the *Board* pays *compensation* for only the proportion of a worker's *loss of earnings* or *permanent impairment* which was caused by a *compensable injury.* If some proportion of a worker's permanent impairment or long-term loss of earnings has resulted from a *cause other than the injury* or a *pre-existing disease or disability,* the level of *Permanent Impairment Benefit* and *Extended Earnings-Replacement Benefit* may be reduced.

Arbitrary Payroll - A payroll which was estimated by the *Board.* This happens when *employers* do not fill in payroll statements as required.

Assessable Payroll - The portion of an employer's total payroll subject to *assessment*. Limits are imposed according to the *maximum assessable earnings.*

Assessment - [*Act,* ss. 115] The annual amount determined by the *Board,* and payable by employers into the *Accident Fund,* to provide sufficient funds to pay benefits for workplace *accidents* and *occupational diseases.*

Assessment Rate - See *Rate*, *Assessment*.

Assessment Year - The twelve month period beginning on January 1 in a given calendar year and ending on December 31 in that calendar year.

Attendant Allowance - [*Policy* 2.1.6R1] A *medical aid* allowance paid to a worker who has suffered a *permanent medical impairment* as a result of a *compensable injury.* An attendant allowance is intended to assist workers regarding mobility, health care and any in- home treatment required for the compensable condition. This allowance is usually, but not always, limited to those workers who have suffered a 100% *permanent medical impairment*.

Automatic Assumption - [*Act,* s. 35; *Policy* 1.2.1R1] Refers to the section in the *Act* which provides that any coal miner who has worked at the face of a mine or in similar conditions for twenty years or more, and who suffers from a *permanent impairment* that is a loss of lung function, shall automatically be entitled to a *permanent impairment benefit* according to the degree of *permanent impairment.*

Average Industrial Wage - For purposes of establishing *maximum insurable earnings*, pursuant to Subsection 41(c) of the *Act*, the average industrial wage is defined as Statistics Canada's 'Average weekly earnings, for all employees, industrial aggregate, Nova Scotia' for the 12-month period ending March 31 of the year prior to the year in which the average shall apply.

- B -

Benefit - The end product following calculation of a *rate*, i.e., the payment to the worker.

Benefit of the Doubt - [*Act,* s.187] A legislative decision-making guideline which requires the *Board*, where there is doubt with respect to an application for *compensation* and the evidence for and against the worker's claim is evenly balanced, to decide in favour of the worker.

Benefit Year - (re *Supplementary Benefits*) The twelve month period beginning on October 1 of a given year and ending September 30 of the following year. For example, the Supplementary Benefit year 1997 includes the period from Oct. 1, 1997 to Sept. 30, 1998.

Board - [*Act,* s. 2(e)] Workers' Compensation Board of Nova Scotia.

Board of Directors - [*Act*, ss. 2(f), 151] The board of directors established to oversee and direct the operations of the *Board.*

Business Days - Monday to Friday, with the exception of statutory holidays observed in Nova Scotia.

- C -

Carpal Tunnel Syndrome - [*Policy* 1.2.4R] A compression of the median nerve as it passes through an area in the wrist known as the carpal tunnel. [See also: *repetitive*]

Cause Other than the Injury - [*Act,* s. 10(5); *Policy* 3.9.11R1] Any aspect of the physical condition of an individual worker which, due to its nature or severity, could be reasonably expected to have a significant impact on the duration and/or the degree of a worker's *loss of earnings* or *permanent impairment* resulting from a *compensable injury.*

Chair - The chairperson of the *Board of Directors.*

Child - [*Act,* s. 2(h)] Includes a child born outside marriage, a grandchild, a child of a *spouse* by a former marriage and a child to whom a *worker stands in place of a parent.*

Chronic Pain - [*FRP Regulations*, Sec. 2(b)] Pain which continues beyond the *normal recovery time* for the type of *compensable injury* or which is disproportionate to the type of *compensable injury*. [see also *Functional Restoration Program*]

Claims Costs - Collective term used by the AWCBC, and the *Board* in its financial reports, to refer to the total of *short-term disability* benefits, *long-term disability benefits*, *survivor benefits*, *health care benefits*, and *rehabilitation benefit costs* incurred.

Clinical Rating Schedule (CRS) - see *Permanent Medical Impairment (PMI) Guidelines***.**

Closed Claim - A claim for which no further action or activity is expected; or, a claim which is not actively being adjudicated, and for which there are no on-going appeals, and which may be placed in semi-active (off site) storage.

Clothing Allowance - [*Policy* 2.1.5R3] A *medical aid* allowance paid to an *injured worker* who is prescribed an orthotic or prosthetic device of the type described in *Board Policy* or is confined to a wheelchair as the result of a *compensable injury.* A clothing allowance is intended to compensate the worker for the excessive or premature wear and tear caused to clothing by the wearing of the prescribed device or the use of the wheelchair.

Collateral Benefits - [*Act, s*s.2(j) & 49; *Policies* 3.9.4, 3.9.7, 3.9.8 and 3.9.9] Any payment made by an *employer* to a *worker* in connection with a *compensable injury (* e.g., a "top-up" of the benefits provided for under the *Act*). Collateral benefits also include Employment Insurance benefits paid in connection with the *compensable injury*. Collateral benefits may be exempt (i.e., paid by an employer pursuant to a *collective agreement* or *employment contract* in effect as of February 1, 1996); non-exempt (i.e., paid by an employer but not pursuant to a *collective agreement* or *employment contract* in effect on February 1, 1996); allowable (i.e., non-exempt but within the allowable ceiling of "85% of net actual *Pre-LOE Earnings*"); or excess (i.e., non-exempt and in excess of the allowable ceiling of "85% of net actual *Pre-LOE Earnings*"). (See also *Taxable Collateral Benefits*.)

Collective Agreement - An agreement in writing made between an *employer* and a union which contains the terms and conditions under which work is to be performed and sets outs the rights and duties of the employer, the employees and the union.

Collective Liability - An *AWCBC* standard term used by the *Board* to describe the concept that all employers in a *rate group* are liable for the *claims costs* of any and all *accidents* and *occupational diseases* that occur in the operations of those employers.

Commutation - [*Policies* 3.6.4, 3.7.2R1, 3.9.5, 7.3.13] The payment of a permanent *periodic benefit* as a *lump sum*.

Compensable Injury - A personal injury by *accident* arising out of and in the course of employment for which a *worker* is entitled to be paid *compensation.* (See also: *Accident*)

Compensation - A term commonly used to refer to benefits paid by the *Board.*

Concurrent Employment - [*Policy* 3.1.1R4] Having two or more *employers* at the same time.

Contract, Employment - An agreement made by the *worker* and the *employer* that sets out the terms and conditions of employment (may be written or verbal).

Contractor - An *employer* who, through normal course of business, contracts others (i.e. a sub-contractor) for products and services which include labour. If the sub-contractor is not separately covered by the *Board* then the workers of the sub-contractor are considered workers of the contractor.

Cost Experience - A measure of the risk associated with an *employer account's* business activity. It is calculated, from a three year history, as the ratio of *new injury costs* over *assessable payroll.*

Covered (Employer) - Refers to any *employer* whose employees are within the scope of coverage under the *Act*, whether mandatorily or by election.

- D -

Date of Earnings Loss - The day on which the *employer* stops reimbursing the injured *worker* for employment, as a result of the *compensable injury.*

Date of Injury - [*Act,* s.12(2)] The date on which the *compensable injury* takes place. In the case of *occupational disease*, the date when the disease results in a *loss of earnings*, the date on which the *Board* determines the worker has a *permanent impairment* caused by the disease, or the date on which the *worker's* death is caused by the disease, whichever comes first.

Date of Injury (*Re-employment*) - [*Policy* 5.2.1R] For *re-employment* purposes the date of injury is the date that time loss due to the *compensable injury* commences. This date might be different from the *date of injury* in cases where the *worker* does not have to leave the workplace immediately for treatment, convalescence and/or rehabilitation. For accidents which occurred prior to February 1,1996 **but** the time loss commences after February 1,1996, the re-employment obligations **do** apply.

De-indexing - Applying a factor to an amount of money for the purposes of making it consistent with a past year's dollar value. (See also *Indexing)*

Death Benefit - [*Act,* ss.59(a), 60(1); *Policy* 6.1.1] A *lump sum* payment, in an amount prescribed by *regulation*, paid to the dependent *spouse* of a deceased *worker*.

Death Pay-Out - [*Act, s*s. 60(7)(8); *Policy* 6.1.4] A *lump sum* amount paid to the dependent *spouse* or *dependent children* of a deceased *worker* which is equal to three (3) months of the *compensation* being paid to the *worker* at the time of death; the amount is increased to the equivalent of twelve (12) months of *compensation* if the deceased *worker* had a *permanent medical impairment* of one hundred percent (100%).

Deductible - see *Waiting Period*

Defences (*Re-employment)* - [*Act, s*. 95; *Policy* 5.3.1] Reasons or justification provided by an *employer* to the *Board* when the employer believes it has grounds to justify non-compliance with the *re-employment* obligations under the *Act*. The onus is on the employer to prove the inability to offer to re-employ the injured worker. Acceptable defences include reasons that, in the opinion of the Board, were beyond the control of the employer and could not have been foreseen and avoided by the exercise of due diligence and other reasonable justifications.

Delayed Onset (of Loss of Earnings) - Occurs when the *loss of earnings* arises some time after the *date of injury*; i.e., when the *date of earnings loss* is not equal to the *date of injury*.

Dependent Child - Includes a *child* of a deceased *worker* who is: (i) under 18 years of age; (ii) between 18 and 25 years of age and attending an approved educational facility; or (iii) physically or mentally incapable of earning. Must also satisfy requirements re: *dependant*. (See also *Dependant*)

Dependant - [*Act,* s. 2(l)] A *member of the family* of a *worker* who was wholly or substantially dependent on the worker's earnings at the time of the worker's death or injury.

Dependent Child Benefit - [*Act,* ss. 59(b), 60 (1), 64; *Policy* 6.2.3] A *periodic benefit*, in an amount prescribed by *regulation,* paid to the *dependent child*(ren) of a deceased *worker*.

Deposit Account - See *Self Insured Employer.*

Disability - The limiting loss or absence of capacity of a *worker* to meet personal, social or occupational demands, or to meet statutory or regulatory requirements.

Disallowed (claim) - A claim which has been *adjudicated* and for which no entitlement under the *Act* has been recognized.

Division - A definable subset of a *firm* for which the *Board* establishes a separate account for assessment purposes. Several criteria must be met for a single firm to have multiple divisions. For example, the divisions must have separate staff.

Doward Decision - A decision of the Nova Scotia Court of Appeal which required the *Board* to recalculate the *compensation* payable to those workers who suffered a long term *loss of earnings* in connection with a *permanent impairment* resulting from a *compensable injury* during the *window period.* The date of the decision was April 18, 1997.

- E -

Earnings - Wages, salary, overtime or any other employment-related remuneration designated by the *Board.*

Earnings Profile (Initial) - [*Policy* 3.1.1R4] A *worker's Pre-LOE* average weekly *gross earnings* calculated based on the worker's actual weekly *earnings* for the four weeks immediately preceding the commencement of a *loss of earnings.* The initial earnings profile is used to calculate the *rate* of *compensation* payable during the first twelve (12) weeks the worker receives *Temporary Earnings-Replacement Benefit.*

Earnings Profile (Long Term) - [*Policy* 3.1.1R4] A worker's *Pre-LOE* average weekly *gross earnings* calculated based on the long term average weekly *earnings* of the *worker.* The period used to calculate the long-term earnings profile will vary according to the employment category applicable to the *worker* (i.e., *Long term/permanent worker, New Entrant/Re-Entrant to Labour Force,* New Employment - Likely to be of a Long-Term Nature and All Other Workers). Adjustments may also be made for workers under 30 years of age and *Learners.* The long-term earnings profile is used to calculate the *rate* of any *Temporary Earnings-Replacement Benefit* payable beyond week 12 of the claim as well as any *Extended Earnings Replacement Benefit***,** *Permanent Impairment Benefit* and *Survivor Benefits* payable.

Earnings Profile (Provisional) - [*Policy* 3.1.1R4] A temporary estimate of a worker's *Pre-LOE* average weekly *gross earnings,* used to calculate the *rate* of *Temporary Earnings-Replacement Benefit* payable during the first 12 weeks of a claim, when there is insufficient information to establish an *Initial Earnings Profile.* The provisional earnings profile will be adjusted once documentation of the worker's actual *earnings* is received.

Earnings-Replacement Benefit (ERB) [*Act,* s.37; *Policy* 3.9.2] - A *periodic benefit* paid to a *worker* who experiences a *loss of earnings* as a result of a *compensable injury* (See also: *Extended Earnings Replacement Benefit and Temporary Earnings Replacement Benefit).*

Effective Date (Benefits) - Refers to the date on which a *worker* was eligible to receive a specific benefit.

Employer - An individual, partnership or limited company which employs *workers*. Under the *Act*, s.2(n), "employer" means an employer within the scope of Part I of the *Act*. [See also: *Covered Employer, Employer (Mandatorily Covered), Employer (Non-Registered), Employer (Re-employment)* and *Firm.*]

Employer Account - See *Division*.

Employer (Mandatorily Covered) - [*Act*, s.3; *Policy* 9.1.1R] An *employer* who is required by the *Act* and the *regulations* passed pursuant to the *Act* to register for workers' compensation coverage.

Employer (Non-Registered) - [*Policy* 9.5.3R1] A *mandatorily covered employer* who has failed to register with the *Board.*

Employer (*Re-employment)* - Is the person or entity with which the worker has an *employment contract* and the entity which the *Board* records for *assessment* purposes under the company's policy number. For the purposes of re-employment, this includes employers with twenty or more employees, except those in the construction industry, and others exempt by regulation.

Employment Contract - see *Contract, Employment*

Employment Incentives Program (EIP) - A *vocational rehabilitation* program which provides eligible *employers* with financial assistance, in the form of a forgivable loan, to assist in the creation of training and employment opportunities for *injured workers*. As part of the EIP the *employer* and the *worker* are also provided with a range of support services designed to promote the expected outcome of each EIP: the provision of long-term, full time employment to the *worker.* The EIP is not intended for use with the *accident employer* who may, however, utilize the *Accident Employer Training* program.

Essential Duties (*Re-employment)* - Those core tasks which achieve the actual outcome or end product / service of the pre-injury work at a *normal rate of productivity.* To determine the difference between essential and non essential duties consideration must be given to the employer's central purpose for employing someone in the position by determining the outcome or end-product / service of the work as well as the duties which achieve the outcome. [See also: *Accommodation*]

Estimated Payroll - An *employer's* estimate of their payroll for a year.

Estimation of Potential Earnings Ability (EPEA) - [*Policies* 3.5.1 to 3.5.3, inclusive] A judgement made by the *Board*, where appropriate, with respect to the amount of money a *worker* is capable of earning in *suitable* and *reasonably available employment.*

Experience Rated Costs - The total *claims costs* for the most recent three full calendar years for which such data is available. In some cases, however, actual *claims costs* are not used. For example, costs recovered by way of a *third party action,* costs transferred to another *employer* or fund and costs related to certain *occupational disease* claims are not included. In addition, costs related to *fatal claims* are only included to the extent of the *maximum assessable earnings* for the year of the *accident.*

Experience Rating - [*Act,* s.121; *Policies* 9.3.1R3, 9.4.1R1, 9.4.2R4, 9.4.3R1, 9.4.4R2 and 9.4.5R2] An *assessment* program which assigns *employer accounts* assessment merits or demerits by comparing the employer account's *cost experience* to the *rate group* average cost experience. The program can therefore provide incentives for employers to improve safety and prevention programs in the workplace through providing a measure of equity by charging employers an *assessment rate* that varies with their cost experience. **Experience Ratio** - The ratio of *experience rated costs* to *assessable payroll*.

Extended Earnings-Replacement Benefit (EERB) - [*Act, s.*2(o); *Policies* 3.4.1R1, 3.4.2R2, 3.9.5 and 7.2.1] A long-term *periodic benefit* paid to a *worker* who has a *permanent medical impairment* and is suffering a *loss of earnings* as a result of a *compensable injury* which is in excess of the *permanent impairment benefit* payable as a result of that injury. (See also: *Earnings Replacement Benefit* and *Temporary Earnings Replacement Benefit*).

External Appeal - An appeal from a decision of a *Hearing Officer* to the *Appeals Tribunal* or the Supreme Court of Nova Scotia or from a decision of the Appeals Tribunal to the Court of Appeal.

- F -

Fatal Claim - A claim where a *worker* has died as a result of a *compensable injury* or *occupational disease.* [See: *survivor benefits* and *survivor pension*]

Firm - An *employer*. A firm can have one or more *divisions* (See also*: Employer*).

First Payment Date - The date on which a worker's initial temporary disability or earnings loss payment is authorized and subsequently processed for issuing; used in Annual Report benchmark statistics.

Form 67 - The initial accident report form, which is completed by both the *worker* and the *employer.*

Form 8/10 - The form used by physicians to report the findings and treatment on the *injured worker's* initial visit following a *compensable injury* as well as the findings, treatment and progress during follow-up visits.

Form 51 - The form used by *Board* staff members to record decisions with respect to a *worker's* claim for *compensation benefits.*

Former Act - The Workers' Compensation Act (Chapter 508, R.S.N.S. 1989, as amended by 1992, c.35, ss. 3-18) (the predecessor to the *Act).*

Fraud - [*Policy* 10.3.7R2]A *misrepresentation* made with knowledge that the fact is false (where the fact is stated) or *relevant* (where the fact is not disclosed) and made with intent to deceive the *Board* into acting to its detriment.

FRP Regulations- Functional Restoration (Multi-Faceted Pain Services) Program Regulations, made pursuant to the *Act* and applicable to all decisions, orders or rulings made pursuant to the *Act* on or after February 1, 1996. (See also: *Functional Restoration Program*)

Full Salary Benefits - Generally, where a *worker* continues to receive salary payments from their *accident employer* during a period of compensable disability. Typically, the *Board* will reimburse the employer for the amount of *compensation* which would have been payable to the *worker*. In the case of a *Self Insured Employer* the Board does not reimburse the employer; however, the payments are tracked for Revenue Canada tax reporting (T5007) purposes.

Functional Restoration Program (FRP) - [*Policies* 2.4.1R to 2.4.7R1, inclusive, and 8.1.2R] A pro-active program established by the *FRP Regulations* and designed to assist *workers* in preventing and managing *chronic pain.* The objective of the FRP is to manage the pain and pain-related symptoms as the factors limiting a return-to-work. It is offered, in conjunction with regular case management activities, to eligible workers identified as potentially benefitting from the services of the program.

Funded Ratio - The ratio of the *Board's* recorded assets to its recorded liabilities (See also: *Unfunded Liability*).

- G -

GECA - Government Employees' Compensation Act (R.S.C. 1985, Chapter G-8). The provisions of GECA govern the initial entitlement to *compensation* of employees of the federal government. Once initial entitlement is established, employees covered by GECA are entitled to compensation benefits under the same terms and conditions as are provided for under the *Act.*

Gross Earnings - [*Policy* 3.1.1R4] *Earnings* before any deductions for income taxes, Employment Insurance premiums and Canada Pension Plan premiums (See also: *Net Earnings*).

Guaranteed Income Supplement (GIS) Program - An income security program administered under the authority of the Old Age Security Act. GIS qualifying income levels are used by the *Board* to determine eligibility for *Supplementary Benefits* as well as to determine the possibility of financial hardship when considering the means of recovery of an *overpayment.*

- H -

Hayden Decision - A Nova Scotia court decision which required the *Board* to change to an earnings loss system of *compensation* for *long-term disability*. The date of the decision was March 23, 1990.

Health Care Benefits - [*Act,* s.102-111] *AWCBC* standard term, used by the *Board* for financial accounting purposes, which refers to "all benefits related to providing *medical aid* or health care to the *injured worker,* and includes such items as hospital charges, physician fees, drugs and physical therapy"; formerly referred to at the *Board* as *medical aid* benefits.

Health Care Service Providers- Health care professionals (e.g., physiotherapists, chiropractors, psychologists, audiologists, etc.) who meets the Board's *Service Provider Standards* and are approved by the *Board* to provide health care services to *injured workers.*

Health and Safety Hazard to the Worker or Co-worker *(Re-employment)* - Refers to the risk posed by the worker's inability to perform certain work functions safely or to avoid danger in the workplace. It considers the worker's complete ability, not simply the compensable condition. [See also: *Suitable Work*]

Hearing Officer - [*Act,* ss. 197-200] An employee of the *Board* who has the authority to conduct an oral hearing or a paper review in respect of an appeal from a *reconsideration* decision made pursuant to s. 196 of the *Act* and to render a final decision of the *Board.*

Hierarchy of Objectives - [*Policy* 4.1.3] The objectives, in descending order, followed in developing a *vocational rehabilitation* program for an *injured worker.*

Home Area, Worker's - All points within a 100 km radius of the *worker's* ordinary place of residence, or a greater distance if the worker was travelling a greater distance to work prior to the *accident*; generally used for the purposes of *Estimation of Potential Earning Ability* (*EPEA)*.

Home Modifications - Those modifications to the structural, electrical and plumbing aspects of the *principal residence* of an *injured worker* that are necessary to permit access to and to ensure mobility within the residence and to allow for the safe performance of the activities of daily living such as personal hygiene, food preparation and sleeping.

- I -

Impairment (from the *Board's PMI Guidelines*; *Policy* 3.3.2R) - The loss, loss of use, or derangement of any body part, system or function (after maximum recovery).

Indexing - [*Act,* ss.69-70] Applying a factor(s), as determined by the *Board* (based on the Consumer Price Index), to an amount of money in past year dollars for the purpose of making that amount comparable with dollar values in a subsequent year (See also: *De-Indexing*).

Industrial Disease - see *Occupational Disease*

Industry Group - A group of *standard industrial classification* codes which are similar in terms of nature of business activity.

Injured Worker/Client - A *worker* who has suffered a *compensable injury.*

Initial Rate - An earnings replacement *rate* of *compensation* calculated based on the worker's *earnings profile (initial)*. The initial rate is used to set the *benefits* payable during the first twelve (12) weeks a *worker* receives *Temporary Earnings-Replacement Benefit.*

Interim Earnings Loss Policy - A *policy* adopted by the *Board of Directors*, effective November 26, 1992, which allowed payment of interim awards to persons with an earnings loss and a permanent disability as a result of a *compensable injury*; the policy provided for the payment of the equivalent of a *Clinical Rating Schedule (CRS)* pension.(amended by the *Amended Interim Earnings Loss Policy*)

Internal Accounts - Accounts set up by the *Board* to provide a mechanism for recording *claims costs* which cannot or, in the view of the *Board*, should not be allocated to an *employer account*.

Internal Appeal - [*Policies* 8.1.2R, 8.1.3R3, 8.1.4R, 8.1.6, 8.1.7R2, 8.2.1, 8.2.2R1 and 10.2.2R] An appeal process, administered within the *Board,* available to any *worker* or *employer* who objects to a decision of the *Board* with respect to a claim for *compensation benefits*. An internal appeal proceeds through *Reconsideration* by the original decision maker in the Client Services Department (or by the Director of Assessments for assessment issues) and, if the *Reconsideration* decision is appealed, to the *Hearing Officer* level. If the appellant wishes to appeal the decision of the Hearing Officer, the next step is to apply for leave to appeal to the external *Appeals Tribunal*.

- J -

- K -

- L -

Lay-off Date (Date of Lay-off) - The date the *worker* stops working due to a work-related injury.

Learner - [*Act,* s.2(q); *Policy* 3.1.1R4] An apprentice or a person who becomes subject to the hazards of an industry for the purpose of training, testing or probation as a preliminary to employment.

Long-term Disability Benefits - *AWCBC* standard term, used by the *Board* for financial accounting purposes, which refers to all *benefits* paid to *workers* after *short-term disability benefits* have ceased (e.g., *Permanent Impairment Benefits* and *Extended Earnings Replacement Benefits*). **(**See also *Short-term Disability Benefits)*

Long Term/Permanent Worker - A *worker* who has been employed with the *accident employer* for 12 or more consecutive months immediately preceding the commencement of the *loss of earnings.*

Long Term Rate - [*Policy* 3.1.1R4] An earnings replacement *rate* of *compensation* calculated based on the worker's *earnings profile (long-term).* Typically a long term rate is established after the first 12 cumulative weeks of *temporary earnings replacement benefits* have been paid on a claim. This rate may be calculated earlier where an *extended earning replacement benefit, permanent impairment benefit* or *survivor benefit* is payable before 12 cumulative weeks of *benefits* have been paid.

Loss of Earnings (LOE) - [*Act,* ss. 38-39] The difference between a *worker's* net *pre-LOE earnings* (up to the *maximum insurable earnings*) and their net *post-LOE earnings*.

Lump Sum (Payment) - Generally, any *benefit* paid to a *worker* on a one-time-only basis when a series of periodic payments could have been made. Retroactive payments, *adjustment payments* and *commutation* payments are generally paid as a lump sum (See also: *Periodic Benefit*).

- M -

March 23, 1990 - Established in the *Act* [s.227] as the dividing line between accidents resulting in permanent disability compensated for under the *former Act* (all prior to March 23, 1990) and those compensated for under the new *Act* (all on or after March 23, 1990). (See also *Hayden Decision*).

Maximum Assessable (Earnings) - [*Policy* 3.9.1R] The statutory ceiling on an individual *worker's earnings* upon which *assessment* premiums are calculated (See also: *Maximum Insurable Earnings*).

Maximum Insurable (Earnings) - [*Policy* 3.9.1R] The statutory ceiling on an individual worker's *pre-LOE earnings* upon which the worker's *rate* of *benefit* will be based (See also: *Maximum Assessable Earnings*).

Maximum Medical Recovery (MMR) - The point at which further medical treatment or intervention will not, in the opinion of the *Board*, result in a significant improvement in the *worker's* medical condition.

Maximum Per Claim Cost (MPCC) - A specified maximum per claim applied to *claim costs* when calculating *assessment* rates. Its' use ensures that a major accident will not result in undue hardship for the *accident employer.*

Mediation *(Re-employment)* - A neutral, process oriented intervention aimed at assisting disputing parties to reach consensus on outstanding issues.

Medical Advisor/Officer - A physician employed by the *Board* to provide advice and opinions with respect to medical issues arising in connection with claims for *compensation benefits.*

Medical Aid - [*Act,* ss.2(r) and 102-111] Generally, any authorized costs associated with medical or rehabilitative treatment, products or services paid with respect to a worker's injury; more commonly referred to as *Health Care Benefits*.

Medical Aid Only (Claim) - A claim which has been accepted by the *Board* but for which no time-loss compensation has been authorized. Includes *No Time Loss - Medical Aid Only* and *Time Loss - Medical Aid Only* claims.

Medically Able - Refers to the worker's true medical capacity, considering compensable and non-compensable factors. This is measured by comparing the worker's medical restrictions to the normal demands of the work, with the expectation that the worker meets their *normal rate of productivity.* The term is used in connection with *Estimation of Potential Earnings Ability (EPEA)* and *Re-employment*. [See also: *Suitable Employment/Work*]

Member of the Family - Defined in Section 2(s) of the *Act;* primarily applies with respect to *Survivor Benefits* (especially *Other Dependants*).

Misrepresentation - [*Policy* 10.3.7R2] The misstatement of a *relevant* fact or the failure to disclose a *relevant* fact.

- N -

Nature of Injury - A Statistics Canada standard code employed by the *Board*; refers to the "principal physical characteristics" of the injury or illness (eg. sprain, burn).

Necessary Skills *(Re-employment)* - Refers to the worker's current skills and ability to acquire specific knowledge within the normal time frame of a newly hired employee who meets the qualifications to perform the work. [See also: *Suitable Work*]

Net Earnings - [*Policy* 3.1.2R1] The worker's *gross earnings* less deductions for probable income tax, Employment Insurance premiums and Canada Pension Plan premiums payable by the *worker.*

New Entrant to Labour Force - [*Policy* 3.1.1R4] A *worker* who has joined the labour force for the first time within the 12 months immediately preceding the commencement of the loss of earnings.

New Injury Costs - The payments in a specified time period for all claims whose *accident dates* fall in that time period.

No Action (NOA) - A term which has been replaced in *Board* documentation by *not pursued*. The code NOA is, however, still used as a disposition code for statistical purposes in the Board's computer system.

No Time Loss - Medical Aid Only - An *accepted* claim for which no *earnings loss* from work was reported. Applies to any no time loss claim eligible for *medical aid*, regardless of whether actual medical aid payments have been made.

Non-Compensable Injury - An injury which did not arise out of and in the course of employment and in respect of which *compensation* is not payable.

Normal Recovery Time - [*FRP Regulations*, s. 2(f)] The estimate by the *Board* of the normal time required by *workers* with a specific type of personal injury to return to work after the injury.

Normal or Usual Rate of Productivity (*Re-Employment)* - A rate of productivity comparable to and not less than the average rate of productivity generally accepted for other *workers* performing the same work for similar wages with the *accident employer* or comparable to the worker's pre-injury rate of productivity if this was less than the average productivity of such other workers. If the employer claims the worker was not performing at an acceptable level before the accident, but did not identify performance as an issue with the worker prior to the accident, then, for the purposes of the re-employment provisions, it is determined that the worker was performing at a rate satisfactory to the employer prior to the accident.

Notice to Re-employ *(Re-Employment)* - [*Act,* ss. 96, 97] Refers to *actual notice* or *Board* generated *written notice* to an *employer* of the *worker's* fitness to perform the *essential duties* of the pre-injury work or fitness for *suitable work*. **Actual Notice** is any reliable evidence that the employer knew of the worker's ability to perform a certain type of work. **Written Notice** is a letter from the *Board* specifically informing the employer of the worker's fitness to return to work and the nature of the re-employment obligations relative to the worker's ability.

Not Pursued Claim - A claim for which insufficient evidence or documentation has been received to make an entitlement decision (See also: *No Action*).

November 26, 1992 - Referred to in the *Act,* s.228(3)(c), as the earliest possible retroactivity date with respect to recalculations under the *Transitional Benefit* provisions; it is also the date on which the *Board's Interim Earnings Loss Policy* took effect.

- O -

Occupational Disease - [*Act*, s. 2(v); *Policies* 1.2.1R1 to 1.2.13, inclusive] - A disease arising out of and in the course of employment and resulting from causes or conditions which are peculiar to or characteristic of a particular trade or occupation, or peculiar to the particular employment. Generally considered an *accident* for compensation purposes.

Occupational Hearing Loss - [*Policies* 1.2.5R1, 1.2.6R1] A loss of hearing, which may be either traumatic (i.e., sudden deafness, affecting one or both ears, caused by a blast or head injury) or noise-induced (i.e., gradual onset of deafness, affecting both ears, caused by exposure to noise at the workplace at levels and for durations specified in the *Permanent Medical Impairment Guidelines).*

Offer to Re-employ (*Re-employment)* [*Act,* ss.97,98] **-** A definite, explicit offer of specific work. It must include a stated start date and clear terms of reinstatement. The *Board* will normally require a written offer to re-employ. In some instances, oral evidence of an offer received and documented may be sufficient.

'Old Act' Pensions - [*Policy* 3.7.1] Any periodic *compensation* for permanent disability payable with respect to an *accident* prior to March 23, 1990; also referred to as a *CRS* pension.

Order to Re-employ *(Re-employment)* [*Act,* s. 99] - A directive in the form of an order in which the *Board* specifies the terms and conditions for the *employer's* obligation to re-employ the *injured worker*. The order will specify the employer's duty and the manner in which it is to be met. (eg. placement of the worker on certain dates at a set time and the consequences if the employer fails to obey the order)

On-the-Job Training (OJT) - A *vocational rehabilitation* program which gives *injured workers* an opportunity to learn marketable skills and obtain experience at an *employers's* work site. *Workers* continue to receive *vocational rehabilitation benefits* for the duration of an OJT program and the *employer* may, but is not obligated to, offer employment at the end of the program. The OJT program may not be used with the *accident employer* who may, however, utilize the *Accident Employer Training* program.

Other Dependants - [*Policy* 6.2.4R] Where a deceased *worker* is not survived by a *dependent spouse or dependent child*, other *members of the family* of the worker may qualify for *periodic benefits* as 'other dependants'.

Overpayment - [*Policies* 10.2.1R1, 10.2.2R] The result of paying a *worker, employer* or *health care service provider* more than what they are entitled to receive under the *Act*, through entitlement change, *fraud, misrepresentation* or human or system error. Overpayments may be declared by the *Board* to be recoverable or non-recoverable in accordance with criteria set out in *Board policy*.

- P -

PMI Guidelines - see *Permanent Medical Impairment Guidelines.*

PPD - Refers to a 'Permanent Partial Disability' award based on physical disability and granted pursuant to the *former Act.* (See also: *Old Act Pensions).*

Part of Body - A Statistics Canada standard code employed by the Board; refers to the part of the worker's body "directly affected by the injury or illness".

Participation Level - [*Policy* 9.4.1R1] The level at which an *employer account* is eligible to participate in the *experience rating* program. Participation is governed by the number of years the account has been with the Board and the average annual *assessment* paid by the account.

Periodic Benefit - Any *compensation* payable on a regular fixed basis; usually bi-weekly or monthly (see also *Lump Sum (Payment).*

Permanent Impairment Benefit (PIB) - [*Act,* ss. 34-36; *Policies* 3.3.1R2, 3.3.3R2, 3.9.2, 3.9.5, 7.2.1] A long-term *benefit* payable to a *worker* who has suffered a *permanent medical impairment* as the result of a *compensable injury*; payable for the lifetime of the worker.

Permanent Impairment - see *Permanent Medical Impairment*.

Permanent Medical Impairment (PMI) - The percentage representing the amount of *permanent impairment* suffered by an *injured worker* as the result of a *compensable injury*. A worker's PMI rating is determined by using the *Permanent Medical Impairment Guidelines* (See also: *Disability*).

Permanent Medical Impairment Guidelines - [*Policy* 3.3.2R4] Guidelines used by the Board in the evaluation of percentage of medical impairment; also referred to as the *Clinical Rating Schedule*. The formal title is 'Guidelines for Assessment of Permanent Medical Impairment'.

Person Standing in Place of Parent - see *Standing in Place of Parent, Person*.

Policy - [*Act,* s.183] An official directive issued and approved by the *Board of Directors* setting out the *Board*'s position on a given issue; policies generally state what the *Board* is to do in certain circumstances and are binding, at all times, on *Board* staff, and the external *Appeals Tribunal* (See also: P*rocedure*).

Post-LOE Earnings - The sum of a *worker's* actual *earnings*, the *estimation of potential earnings ability (EPEA)* of the *worker* and 50% of the Canada Pension Plan disability benefits the worker is receiving or is entitled to receive, as calculated after the *loss of earnings* commences.

Pre-existing Disease or Disability - [*Act,* s. 10(5); *Policy* 3.9.11R1] A *non-compensable* disease or disability which existed prior to the *compensable injury.*

Pre-Injury Work (*Re-employment)* - The work performed on the date of injury, with all of its duties, functional demands, obligations, rights, rules, earnings, qualifications, opportunities and other pertinent aspects. [See *also: Accommodation*]

Pre-LOE Earnings - A *worker's net* average weekly *earnings,* as determined by the *Board,* before the *loss of earnings* commences (See also: *Earnings Profile (Initial), (Long Term) and (Provisional).*

Principal Residence - The residence in which the *worker* is living when the services required are provided (e.g. a year-round home, a cottage or the home of a relative or friend with whom the worker is living). For the purpose of *home modifications* there can be only one principal residence.

Procedure - A detailed, operational level, internal document of the *Board* which describes how a given process or task is carried out, often including details re: calculations, workflow, system data entry and forms. Procedures are issued/approved by *Board* management. Procedures often explain how a *policy* is to be implemented.

Provisional Rate - [*Policy* 3.1.1R4] An earnings replacement *rate* of *compensation,* calculated based on the worker's *earnings profile (provisional),* used temporarily when there is insufficient information available with respect to *pre-LOE earnings* to establish an *earnings profile (initial)* and an *initial rate*.

- Q -

- R -

Rate, Assessment - [*Policy* 9.3.1R3] The sum of the *basic rate*, the *merit/demerit rate*, and the *levy rate*. It is the total rate which is applied to an *employer* account's *assessable payroll* to determine the *assessment* amount payable to the *Board.*

Rate, Baseline - The rate assigned to each *rate group*. It is determined by "pricing" the delivery of programs to the employers within the rate group so that the group will generate sufficient revenue to ensure that the *Board* has the required funds to maintain quality program delivery for the members of that group.

Rate, Basic - The portion of an *employer* account's *assessment rate* which would be payable in the absence of a rate *levy* or *merit/demerit*.

Rate (Benefit) - The end result of applying the necessary rules and calculations to *pre- and post-LOE earnings* and upon which a *benefit* is based.

Rate Group - [*Policy* 9.3.3R2] A collection of *industry groups* which demonstrate similar risk of injury patterns. *Employer* accounts within a rate group will have the same *baseline rate*.

Rate, Levy - A component of the *assessment rate*. The Construction Safety Association is funded through a levy on construction employers. No other levies are currently in place.

Rate, Merit/Demerit - A rate decrease (merit) or rate increase (demerit) which, when combined with the *basic rate* and *levy rate*, forms the *assessment rate* for an *employer account*. The merit or demerit is calculated by looking at *cost experience*.

Rate, Prevailing - The *basic rate* assigned to a new *employer account*, on the basis of *Standard Industrial Classification.*

Rate Setting - The process by which the *Board* sets worker *benefit rates* or employer *assessment rates.*

Reasonably Available (Employment) - [*Policy* 3.5.2] Employment will be said to be "reasonably available" if there are currently employment opportunities within the worker's *home area* and the *worker* has a reasonable chance of securing employment; generally used in connection with *Estimation of Potential Earnings Ability(EPEA).*

Reconsideration - [*Act,* ss. 185 and 196; *Policies* 8.1.2R and 8.1.7R] A review by the *Board* of a decision of a staff member of the Board regarding a claim for *compensation benefits.* Reconsideration may be requested by a *worker* or an *employer.* Employers can also request reconsideration of decisions concerning their *assessment.* A request for reconsideration pursuant to s. 185 must be supported by new evidence.

Recurrence - [*Act,* s.40; *Policies* 1.1.1R4 and 3.1.1R4] Refers to a situation where a *worker* who has previously suffered a *loss of earnings* and returned to work suffers a subsequent *loss of earnings* arising from the same injury.

Re-employment - [*Act,* ss.89 -101; *Policy* 5.6.1] A general term referring to the legal obligation of certain *employers* to re-employ eligible *injured workers* following recovery from a *compensable injury.* The precise nature of the re-employment obligation depends on the worker's functional abilities. Failure to fulfil the obligation include orders and penalties. [See also: *Accommodation*, *Employer (Re- employment*].

Re-entrant - A *worker* who has re-joined the work force within 12 months prior to the commencement of the *loss of earnings* after being out of the workforce for a period of 24 months or more.

Refusal to Accept the Re-employment Offer *(Re-employment)* - A definite rejection of the offer of re-employment, preferably made in writing by the *worker*. The *Board* may conclude that certain actions/conduct on the part of the worker indicates refusal of the worker to accept the offer of re-employment. Such conduct is that which clearly violates the reasonable standard of behaviour or performance requirements of the work.

Registered Date - Refers to the date on which a claim is first processed by the *Board*; used in Annual Report statistics.

Regulation - (paraphrased from the Canadian Law Dictionary, 2nd Edition) A form of subordinate legislation which allows the Governor-In-Council to amend or add to the legislation; often used in the worker's compensation context to establish or amend *benefit* levels (eg. amount of *lump sum death benefi*t), and to comply with various requirements (discretionary or otherwise) within the *Act* (e.g. discretion in s.12 to establish *occupational disease* schedule).

Rehabilitation Benefits - *AWCBC* standard term, used by the *Board* for financial accounting purposes, which refers to all amounts related to the rehabilitation of an *injured worker* during a period of *vocational rehabilitation* (excluding *earnings-replacement benefits*).

Relevant - (from The Concise Oxford Dictionary, 8th Edition) Bearing on or having reference to the matter at hand.

Reopened Claim - A claim which was considered *closed,* but for which further activity is subsequently required.

Repetitive - [***re:*** *Carpal Tunnel Syndrome*; *Polic*y 1.2.4R] Manual work is repetitive when it involves brief cycles of tasks requiring either: (i) flexion/extension/gripping with the fingers; or (ii) flexion/extension or ulnar/radial deviation of the wrist. Typical cycle lengths for single-task activities would be less than thirty (30) seconds, meaning that the repetition rate for these at-risk tasks would be on the order of 120 tasks per hour.

Reserve - An amount determined to be required for payment of future benefits based on the projected costs of the claim; used primarily for financial accounting purposes.

Reviews - [*Act,* ss.71-73; *Policies* 3.3.3R2, 3.4.2R2] A general term used to refer to the rules and requirements with respect to the review of the amount of *compensation* payable to a *worker.*

- S -

Seasonal Worker - [*Policy* 3.1.1R4] A *worker* who is employed in an industry which operates for only a portion of the year.

Self Insured Employer - An *employer* who, in lieu of *assessment* premiums, reimburses the *Board* for all *claims costs* incurred. An administrative fee is levied to reimburse the *Accident Fund* for *adjudication*/ administrative costs. For an employer to become self-insured, they must be established by schedule by the

Board of Directors. Existing self insurers include federal government departments, provincial government departments, and select crown corporations.

Service Provider Standards - Minimum standards developed by the *Board* which must be met by *Health Care Service Providers* before they are approved to provide health care services to *injured workers.*

Short-term Disability Benefits - *AWCBC* standard term, used by the *Board* for financial accounting purposes, which refers to all income *benefits* paid to *workers* during the initial period following the *compensable injury,* before the injury has stabilized or plateaued (e.g., *Temporary Earnings Replacement Benefits* and income benefits during a period of *vocational rehabilitation*). (see also *Long-term Disability Benefits)*

Source of Injury - A Statistics Canada standard code employed by the *Board*; refers to the "object, substance, exposure, or bodily motion which directly produced, transmitted or inflicted the injury or illness" (e.g., scaffold, chemical, tools, etc.).

Special Protection - [*Act*, s. 4; *Policy* 9.1.2R] Voluntary workers' compensation coverage purchased by owners of proprietorships and partnerships which would otherwise not have coverage under the *Act*; minimum and maximum guidelines govern the amount of coverage available.

Spouse- [*Act*, s. 2(ab)] May include a person who co-habited with the *worker* for 12 months leading up to the worker's death, and who was wholly or substantially dependent on the worker's earnings at the time of the worker's death.

Stakeholders - Groups and individuals who have an interest in the workers' compensation system. Stakeholders include injured *workers, employers*, labour organizations, injured workers' associations, employer associations, the medical community, the educational system and *health care service providers.*

Standard Industrial Classification (SIC) - A Statistics Canada system with respect to industrial classifications, employed by the *Board* for *assessmen*t and statistical reporting purposes. Each *employer* account is assigned an SIC code.

Standing in Place of Parent, Person - [*Policy* 6.2.5] A person who stands in the place of a parent to the *worker's dependent child(ren*), after the compensable death of a worker, and where both of the child(ren)'s parents are deceased.

Start Date (Benefits) - The date on which *periodic benefit* payments to a *worker* began (as distinguished from *effective date*).

Suitable Employment/Work - Any employment/work which a *worker* has the *necessary skills* to perform, is *medically able* to perform and which does not pose a *health or safety hazard to the worker or any co-worker.* (The term "suitable employment" is used in connection with *Estimation of Potential Earnings Ability(EPEA)* and the term *"suitable work"* is used in connection with *Re-employment).*

Summary Date - The point at which sufficient information is received on a claim to refer it for a time-loss decision.

Supplementary Benefits - [*Act,* s.227(4); *Policy* 3.8.1R4] A benefit which may be paid to *workers* receiving (or entitled to receive) an *Old-Act Pension ,* who are eligible to receive CPP Disability benefits and also meet certain income and age restrictions. May also be paid to the *dependent spouse* or invalid *child* of a worker who died prior to proclamation of the *Act.*

Survivor Benefits - **1**. [*Act, ss*.59 - 68; *Policies* 3.6.1, 3.6.7R, 6.1.1 to 6.3.1R, inclusive] All benefits payable to the surviving *spouse*, *dependent children* or other *dependants* with respect to the death of a *worker,* including *survivor pensions*, *death benefits*, *dependent-child benefits*, expenses re burial and transportation of the body, and benefits to other *dependants*. **2**. An AWCBC standard term, used by the *Board* for financial accounting purposes, which refers to all benefits paid as described above.

Survivor Pension - [*Act,* s. 59(c); *Policies* 6.2.1R, 6.2.2] A *periodic benefit* paid to the *dependant spouse* of a deceased *worker* equal to 85% of the worker's *net* average weekly *earnings* before the *accident;* paid until the spouse reaches age 65, or the worker would have reached age 65, whichever is later.

- T -

TD1 Code - The *worker's* personal tax exemption code. Used to help convert a worker's *gross earnings* to *net earnings*.

Taxable Collateral Benefits - [*Act,* s. 49] *Collateral Benefits* payable to the *worker* as per a *collective agreement* or *employment contract*, including long-term disability, compassionate disability and employer top-ups; also includes EI disability benefits; must be payable as a direct result of the *compensable injury* to be considered within the *ERB* calculation.

Temporary Earnings-Replacement Benefit (TERB) - [*Act,* s.2 (ad); *Policies* 3.2.1R to 3.2.3R, inclusive] A short-term *periodic benefit* paid to a *worker* who is suffering a *loss of earnings* as a result of a *compensable injury.* (see also *Earnings-Replacement Benefit* and *Extended Earnings Replacement Benefit*).

Termination - Includes dismissals, suspensions, layoffs or other cessation of active employment resulting in the termination of employment income and all other employer paid benefits.

Third Party Claim/Action - [*Act*, ss. 28-33] A claim or action, generally brought by the *Board,* against a party (other than the *employer*) who, in the opinion of the *Board,* is responsible for all or part of the damages suffered by a *worker* as a result of a *compensable injury*.

Time Loss - Earnings Replacement Benefit (Claim) - An *accepted* claim for which earnings loss from work greater than the *waiting period* was reported (i.e. *earnings replacement benefits* paid).

Time Loss - Medical Aid Only (Claim) - An *accepted* claim for which the reported *earnings loss* from work is less than, or equal to, the *waiting period* amount. (i.e. no *earnings replacement benefits* payable).

Transitional Benefit Provisions - [*Act,* ss. 225 - 237] Legislative provisions governing the transition of claims and appeals from administration under the *former Act* to administration under the *Act.*

Transitional Claim/Benefits - [*Policies* 7.1.1, 7.2.1 and 3.9.10] A claim affected by or *compensation* benefits paid pursuant to the *transitional benefit provisions.*

Transitional Rate Provisions - Each *employer* account in a given *rate group* will have its *basic rate* moved toward the *baseline rate* for the *rate group*, over a transition period. At the end of transition, the employer account's basic rate will be the baseline rate.

Twelve Continuous Months *(Re-employment)* - [*Act, s.*90] The period of time that a *worker* must have been employed with the *accident employer* prior to the *date of injury* before the employer is obligated to offer *re-employment to the worker*. Some pauses in work activity do not constitute a break in the continuity of the employment relationship. Such pauses include: (i) those lasting less than 30 calendar days; (ii) those lasting 30 calendar days or more but authorized by the employer or the right of the worker under other legislation; or (iii) those lasting 30 calendar days or more but there is substantive evidence of a continuing employment relationship, such as, payment of ongoing employer paid benefits or a mutual agreement that the worker will return to work for the employer upon recall, subject to applicable seniority provisions. [See also: *Worker (Re-employment)]*

Type of Accident - A Statistics Canada standard code employed by the *Board*; refers to the "event or exposure which directly caused the injury or illness" (e.g. fall, motor vehicle accident).

- U -

Unable to Work (*Re-employment)* - The *worker* cannot safely or productively perform any activity with the *accident employer* for a period of time.

Undue Hardship *(Re-employment)* - [*Act,* s. 91] Evidence of detrimental impact on productivity, the operation or profitability of an employer's business. Used in connection with *Re-employment* and the employer's duty to alter the duties of the work or the work environment to facilitate an *injured worker's* return to work. The onus is on the employer to show adequate evidence of undue hardship. [See also: *Accommodation*]

Unfunded Liability - The difference between the Board's recorded assets and recorded liabilities; used for financial reporting purposes. [See also: Funded Ratio]

- V -

Vocational Rehabilitation (VR) - [*Act,* ss. 112-113; *Policies* 4.1.1R1 to 4.3.1, inclusive] Generally, any effort by the *Board* to assist an *injured worker* in returning to the workplace. Some examples of vocational rehabilitation programs and services are: assessment of a worker's functional abilities and/or limitations *,work hardening*, job search preparation, *on-the-job training,* formal retraining and the *employment incentives program* (see also *Rehabilitation Benefits*).

- W -

WCB - Workers' Compensation Board of Nova Scotia.

Waiting Period - [*Act,* s. 37(4); *Policy* 3.2.2R1] A period of time at the beginning of a claim, during which two-fifths of the *worker's* net average weekly compensation from employment would have been paid, that the *worker* must wait before being eligible for an *earnings replacement benefit*; also referred to as the *deductible*.

Window Period - The period between March 23, 1990 (the date the *Board* started its shift to an earnings loss system of paying benefits) and February 1, 1996 (the date of the full implementation of the new *Act*). (See also *Transitional Claim/Benefits.*)

Worker - [*Act*, s.2(ae)] Generally, any person eligible to make a claim for *compensation* following a workplace *accident*; any person within the scope of the *Act* in the capacity of a worker.

Worker (*Re-employment)* - All workers for whom the employer will complete a T4 Supplementary, such as full-time, part-time and temporary employees and workers absent with pay. Categories of workers are the same as those required to be included for Revenue Canada reporting purposes and include:

- regular or permanent full time: employment for a minimum of 35 hours per week;
- regular or permanent part time: employment for less than the normal schedule or less than 35 hours per week;
- temporary: employment for a fixed period of time, for either full-time or part-time hours; may be employed intermittently by the same employer a number of times;
- contract: hired on either a full-time or part-time basis for a limited duration; often self-employed individuals;
- casual/contingent: employment on an occasional or "on call" basis, usually for brief periods of time depending on the requirements of the employer; hours of work may vary from a few hours per week to full time;
- seasonal: employment for part of the year dependent on an employer's needs to meet seasonal changes in supply of labour; and

- job sharing: a new version of regular or permanent part time employment in which two or more employees voluntarily share responsibilities for one position.

Workers' Advisers Program [*Act,* ss. 259 - 274] - A program, administered by the Nova Scotia Department of Labour, which provides legal advice and representation, free of charge, to *workers* who wish to appeal a decision of the *Board* and who satisfy the eligibility criteria set out in the Workers' Advisers Program Eligibility Regulations; preceded, under the *former Act,* by the Workers' Counsellor Program.

Work Hardening - A *vocational rehabilitation* program designed for a *worker* who has been out of the work place for a lengthy period and/or is unable to return to their pre-accident position. This program will focus on maximizing the workers's physical capabilities and increasing work day tolerance. Education, as well as stress and pain management, constitute major portions of the program.