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OVERVIEW OF THE POLICY & PROCEDURE MANUAL

What is policy and how does it relate to legislation

Policy fits within a hierarchy of authority that permits a legislature to implement its intentions.

**Statute Law** is the highest authority for translating an electoral mandate into action. Statutes are created in form of a Bill, which is formally debated and ratified by the legislature to become an Act. An Act normally delegates authority to a government department, agency, crown corporation, etc. to administer and implement the government’s intent.

In the past, statutes were written in such a manner that it was open to wide interpretation, resulting in the necessity for regulations and policies to establish the detail. More recent practice is to cast legislation with more detail to minimize the opportunity for misinterpretation or re-interpretation via judicial process.

**Regulation** is similar to law, but is approved by the Lieutenant-Governor in Council (the Cabinet) rather than by the whole legislature. Regulations are much easier to amend and, to the extent permitted by the statute, permit a government to fine-tune the detail of its intentions in light of changing needs or circumstances. Moreover, regulations are usually more specific in the powers and duties they convey to officials, so that officials are aware of their responsibilities and authorities, and can be held accountable. Like legislation, regulations are now being written with greater inclusion of detail.

**Policy** is authorized by the Board in order to interpret legislation and regulation and, from such interpretation, identify intentions and specify actions. They do this in a number of ways, such as:

- Interpret law under powers delegated to them by the Act.
- May broaden or restrict the application of the law where authorized to do so.
- Decide what programs and actions will be designed and implemented to meet the instructions in the Act.

**Procedure** is authorized by the Chief Executive Officer and specifies how a given policy will be implemented. Where procedures are approved for a given policy, the corresponding policy is referenced in the Background and Complements sections of the procedure.

**Authority**

The WCB Board is given express authority by *The Workers’ Compensation Act, 2013* to interpret and implement the intentions of the Legislature within the context of the Act. It follows that corporate policies authorized by the WCB Board represent the primary operating authority under the Act and provide guidelines for WCB staff. Thus, staff are specifically directed to use policy where applicable, rather than re-interpret the legislation.
There may be circumstances where a claimant or individual feels that a policy ought not to apply due to special circumstances. Consideration may be given to the special circumstances but appropriate authority to deviate from policy must be sought.

WCB Policy constitutes the day-to-day decision-making framework and authority for all WCB employee decisions and actions. Only WCB Board members and those to whom they specifically delegate such authority are authorized to interpret the Act and transform such interpretation into action.

Policy development process

Policy development is a formal process within WCB, with specific forms, procedures and sign-offs designed to ensure organization-wide consultation and collaboration in the drafting and revision of policies and procedures. This process captures the practical considerations of those who have to deliver programs as well as the administrative and organizational considerations of management. Proposals for policy originate at the executive management level, and once initiated, enter the formal process and are tracked until such time as they are accepted and ratified, or are rejected.

How it should be used

Level of authority

The Policy Manual is the primary source of authority and reference for current decisions on claims and assessment of premiums. The WCB has installed the policy manual on its website for use by external stakeholders and internal staff.

Usage

The Table of Contents may be consulted at the front of the manual to identify the broad area of interest. Each sub-section also has a table of contents that will show each of the individual policies or procedures within the section.

Complete historic policy documentation for archival and reference purposes is retained by the Board, but not published in this Manual.

Cross-Referencing Information

In the electronic copy of the Policy Manual, cross-reference hyperlinks to complementary or related policy or procedure are also in the Data Block.

**Document Number** is the first field in the Policy or Procedure document, and appears at the top left corner of the page. This number reflects the organization of the Policy Manual by book, section and specific document. Following the Document Number is the title and policy or procedure number. Document numbers may be updated periodically by Corporate Policy in order to maintain effective organization within the Policy Manual.

**Policy/Procedure Number** conveys:

- year the policy or procedure was first created
where it fits in the order of policies/procedures created that year

Data Block is located at the end of the policy/procedure text. The data block contains five pieces of information as follows: Act Section; Effective Date; Application; Supersedes and Complements.

Act Section identifies the Section of the Act that forms the underlying authority for the policy or procedure.

Effective Date identifies the date on which the policy or procedure becomes effective.

Application indicates to what special groups, what general groups, or under what circumstances the policy or procedure is applicable. For example, “All new claims” would indicate that all new clients would be governed by the new policy after the effective date, but that all claims received before the effective date would be adjudicated based on the old or superseded policy.

Supersedes indicates the number and title of any policy or procedure that is cancelled and superseded by the new policy or procedure. Lack of such a number may indicate that this policy or procedure may deal with an issue that has not been considered previously.

Complements sections list policies or procedures that deal with the same or similar subject matter and may add new insights or further considerations to the topic.

Stakeholder Notification

Stakeholders can access the Policy Manual on-line at www.wcbsask.com using Adobe Reader, free software that may be downloaded for viewing and printing. Anyone wishing to update their paper manual may print new or amended policies from the website.

To provide our stakeholders with timely access to new and updated policies, WCB offers a Policy Manual Subscription Service. Subscribers are notified by email whenever new or updated policies are posted to this website. If you or your organization are interested in this service, click here to subscribe.

It is your responsibility to inform us:

- of your preferred email notification address
- if your email address changes
- if you would like to be removed from our notification list

Stakeholders may also view paper copies of the Policy Manual at both the Saskatoon and Regina offices reception areas.
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1.1 Coverage – Personal (POL 03/2014)

Document Date 29 April 2014

Purpose To establish guidelines for personal coverage.

DEFINITION

**Personal coverage** is optional coverage for individuals not automatically covered under *The Workers’ Compensation Act, 2013* (the “Act”).

BACKGROUND

1. Section 20 provides the Workers’ Compensation Board (WCB) exclusive jurisdiction to determine whether any industry or worker is within the scope of the Act.

2. Section 12 of *The Workers’ Compensation General Regulations, 1985* (the “General Regulations”), provides the guidelines for employer coverage. Section 12 indicates coverage is subject to a period of three months and empowers the Board to grant an employer personal coverage "on any terms and conditions, and for any period, that the Board may prescribe."

3. Section 14 (1) of the General Regulations allows a proprietor or partner of a business or an executive officer of a corporation not on the company’s payroll to obtain personal coverage.

4. Section 14 (2) of the General Regulations states:

   Every proprietor or partner of a business who employs no workers or who does not submit to the board the statement required by… the Act, and every executive officer of a corporation who is not on the corporation’s pay-roll is deemed to be a worker when under contract to a principal and the earnings in respect of his or her services, as the board may determine, are assessable on the principal’s account unless ordered otherwise by the board.

5. Section 15 of the General Regulations states “where the spouse of a sole proprietor or partner of a business wishes to obtain coverage for himself or herself, section 12 applies”.

6. Section 13 of the General Regulations states:

   Unless otherwise fixed by the board, personal coverage requested for an employer engaged in more than one industry under the Act is to be assessed at the rate applying to the industry with the largest payroll reported to the board for the preceding year.
7. Employers are classified on the basis of industrial undertaking following the premise that employers in like industries are subject to the same relative risks. As noted under Background Point 6, the General Regulations suggest that payroll be the basis on which assessments should be made. In keeping with the underlying principle of risks, the Board believes that it is more fair and equitable to apply assessments on the basis of time spent in the industry working. The Board believes this is a better reflection of the risks to which the employer and workers are subject. Therefore, the Board directs that time spent in the industry or province will be the basis on which premiums will be assessed.

POLICY

1. Personal coverage may be purchased by:
   a. Proprietors and their spouses.
   b. Partners and their spouses.
   c. Directors of a corporation who are not carried on the payroll.
   d. Elected officials of a city, town or village, and
   e. Members of the governing body of a non-profit corporation or organization.

2. When personal coverage has been purchased, the applicant becomes a worker and is eligible for benefits under the Act. Wage loss benefits will be based on the amount of coverage purchased by the applicant.

3. Personal coverage protects the individual only while working in the industry or industries for which coverage was purchased and approved.

4. Where an employer in an industry covered by the Act chooses not to purchase personal coverage for themselves, they will be considered a worker, but one who has chosen not to purchase protection for their own work injuries. This will mean they are a worker for the purposes of a barred action application under Section 169 of the Act (POL 01/2013, Determination of a Worker’s Right to Bring Action). All other benefits under the Act will not apply.

Application for Coverage

5. An application for personal coverage can be made by telephone or in writing to the WCB.

6. Coverage will be effective 12:01 a.m. the day following the date the application is received by the WCB or at a later date if requested by the applicant. An injury claim that occurs prior to the effective date of coverage will not be accepted.
7. Personal coverage may be purchased for any amount between the minimum personal coverage amount and the maximum assessable wage rate set for that year. POL 07/2015, Maximum Assessable Wage Rate, will apply.

8. The minimum personal coverage amount is based on assessable earnings for a 40 hour work week at the provincial minimum wage. If the provincial minimum wage changes within the year, the minimum personal coverage amount will not be adjusted until January 1st of the subsequent year.

9. Personal coverage is subject to a minimum premium of three months.

10. Where coverage is purchased during the year, the premiums will be prorated to the end of the calendar year.

11. Coverage will remain in effect with premiums payable until the applicant requests in writing that the coverage be cancelled or until the WCB cancels it for a reason, which includes:
   a. Non-payment of premiums.
   b. Failure to provide the required payroll information.
   c. Providing false or misleading information to the WCB.
   d. Mail is returned and an alternate address cannot be found, or
   e. Any other instance where the WCB determines coverage should be terminated.

Proof of Earnings

12. Where the amount of coverage requested is higher than the minimum personal coverage amount, the applicant will be required to substantiate actual employment earnings in the event of an injury. The WCB will accept one of the following documents as proof of earnings:
   a. A T4 income tax slip as submitted to the Canada Revenue Agency (CRA).
   b. A Statement of Business or Professional Activities as submitted to the CRA, or
   c. A declaration from a Chartered accountant, a Certified Management Accountant (CMA), or a Certified General Accountant (CGA) verifying the actual employment earnings.

   In the absence of these documents, the WCB may accept an audited financial statement.

13. Only earnings reported in industries covered under the Act may be used for substantiation, unless voluntary coverage has been requested and approved by the WCB for an industry excluded under the Act.
14. Failure to provide proof of earnings at the time of injury will result in the coverage being reduced to the minimum personal coverage amount.

15. It is the applicant’s responsibility to ensure that the amount of coverage purchased is not more than their actual employment earnings. Where the applicant is unable to substantiate the amount of coverage purchased, they will not be reimbursed for the extra premium paid.

16. Where the applicant can substantiate earnings above the amount purchased, wage loss benefits will be based on the level of coverage purchased.

17. Coverage amounts may be increased or decreased at any time. Any changes will be effective the day the WCB is notified of the change by the applicant. Where coverage is being increased, proof of earnings will be required at the time the increase in coverage is requested.

**Premium Assessment**

18. Premiums are based on the amount of coverage purchased and the industry in which the applicant operates.

19. Based on the rationale provided under Background Point 7:
   a. Where an applicant operates a business within more than one industry, premiums for personal coverage will be prorated based on the amount of time the applicant spends in each industry.
   b. Where the applicant works in more than one province, the WCB will prorate the premiums charged based upon the amount of time spent in each province. Benefits continue to be based on the personal coverage amount selected regardless of how the coverage is split. The coverage amounts are subject to Saskatchewan’s minimum personal coverage amount and maximum assessable wage rate.

**Act Sec #** 3, 20, 43, 119, 169;  
*The Workers’ Compensation General Regulations* 12, 13, 14, 15, 16

**Effective Date** 01 May 2014

**Application** All personal coverage applicants on or after the effective date.

**Supersedes**  
POL 31/71 Coverage, Personal  
POL 28/91 Coverage, Personal, and for Elected Officials  
POL 19/2001 Assessment – Minimum Employer Personal Coverage

**Complements**  
POL 11/2011 Employer Coverage and Registration  
POL 07/2015 Maximum Assessable Wage Rate  
POL 15/2000 Coverage, Independent Worker  
POL 14/2014 Coverage – Directors  
POL 01/2013 Determination of a Worker’s Right to Bring Action
1.2 Coverage – Voluntary (POL 21/2014)

Document Date 10 December 2014

Purpose To establish guidelines for extending voluntary coverage to industries and occupations excluded from The Workers’ Compensation Act, 2013.

BACKGROUND

1. Section 3 of The Workers’ Compensation Act, 2013 (the “Act”), states that the “Act applies to all employers and workers engaged in, about or in connection with any industry in Saskatchewan except the farming and ranching industry and those industries, employers or workers excluded” by The Workers’ Compensation Act Exclusion Regulations, 2014 (the “Exclusion Regulations”).

2. Under Section 3 of the Act, “an industry, employer or worker excluded from this Act may apply to the board to be brought within the scope of this Act.” Further, when an excluded employer requests coverage, they are required to notify the workers or their union that WCB coverage has been requested. Additionally, a worker must give notice to their employer that coverage has been requested.

3. Section 20 provides the Workers’ Compensation Board (WCB) exclusive jurisdiction to determine whether any industry or worker is within the scope of the Act.

4. In accordance with Section 5 of the Exclusion Regulations, if an employer is responsible for an operation that is within the scope of the Act and another operation that the Act does not apply to, coverage will only apply to the work performed in the industry to which the Act applies.

POLICY

1. An industry, employer, or worker who is excluded from coverage under the Act may apply for voluntary coverage.

2. An application for voluntary coverage must be made in writing to Employer Services. An application concerning an industry not previously approved by WCB will be reviewed by the Vice President of Prevention and Employer Services who will determine whether coverage should be granted.

3. Once an application has been approved, coverage will be effective 12:01 a.m. the day following the date the application is received by the WCB. If a worker is injured prior to the effective date of the coverage, the claim will not be accepted.
4. When voluntary coverage has been purchased, the employer and workers are subject to the same requirements and entitled to the same benefits as those required to have coverage under the Act.

5. Once an application for voluntary coverage is approved, an employer is required to provide coverage for all of the employer’s workers in that industry.

6. Coverage will remain in effect until the employer requests in writing that coverage be cancelled or until the WCB cancels it for a reason which includes:
   a. Non-payment of premiums.
   b. Failure to provide the required payroll information.
   c. Providing false or misleading information to the WCB.
   d. Mail is returned and an alternate address cannot be found, or
   e. Any other instance where the WCB determines coverage should be terminated.

7. Where an employer has operations within a mandatory and an excluded industry, the employer and workers will only have coverage while they are performing work under the industry that is mandatory, unless a voluntary application has been submitted and approved by the WCB.

8. The following industries and occupations may not be found eligible for voluntary coverage due to considerations such as their high rate of injury and/or difficulty in establishing a wage base:
   a. Artists, entertainers, and performers.
   b. Circus operations.
   c. Sports players, including sports coaches and instructors, while participating as a player or competitor in a sporting event.
   d. Sports coaches and instructors employed by professional sports organizations whose intent is to derive profit from the playing of the sport rather than the providing of instruction, and
   e. Voluntary workers, except those in mine rescue work, members of the Emergency Measures Organization, volunteer fire fighters, and first responders.

9. Any decisions made under this policy may be appealed directly to the Board Appeal Tribunal (POL 22/2013, Appeals – Board Appeal Tribunal).
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<th>Act Sec #</th>
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1.3 Coverage Within Saskatchewan – Out of Province Employers (POL 07/2002)

Document Date 29 July 2002

Purpose To establish guidelines for out-of-province employers (incidental incursions).

DEFINITION

Incidental means out-of-province workers come into Saskatchewan two or less times per year or for a duration of four or less consecutive days.

Principal means the employer in a mandatory industry in Saskatchewan who contracts for service with an out-of-province employer (contractor).

Employer is defined as any person, corporation, firm, association or body having in its service any worker engaged in any work in, about or in connection with an industry.

Worker means a person who has entered into or works under a contract of service or apprenticeship, written or oral, whether by manual labour or otherwise, and any other person not otherwise coming within this definition who is deemed to be a worker under the Act.

BACKGROUND

1. When employers based outside of Saskatchewan require their employees to travel into Saskatchewan, either as part of the employer’s operations in another province or solely for the purpose of operating a portion of their business activities in Saskatchewan, clarification is needed as to when or in what circumstances the employer and their employees become subject to The Workers’ Compensation Act, 2013 (the Act) of Saskatchewan.

2. The Saskatchewan Workers’ Compensation Board (the WCB) has exclusive jurisdiction under Section 20 of the Act to determine all matters and questions arising under the Act, including under 20(2)(h) whether any industry is within the scope of the Act and under 20(2)(i) whether any worker is within the scope of the Act.

3. “Industry” is defined in Section 2(1)(q) as “an industry to which this Act applies and includes an establishment, undertaking, trade and business.”

4. Section 3(1) makes application of the Act mandatory to all “employers and workers engaged in, about or in connection with any industry in Saskatchewan”, except industries that are specifically excluded. It is necessary for assessment and injury
coverage purposes, to determine whether an out-of-province employer is carrying on business in a mandatory Saskatchewan industry and therefore, is required to register and pay premiums to the WCB.

5. Section 26 states: “If a worker suffers an injury, the worker is entitled to compensation. Compensation is to be paid by the board out of the fund.”

6. Employers required to register with the WCB who are in default of submitting a statement of payroll or paying assessments to the Board, shall be subject to the penalties set out under Section 153 of the Act, and Sections 3, 4, 5 and 8 of The Workers' Compensation General Regulations, 1985 (the “General Regulations”).

POLICY

Mandatory Coverage

1. Where an out-of-province employer is awarded a contract for work to be carried out in a mandatory Saskatchewan industry, registration with the WCB is required if the employer:
   a. has established a place of business in Saskatchewan, or
   b. employs Saskatchewan resident workers.

2. Where neither of the above is true, out-of-province employers performing work for a principal in a mandatory Saskatchewan industry will be required to register if:
   a. the employer comes into the province 3 or more times per year, or
   b. the employer comes into the province 5 or more consecutive days per year.

3. Where an employer has both a Saskatchewan base of operations (in a mandatory Saskatchewan industry) and a non-Saskatchewan base of operations, coverage will only be extended to workers who are engaged in activities that are part of the Saskatchewan base of operations. Workers employed in the employer's non-Saskatchewan base of operations will not be covered if they are engaged in activities that are not part of the Saskatchewan base of operations, even when working in Saskatchewan.

Voluntary Coverage

4. Where the work performed by an out-of-province employer is incidental, registration with the Board is not required and the workers of the out-of-province employer will not be considered workers under the Saskatchewan Act. The Saskatchewan principal may be liable for any legal action commenced by an out-of-province worker in the event of a work injury, unless:
   a. the Saskatchewan principal becomes responsible for the premiums payable to the Board, or,
b. the out-of-province employer elects voluntary coverage with the WCB.

Exceptions

5. The Independent Worker policy (POL 15/2000), will be considered in conjunction with this policy, as registration criteria vary from the provisions contained here.

6. Any other exceptions to the policy outlined above will be forwarded to the Director of Employer Services for consideration.

Payroll Reporting and Payment of Premiums

7. When it has been determined that an out-of-province employer is required to register with the WCB, a statement of the employer's payroll must be submitted within 30 days of the commencement of business and premiums paid accordingly.

8. Where a registered out-of-province employer defaults on premiums payable with respect to the work being carried out in a Saskatchewan industry, the principal will be personally liable to pay the premium on the labour portion of that contract.

Act Sec # 2(1)(l), 2(1)(q), 2(1)(ii), 3(1), 20, 26, 122, 131, 132, 153, 158(1)
Effective Date August 1, 2002
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All employers based outside of Saskatchewan who carry on or undertake to carry on activities in Saskatchewan
Supersedes POL 03/2000 (Amended by ADM 11/2000) Incidental Incursions
Complements PRO 07/2002 Coverage Within Saskatchewan – Out of Province Employers
POL 15/2000 Coverage, Independent Worker
POL 14/2014 Coverage – Directors
PRO 56/2015 Default in Assessment Payment
POL 22/2014 Employer Accounts – Clearances and Letters of Good Standing
1.4 Coverage – Contracts Involving Equipment (POL 02/2011)

Document Date 19 January 2011

Purpose To establish coverage when an equipment owner enters into a contract requiring equipment.

DEFINITION

Equipment, as referenced in Section 8 of The Workers’ Compensation Act, 2013 (the “Act”), means major, industrial-grade equipment that is used to fulfil the terms of a contract for which the owner of the equipment is being paid. The owner of the equipment generates revenue from entering into contracts that require the use of equipment. Light- or home-use grade items such as hand tools, lawnmowers, snowblowers, and personal transportation vehicles are not considered equipment.

BACKGROUND

1. Under Section 8(2) and 8(3) of the Act, the owner of equipment, who has not been assessed as an employer and enters into a contract with a principal, is deemed a worker in the employ of the principal. Any individuals hired by the owner to operate the equipment are considered a worker of the principal.

2. Under Section 8(4) of the Act, when a principal is required to pay premiums for the equipment owner, the principal may deduct from the owner the sum equivalent to the premiums assessed by Workers’ Compensation Board (WCB).

POLICY

1. When a principal contracts with an owner of equipment who is not registered with WCB, the owner is considered a worker of the principal. Any individual the owner may hire to operate the equipment and fulfil the contract is also considered a worker of the principal.

2. When the owner and/or operator is considered a worker of the principal, the principal may deduct or recover from the equipment owner the sum equivalent to the premiums paid based on the firm’s net premium rate for the work being completed.

3. Those considered workers of the principal will be provided with coverage under the Act from the start of the contract until twelve midnight of the tenth calendar day following completion of the contract or the effective date of a new contract if earlier. Coverage will be provided for directly-related activities including equipment servicing and will be in effect to include travel to and from the contracted worksite, provided the worker proceeds by the most practical route.
4. The principal’s premium will be based on the labour portion of the contract.

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1.5 Coverage – Trucking, Leased Operators (POL 08/2011)

Document Date 16 August 2011

Purpose To establish coverage guidelines for leased operators in the trucking industry.

DEFINITION

Leased operator means a business or person that owns a truck and provides transportation services under contract to another business or person.

BACKGROUND

1. Under Section 8(2) and 8(3) of The Workers’ Compensation Act, 2013 (the “Act”), the owner of equipment, who has not been assessed as an employer and enters into a contract with a principal, is deemed a worker in the employ of the principal. Any individual hired by the owner to operate the equipment is considered a worker of the principal.

2. In accordance with Section 8(4), when a principal is required to pay premiums for the equipment owner, the principal may deduct from the owner the sum equivalent to the premiums assessed by the Workers’ Compensation Board (WCB).

3. Section 18 of The Workers’ Compensation General Regulations, 1985 (the “General Regulations”) defines the holder of the Operating Authority Certificate issued pursuant to The Motor Carrier Act as an employer within the commercial transportation industry. Under The Motor Carrier Act, leased operators were not eligible for an Operating Authority Certificate and therefore were not eligible for an account, regardless of whether they hired workers.

4. Deregulation of the trucking industry occurred in 1998 and The Motor Carrier Act was repealed in 2006. The Traffic Safety Act, which replaced The Motor Carrier Act, does not require an Operating Authority Certificate for the transportation of goods. Consequently, Section 18 of the General Regulations is no longer relevant in defining who is an employer within the trucking industry.

POLICY

1. Where a leased operator employs workers on a full-time, part-time, casual, or contract basis, they are required to register for an account with the WCB.

2. If the leased operator does not hire workers, they are considered a worker of the principal unless they are eligible for coverage as an independent worker and have purchased personal coverage.
3. Where a leased operator is not required to register and has not purchased personal coverage, they are considered a worker of the principal they have contracted with. The principal may deduct or recover from the leased operator the sum equivalent to the premiums paid based on the firm’s net premium rate for the work being completed.

Act Sec # 8; The Workers’ Compensation General Regulations 18
Effective Date 01 January 2012
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All firms in the trucking industry.
Supersedes n/a
Complements POL 15/2000 Coverage – Independent Worker
POL 07/2004 Assessable Labour Portion of Contracts
PRO 07/2004 Assessable Labour Portion of Contracts
POL 02/2011 Coverage – Contracts Involving Equipment
PRO 02/2011 Coverage – Contracts Involving Equipment
POL 24/2010 Assessable Earnings
POL 24/2014 Alternative Assessment Procedure for the Interjurisdictional Trucking Industry
PRO 24/2014 Alternative Assessment Procedure for the Interjurisdictional Trucking Industry
1.6 Coverage, Taxi Cabs (POL 34/77)

Document Date 11 August 1977

Purpose To establish guidelines for coverage of taxi cab operators.

POLICY

1. Remuneration paid to employees, dispatchers, and operators of company-owned vehicles is deemed to be wages for assessment purposes.

2. Owner-operators who merely pay “stall rent” are to be considered as independent operators with the right to elective coverage.

3. Any person in the employ of the owner-operator is to be considered a worker and assessment of owner-operator applies.

Act Sec # 3, 32
Effective Date 01 January 1978
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All Future Applications
Supersedes POL 40/72 Coverage – Taxi Drivers
Complements n/a
1.7 Coverage – Offenders in Work-Based Programs (POL 20/2014)

Document Date 09 December 2014
Purpose To provide coverage to offenders participating in work-based programs.

DEFINITION

Alternative Measures means programs offered to offenders that provide the opportunity to take responsibility for their behaviour and address the harm that has been committed. Offenders participate in programs that resolve cases within a community agency or with community participation.

Community Service Work means unpaid work done for the community at large, community members or a community organization under the supervision of an agent or agency authorized by the Ministry of Justice and Attorney General (“Justice”).

Community Service Order (CSO) Program means an alternative sanction to incarceration (or some other penalty) for offenders that requires them to perform a specific number of hours of community service work.

Correctional Facility means a correctional centre or a community correctional facility pursuant to Section 2 of The Correctional Services Act, 2012.

Fine Option Program means a program authorized and administered by Justice that offers offenders the opportunity to settle a fine by performing community service work in lieu of paying cash for their fine.

Offender means a person who has been accused, charged with or convicted of an offence and who is bound by an alternative measures agreement or court order, including a person sentenced to a correctional facility or youth custody facility. This includes young offenders, meaning a young person charged or who accepts responsibility for committing an offence between the ages of 12 and 17 as defined in the Youth Criminal Justice Act (Canada).

Youth Custody Facility means a place of open custody, secure custody or temporary detention. Facilities may include a centre, home, institution, camp or other place or facility designated under the Youth Criminal Justice Act (Canada).

BACKGROUND

1. Historically, the Workers’ Compensation Board (WCB) has extended coverage for offenders in provincial correctional facilities as well as offenders in the Fine Options
and CSO Programs through agreements between the WCB and Justice. WCB has also extended coverage to young offenders through agreements between the WCB and the Ministry of Social Services.

2. In 2012, responsibility for all youth and adult corrections functions became part of Justice.

3. Under Section 3 of The Workers’ Compensation Act, 2013 (the “Act”), Justice has requested that coverage continue to be extended to offenders while participating in work-based programs approved by Justice.

POLICY

1. Subject to the Memorandum of Understanding (MOU) between WCB and Justice, coverage under the Act is extended to offenders participating in work-based programs within correctional facilities, youth custody facilities, Alternative Measures programs, Fine Option programs and CSO programs that are offered by agencies authorized and sponsored, in whole or in part, by Justice.

2. Under authority of Section 3 of the Act, WCB deems offenders to be workers while in the course of participating in a work-based program and by Section 20(2)(b) orders that offenders sponsored by Justice are in the course of employment.

3. To be covered by the Act, offenders will be considered workers of Justice while in the course of completing a work-based program.

4. Earnings loss benefits will be suspended during any period of incarceration.

5. If there is a loss of earnings, the calculation of earnings loss benefits for any claims arising out of this policy will be based on:
   a. All earnings from the offender’s employment in industries covered by the Act.
   b. Where there are no covered earnings or the offender is participating in a Fine Option or CSO program, the provincial minimum wage for a 40 hour workweek for the first 24 months of demonstrated earnings loss.
   c. The earnings from both the Fine Options program and an offender’s regular employment, where the offender has indicated that they are missing time from their employer due to an injury suffered while participating in the Fine Options program.
   d. After earnings loss benefits have been paid for a period of 24 consecutive months, two-thirds of the average weekly wage as of June in the year immediately preceding the year in which the loss of earnings or ability to earn occurs, and
   e. In the event of a fatality, benefits to dependents will be based on the provisions of the Act.
6. Any claims costs arising out of this policy will be applied directly to the cost experience of Justice and will be reflected in the premiums charged to the Government of Saskatchewan.

7. Where an offender is participating in a work-based program for an employer who is covered under the Act and pays them an actual salary, the offender will be considered a worker of the employer and any costs arising out of an injury will be charged to the employer's claims experience.

8. Coverage under this policy is not extended to offenders incarcerated in any federal penitentiary or prison.

9. The Chief Executive Officer (CEO) or designate shall have the authority to execute the MOU on behalf of the WCB.

**Act Sec #**
- 2(1)(ii), 3, 20, and 80; *Criminal Code of Canada* 717(1); *Youth Criminal Justice Act* 10; *The Correctional Services Act, 2012*

**Effective Date**
- 01 March 2015

**Application**
- All offenders in work-related programs sponsored by Justice.

**Supersedes**
- POL 83 Coverage - Inmates
- POL 47/83 Coverage, Community Service Order Participants
- POL 12/85 Coverage, Young Offenders Act

**Complements**
- PRO 20/2014 Coverage – Offenders in Work-Based Programs
- POL 05/94 Suspension – While Incarcerated
1.8 Coverage, Out of Province/Country (POL 08/1999)

Document Date 21 April 1999

Purpose To provide coverage for workers in the course of employment outside of the province or country.

DEFINITION

Resident of Saskatchewan: A worker will ordinarily be considered a resident of Saskatchewan when it can be determined that his or her permanent place of residence is within Saskatchewan or, with submission of reasonable proof, would be within Saskatchewan following the employment contract or work term outside of the province. Examples of information required to prove residency would be, but are not limited to, copies of application for Saskatchewan health coverage, copies of application for Saskatchewan driver’s license, etc.

Usual place of employment in Saskatchewan:
A worker will ordinarily be considered to have his or her usual place of employment in Saskatchewan if the worker, prior to leaving the province/country:
   a. performed the greatest percentage of his/her employment contract or work term with the employer in question within Saskatchewan,
   b. was hired in Saskatchewan, and
   c. was paid from the employer’s Saskatchewan office or on the basis of records submitted by the employer’s Saskatchewan office.

Continuous period, as referenced in this policy, includes any period of work or paid or unpaid leave of absence, which is not interrupted by a return to Saskatchewan for a period of two months or more.

BACKGROUND

1. On an increasingly regular basis, Saskatchewan employers send workers outside the Province of Saskatchewan to perform work in other parts of Canada and/or outside of Canada. This policy will ensure Saskatchewan workers are provided coverage under The Workers’ Compensation Act, 2013 (the Act) when they perform work in the course of their employment outside the province/country and would not have mandatory coverage in another jurisdiction or coverage similar to what they would receive in Saskatchewan.

2. Section 33 of the Act notes that the Workers’ Compensation Board (WCB) may enter into an agreement with its equivalent body of any province or territory of Canada to provide that any compensation payable to any worker or his dependants, where work that is incidental to his employment is performed partly in Saskatchewan and
partly in that province or territory, shall be paid either in accordance with the Act or in accordance with the law of that province or territory. This has been formalized in the Inter-jurisdictional Agreement on Workers’ Compensation that all provinces and territories have agreed to and signed.

3. Section 34 of the Act speaks to an injury outside Saskatchewan:

Subject to the provisions of an agreement pursuant to Section 33, a worker or a worker’s dependants must be paid compensation pursuant to this Act if:

a. the worker is a resident of Saskatchewan or the usual place of the worker’s employment is in Saskatchewan and the employment requires the performance of work both inside and outside Saskatchewan; and

b. the worker is injured while he or she is performing work outside of Saskatchewan.

It is clear that Section 34 requires coverage for injuries outside Saskatchewan in specifically prescribed circumstances. There must be substantial connection with Saskatchewan consisting of residence or usual place of employment in Saskatchewan and the worker must be required to perform some work in Saskatchewan. This policy will provide an interpretation of Section 34 by clarifying the terms used and by placing time limits beyond which the worker is not considered to be performing work within Saskatchewan.

4. Section 43 states that no employer and no worker or any worker’s dependant has a right of action against an employer or a worker with respect to an injury sustained by a worker in the course of his employment. However, this section may not apply to workers and subsequently their employers when injuries are sustained out of the province/country. Coverage is extended on an insurance basis only outside the boundaries of Saskatchewan.

POLICY

1. This policy applies to:

a. Workers employed by an employer carrying on an industry inside Saskatchewan where:

i. mandatory coverage under another jurisdiction does not apply or

ii. mandatory coverage under another jurisdiction applies but the coverage is below that which the Saskatchewan WCB provides. In such cases, the coverage provided by the other jurisdiction will be topped up by the board to the level which would have been provided had the Saskatchewan board provided the initial coverage, and

iii. the definitions of “resident of Saskatchewan” or “usual place of employment” are met as outlined in this policy
b. Workers of subsidiary companies or other business entities of Saskatchewan employers where:
   i. the Saskatchewan employer carries on business activities through a subsidiary or other business entity (e.g. joint venture, partnership) outside of Saskatchewan and these activities are a natural extension of an industry the employer conducts in Saskatchewan, and
   ii. the subsidiary would not require its own account with the WCB, and
   iii. the definitions of “resident of Saskatchewan” or “usual place of employment” are met as outlined in this policy.

c. Workers of Saskatchewan employers who are temporarily transferred or seconded to an employer outside of Saskatchewan where:
   i. the transfer or secondment is two years or less, or
   ii. if the transfer or secondment is more than two years, notice of the transfer or secondment has been received and verified by the board prior to the occurrence of a work injury, and
   iii. the definitions of “resident of Saskatchewan” or “usual place of employment” are met as outlined in this policy.

2. Compulsory Coverage

   If the employer requires the worker to be absent from Saskatchewan for a continuous period of less than two years, the worker shall be considered to be performing work both within and outside of Saskatchewan and the Board shall extend coverage to workers to whom this policy applies. It is not necessary for the employer to make application for coverage for this worker; however, the employer is responsible for reporting the worker’s wages and paying the applicable assessment on these wages.

3. Optional Coverage

   If the employer requires the worker to be absent from Saskatchewan for a continuous period of greater than two years but less than five years, the worker may be considered to be performing work both within and outside of Saskatchewan and the Board may extend coverage to workers to whom this policy applies.

   Under these circumstances, the employer must submit a written request for coverage. Each application will be reviewed on its own merits and will include such things as:
   a. name and position of worker,
   b. detailed explanation of job duties which would remove the worker from the Province of Saskatchewan,
   c. dates of departure and return, and
   d. detailed information, if required, ensuring the worker and employer meet the definitions outlined in this policy.
4. No Entitlement to Coverage

If the employer requires the worker to be absent from Saskatchewan for a continuous period of greater than five years, the worker will not be considered to be performing work both within and outside of Saskatchewan and the Board will not extend coverage to workers under these circumstances.

5. Health Care Costs

Coverage of applicable health care costs associated with a work injury will be provided based on current case management policies and procedures.

**Act Sec #** 2(1)(I), 2(1)(ii), 3, 33, 34, 35, and 43

**Effective Date** 21 April 1999

**Amended** References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

**Application** Employers in Saskatchewan who assign Saskatchewan workers to perform work in other jurisdictions and to the aforementioned Saskatchewan workers.

**Supersedes**
- POL 48/75 Coverage – Out-of-Province
- POL 15/77 Coverage – Out-of-Province

**Complements**
- **POL 24/2014** Alternative Assessment Procedure for the Interjurisdictional Trucking Industry
- **PRO 24/2014** Alternative Assessment Procedure for the Interjurisdictional Trucking Industry
1.9 Coverage – Students in Work-Based Learning Assignments (POL 12/2012)

Document Date 14 November 2012

Purpose To define circumstances for providing coverage to students in work-based learning assignments.

DEFINITION

**Bona fide student** means an individual who is engaged in a work-based learning assignment and who is registered with:

- The Students Records Unit of the Ministry of Education, if the course is offered by a school
- A post-secondary institution, if the course is offered by that institution, or
- The Ministry of Advanced Education (formerly Saskatchewan Advanced Education and Employment), if the course is offered by a community-based organization (CBO).

**Work-Based Learning Assignment**, as per the Memorandum of Understanding (MOU) between the Workers’ Compensation Board (WCB) and the Ministry of Education, means a secondary level course that includes a work placement component which:

- Is offered by a school defined in the MOU between the WCB and the Ministry of Education.
- Provides for students to be engaged with an employer without pay for a minimum of 25 hours in the performance of work normally undertaken by the employer, and
- Is either approved by and/or is partially or totally funded by the Ministry of Education, but

shall not include those components of a course which take place outside of Saskatchewan.

**Work-Based Learning Assignment**, as per the MOU between the WCB and the Ministry of Advanced Education, means a course or component of a course which:

- Is offered by a post-secondary institution or community-based organization defined in the MOU between the WCB and the Ministry of Advanced Education.
- Provides for students to be engaged with an employer without pay for more than one day in the performance of work normally undertaken by the employer, and
- Is either approved by and/or is partially or totally funded by the Ministry of Advanced Education, but
shall not include those components of a course which take place outside of Saskatchewan.

**Community-Based Organization** (CBO) means an organization recognized by the Ministry of Advanced Education that delivers training or employment services for no profit.

**School** means a school listed in Schedule “A” - Schools as updated from time to time by the Ministry of Education.

**Post-secondary Institution** means a post-secondary educational institution listed in Schedule B – Post-Secondary Institutions and Schedule C – Extra Provincial Post-Secondary Institutions as updated from time to time by the Ministry of Advanced Education.

**BACKGROUND**

Historically the WCB has extended coverage to students in work-based learning assignments under agreements with the Ministry of Education and the Ministry of Advanced Education. Presently, the Ministry of Education is responsible for Kindergarten to Grade 12 (K-12) education and the Ministry of Advanced Education is responsible for post-secondary and CBO programs.

**POLICY**

1. Subject to this policy and the MOUs executed between the WCB and each education ministry, coverage under *The Workers’ Compensation Act, 2013* (the “Act”) is extended to those bona fide students participating in a work-based learning assignment that is sponsored in whole or in part, by the Ministry of Education or the Ministry of Advanced Education.

2. Under the authority of Section 3 of the Act, the WCB deems bona fide students to be workers while in the course of completing a work-based learning assignment.

3. Under Section 20(2)(b) and 20(2)(i) of the Act, the WCB deems bona fide students sponsored by the Ministry of Education or the Ministry of Advanced Education to be in the course of employment.

**Terms and Conditions**

4. To be covered by the Act, bona fide students will be considered workers of the Ministry of Education or the Ministry of Advanced Education while in the course of completing a work-based learning assignment with an employer covered under the Act.

5. Coverage is not extended to students who attend “Take Your Kids to Work” or any other job-shadowing or similar type of program.
6. Coverage is not provided for an injury occurring on the education institution's premises unless the injury arises out of and in the course of a work-based learning assignment, as defined by this policy and outlined in the MOUs with the Ministry of Education or the Ministry of Advanced Education.

7. No payment of loss of earnings will be made during a school term or a training period unless actual loss of earnings is demonstrated.

8. If there is loss of earnings between school terms or following termination of schooling, the calculation of wage loss benefits for any claims arising out of this policy will be based on:
   a. All earnings from a bona fide student’s employment in industries covered by the Act;
   b. Where there are no covered earnings, the provincial minimum wage for a forty-hour workweek for the first 24 months of demonstrated earnings loss;
   c. After wage loss benefits have been paid for a period of 24 consecutive months, two-thirds of the average weekly wage as of June in the year immediately preceding the year in which the loss of earnings or ability to earn occurs; or
   d. In the event of a fatality, benefits to dependents will be based on the provisions of the Act.

9. Any claim costs arising out of this policy are to be applied directly to the cost experience of the Ministry of Education or the Ministry of Advanced Education and will be reflected in the premiums charged to the Government of Saskatchewan.

10. The Chief Executive Officer (CEO) or designate shall have the authority to execute the MOUs on behalf of the WCB.

ATTACHMENTS

Ministry of Education

   Schedule A – Schools

Ministry of Advanced Education

   Schedule B – Post-Secondary Institutions

   Schedule C – Extra Provincial Post-Secondary Institutions
| **Act Sec #** | 2(1)(i), 2(1)(ii), 3, 20, and 80 |
| **Effective Date** | Ministry of Education – 01 January 2013; Ministry of Advanced Education – 19 April 2007. |
| **Amended** | References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013* |
| **Application** | All bona fide students participating in approved work-based learning programs sponsored by the Ministry of Education or the Ministry of Advanced Education. |
| **Supersedes** | POL 06/2007 [Coverage – Students in Work-Based Learning Assignments](#) |
| **Complements** | [PRO 12/2012](#) [Coverage – Students in Work-Based Learning Assignments](#) |
Schedule A
Schools

Schools include the following as defined or referred to in The Education Act, 1995 and The Independent School Regulations:

All schools of a school division
All fransaskois schools of the Conseil des écoles fransaskoises
All historical high schools
All independent schools

Effective 01 January 2013
Schedule B
Post-Secondary Institutions

Saskatchewan Polytechnic (formerly SIAST)
Carlton Trail Regional College
Cumberland Regional College
Cypress Hills Regional College
Lakeland College – Lloydminster
Northlands College
North West Regional College
Parkland Regional College
Prairie West Regional College
Southeast Regional College
Dumont Technical Institute and Gabriel Dumont Institute
Apprenticeship and Trade Certification Commission
University of Regina, including its federated and affiliated colleges
University of Saskatchewan, including its federated and affiliated colleges
Saskatchewan Indian Institute of Technologies

19 April 2007
Schedule C

Extra Provincial Post-Secondary Institutions

University of Alberta
British Columbia Institute of Technology (BCIT)
Northern Alberta Institute of Technology (NAIT)
Southern Alberta Institute of Technology (SAIT)

19 April 2007
1.10 Coverage – Directors (POL 14/2014)

Document Date 02 September 2014

Purpose To establish guidelines for determining the coverage of directors.

DEFINITION

Director, also referred to as an executive officer in The Workers’ Compensation Act, 2013 (the “Act”), means a person chosen to control or govern the affairs of a limited company or corporation and who is registered as a director of that corporation.

Carried on the Payroll means the employer is reporting employment income and taxable allowances or benefits on the Canada Revenue Agency T4 income tax slip.

BACKGROUND

1. Under Section 2(1)(ii) of the Act, “an executive officer of an employer, if that executive officer is carried on the employer’s payroll,” is considered a worker.

2. Section 32 of the Act states an employer is deemed to be a worker where the employer carries themselves on the payroll, reports themselves as a worker on the payroll statement mentioned in Section 122 of the Act, and includes their estimated wages.

3. Under Section 14(1) of The Workers’ Compensation General Regulations, 1985 (the “General Regulations”), “every executive officer of a corporation who is not on the company’s pay-roll... may make application to the board for elective personal coverage.”

4. Section 14(2) of the General Regulations states, “every executive officer of a corporation who is not on the corporation’s pay-roll is deemed to be a worker when under contract to a principal and the earnings in respect of his or her services, as the board may determine, are assessable on the principal’s account unless ordered otherwise by the board.”

POLICY

1. A director of a limited company or corporation who is carried on the payroll is considered a worker under the scope of the Act.

2. The employer is required to report to the WCB the assessable earnings for all directors carried on the payroll up to the maximum assessable per calendar year being reported.
3. Where a director of a limited company or corporation is not carried on the payroll, they may apply for personal coverage.

4. A director who is not active in the business is not considered a worker in the scope of the Act and coverage is not required. An inactive director is someone who does not perform any duties relating to the day-to-day operations of the corporation.

Act Sec #
2(1)(ii), 32;
The Workers’ Compensation General Regulations 12 and 14.

Effective Date
For new accounts – 01 November 2014.
For existing accounts – 01 January 2015.

Application
All directors.

Supersedes
n/a

Complements
POL 09/2011    Failure to Register a Business
POL 11/2011    Employer Coverage and Registration
POL 03/2014    Coverage – Personal
POL 15/2000    Coverage – Independent Worker
POL 07/2002    Coverage Within Saskatchewan – Out of Province Employers
POL 07/2015    Maximum Assessable Wage Rate
POL 24/2010    Assessable Earnings
1.11.1 Coverage, Trade Unions (POL 03/98) (Amended by ADM 03/2000)

Document Date 25 February 1998

Purpose To establish guidelines for coverage of trade union members.

POLICY

1. A trade union is an industry subject to The Workers’ Compensation Act, 2013 with its salaried employees regarded as workers.

2. Members of the union who act as representatives of the trade union or the trade union movement at conventions, seminars, etc., or on public bodies or while attending meetings of public bodies, and are paid for these activities, are regarded as workers within the meaning of the Act.

3. Members of the union appointed as delegates in the same activities as 2 above, for which they receive no pay, are not workers, but may be deemed to be by the Board upon application of a trade union pursuant to Section 2(1)(ii)(iv) of the Act.

4. Where the delegate’s usual employer is not a trade union but where the usual employer grants temporary leave of absence for union activities and continues usual salary, benefits, etc., pursuant to Section 2(4) the usual employer is considered to be the employer while the worker is temporarily engaged in union activity.

5. For each delegate who is not a worker of the trade union or is a person who has not been granted leave with pay by the usual employer, a per delegate fee as determined by the Board from time to time, is to apply where the union makes application for coverage. The per delegate fee can only apply to one person, and must be paid in advance of any claim in the same manner as any employer levy.

6. Coverage as delegate shall apply only to administrative functions of the union, and not activities normally thought of as being related to membership activity, such as attending membership meetings or picketing.

7. Scope of Coverage - Except for salaried employees of the union or union organization when travelling to and from their residence to the place of their usual employment, individuals will be considered to be in the course of their employment from the time they leave their place of residence on official business until they return thereto, except for deviation for personal reasons, and activities related to daily living such as the taking of meals, occupancy of accommodation, etc.

8. Accidents occurring while enroute to dine at an establishment in reasonable proximity to the temporary work site or temporary domicile of the individual, or due to
fire, structural failure of the hotel or motel where an individual is housed will be regarded as compensable.

9. Assessment Payable and Allocation of Injury Costs
   
a. Assessment for the salaried employees of a trade union is to be calculated in the normal way, that is, upon the basis of payroll, and injury costs are to be charged to the trade union’s experience.
   
b. Where the delegate’s usual employer is not a trade union, but where the usual employer grants temporary leave of absence for union activities and continues usual salary, benefits, etc., assessment will be expected from the usual employer, and any costs arising out of injury will be charged to the usual employer’s experience.
   
c. For each delegate who is not a worker of the trade union or is a person who has not been granted leave with pay by their usual employer, a per delegate fee, as determined from time to time by the Board, is to apply where the union makes application for coverage. Costs occurring from any injury are to be a charge to the trade union’s experience.

10. Earnings Loss Wage Base
   
a. For salaried employees of a trade union the worker’s usual average weekly earnings as determined by Section 70.
   
b. For delegates who are employees of a trade union or other employer who have been granted leave with pay for union activities, the worker’s average weekly earnings as defined by Section 70.
   
c. While unusual, there may be situations where the delegate is unemployed. Such cases are to be referred to the Members of the Board for the establishment of an earnings loss base if, in fact, there is such a loss claimed.

Act Sec # 2(1)(ii)(iv), 2(4), 3(1), 3(2), 70
Effective Date Immediate
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Amended ADM03/2000 - 10 January 2000
Application Trade Union Members
Supersedes POL 09/94 Coverage of Trade Unions
Complements n/a
1.11.2  Coverage, SGEU, L.T.D. Claimants (POL 13/94) (Amended by ADM 03/2000)

Document Date  13 June 1994

Purpose  To provide coverage of S.G.E.U. members on L.T.D. training.

BACKGROUND

The Saskatchewan Government Employees’ Union (SGEU) requests that those members of the Union’s Long Term Disability Plan who, as a rehabilitation measure, are placed in work placement assignments as a preliminary to employment be extended the coverage of *The Workers’ Compensation Act, 2013* as learners.

POLICY

Coverage is granted under the following conditions:

1. Each placement must satisfy the definition of “learner”. That is, the person becomes subject to the hazards of the industry similar to the hazards an employee in that industry faces for the purpose of undergoing training or probationary work as a preliminary to employment.

2. It will be S.G.E.U.’s responsibility to negotiate an agreement for each placement with the prospective employer and the Long Term Disability Plan recipient.

3. No Act coverage may be assumed until the Board has given formal approval. The agreement for each placement negotiated by the SGEU between the prospective employer and the Long Term Disability Plan recipient will include certification from the recipients attending physician that the position being trained for is within his/her physical or emotional capabilities. Such certification will be forwarded to the Board for approval.

4. The prospective employer, by taking the role of employer, assumes the responsibilities of and receives the protection of *The Workers’ Compensation Act, 2013*.

5. If injury occurs during the placement, which interrupts the training, earnings loss benefits will commence when L.T.D. benefits end, subject to the usual waiting period.

6. Earnings loss benefits are to be calculated on the first step of the pay range of the position being trained for.
7. Claims submitted for personal injury are to be assessed in the normal fashion with consideration being given to the provisions of Section 49 where indicated.

8. Recurrences of pre-training conditions not precipitated by something in the training will not be compensated for.

9. No assessment levy will be required from the employer. However, any costs accruing from an injury attributed to the placement for which the Board accepts responsibility will be a charge to the employer’s experience.

10. This program is subject to cancellation by either party upon 60 days written notice. Cancellation, however, will not affect those individuals already enrolled in the program.

Act Sec # 2(1)(t), 2(1)(ii), 49
Effective Date 13 June 1994
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Amended ADM03/2000 – 10 January 2000
Application All SGEU L.T.D. Members in Work Placement as a Rehabilitation Measure and as a Preliminary to Employment
Supersedes n/a
Complements POL 03/98 Coverage, Trade Unions
1.13 Coverage – First Responders (POL 07/2005)

Document Date 24 October 2005

Purpose To establish guidelines for coverage of first responders.

DEFINITION

First Responders means personnel who are:

a. volunteers that have completed training in emergency first response as certified by the Saskatchewan Department of Health (Saskatchewan Health).

b. registered with Saskatchewan Health; and

c. registered as current members of a first responder group that has a mutual aid agreement with a Saskatchewan health region.

Emergency means an occasion when a Saskatchewan health region calls out or dispatches first responders to an emergency situation.

BACKGROUND

1. Under Subsection 3(3) of The Workers’ Compensation Act, 2013, (the “Act”), the Workers’ Compensation Board (WCB) has extended coverage to volunteer first responders sponsored by the various health regions in the Province of Saskatchewan.

2. First responders are unpaid volunteers trained in first aid and organized to provide prompt initial emergency care for the sick or injured. They are able to offer initial resuscitation, stabilization and support while ambulance services are enroute. The health region typically dispatches first responders through the same mechanism as ambulance services, and usually at the same time.

POLICY

1. Subject to the conditions of this policy, coverage under the Act is extended to those first responders while in the course of responding to an emergency incident when called upon by their respective health regions.

2. First responders must be registered with their respective health region.

Terms and Conditions

3. Coverage shall be in effect from the time of notification of an emergency, and includes travel from the individual's residence or location to the site of the emergency and return, provided there is no deviation for personal reasons.
Coverage does not extend to situations where a first responder is acting as a “Good Samaritan” without the authority of a call out from a health region.

4. If there is loss of earnings the calculation of wage loss benefits for any claims arising out of this policy will be based on:
   a. All earnings from a first responder’s employment in industries covered by the Act;
   b. Where there are no covered earnings, the provincial minimum wage for a forty-hour workweek for the first 24 months of demonstrated earnings loss;
   c. Where wage loss benefits have been paid for a period exceeding 24 consecutive months, on two-thirds of the average weekly wage as of June in the year immediately preceding the year in which the loss of earnings or ability to earn occurs;
   d. In the event of a fatality, benefits to the dependent spouse will be based on the provisions under Section 81 of the Act.

5. The costs for claims arising out of this policy are to be applied directly to the cost experience of the respective health region in which the first responder is registered and will be reflected in future premiums of the health region.

ATTACHMENTS

Schedule A – Saskatchewan Association of Health Organizations Authorized to Call Out First Responders

Act Sec # 2(1)(ii)(ii), 3(3), 81

Effective Date 01 November 2005

Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013

Reference updated 01 May 2015 in accordance with The Workers’ Compensation Act Exclusion Regulations, 2014

Application First Responders of Health Regions of Saskatchewan.

Supersedes POL 11/98 Coverage, First Responders

Complements PRO 07/2005 Coverage – First Responders
Schedule A
Saskatchewan Association of Health Organizations
Authorized to Call Out First Responders

Athabasca Health Region

Keewatin Yatthe Health Region

Mamawetan Churchill River Health Region

Prairie North Health Region

Prince Albert Parkland Health Region

Kelsey Trail Health Region

Heartland Health Region

Saskatoon Health Region

Sunrise Health Region

Cypress Health Region

Five Hills Health Region

Regina Qu’Appelle Health Region

Sun Country Health Region
1.14 Coverage, Independent Worker (POL 15/2000)

Document Date 13 December 2000

Purpose To establish guidelines for coverage of independent workers.

DEFINITION

1. In this policy, pursuant to Sections 2(1)(ii) and 8 of the Act,
   a. “independent worker” is defined as someone, regardless of the form in which he or she carries on his or her enterprise, whether as a proprietorship, partnership, or some other form,
      i. whose own enterprise is not an excluded industry;
      ii. who supplies his or her own work under a contract for services; and
      iii. who does not employ others
   b. an independent worker is not someone who owns and operates equipment provided under contract for use by a principal. Under Section 8 of the Act such people are deemed to workers in the employ of the principal.
   c. a worker cannot be a person who owns equipment provided under contract for use by a principal, unless they themselves operate the equipment, since they are covered by Section 8 of the Act.

2. “contract for service” is where a worker agrees to perform services in return for remuneration. This will only involve those circumstances where no employer/employee relationship exists.

3. “multiple contracts” are defined as contracts with different employers and/or private homeowners which may be in place at the same time or may be a series of short term contracts. For the purpose of this policy, contracts will be considered up to three years prior to application for coverage.

BACKGROUND

1. The Board has the jurisdiction under Section 2(1)(ii)(iv) of The Workers’ Compensation Act, 2013 (the “Act”) to deem persons who do not otherwise come within the definition of “worker” to be workers.

2. The Board has the jurisdiction under Section 20(2)(i) to determine whether any worker is within the scope of the Act and under Section 18(2) may delegate its powers. By necessary implication, the Board may give its delegates guidance on how it wishes the delegated powers to be exercised.
3. One of the purposes of workers’ compensation legislation is to protect persons whose living depends on their own personal work and to protect them from the financial consequences of work-related injury.

4. The changing work environment with its many variations of the traditional employer/worker relationship requires the clarification of who is considered a worker, for the purposes of the Act.

POLICY

1. When making a determination as to the nature of coverage of an independent worker, the following must be considered:
   a. workers who are truly self-employed and who have no employees are to be allowed to obtain their own account with the Workers’ Compensation Board, and
   b. employers are to be prevented from reorganizing their work force in order to avoid responsibility for paying workers’ compensation premiums on behalf of their workers.

2. Generally personal coverage for an independent worker, as defined under this policy, is to be granted if the worker is able to provide satisfactory evidence that they are involved in multiple contracts with more than one employer, private homeowner and/or other enterprise, which may or may not be covered under the Act.

3. Where workers who provide onsite labour obtain personal coverage under this policy, the minimum assessment will apply.

4. Where it has been determined that there is sufficient work with one employer which would make the relationship an employee/employer relationship and the worker has another contract which may be within an excluded industry, personal coverage can be requested for that portion of the wage the excluded industry contract represents.

5. Workers who provide onsite labour and who do not have personal coverage are deemed to be workers of the employers to whom they supply their work except in the case of employers in an excluded industry.

6. This policy does not apply to employment relationships that would be seen as employee/employer, or master/servant relationships. This would include, among others, those circumstances where an individual is working on a full or part-time basis for more than one employer. Such employees would have coverage under the Act by virtue of their employer’s contributions to the fund.
Act Sec # 2(1)(i), 2(1)(ii), 3, 8, 18, 20, 122, 131, 132

The Workers’ Compensation General Regulations 14(1), 14(2)

Effective Date 01 February 2001

Amended References updated 01 January 2014 in accordance with The
Workers’ Compensation Act, 2013

Application All workers as defined by this policy

Supersedes Board Order 56/80 Non-reporting Subcontractors

Board Order 9/86 Non-Employers

Complements POL 02/2011 Coverage – Contracts Involving Equipment

PRO 02/2011 Coverage – Contracts Involving Equipment

POL 08/2011 Coverage – Trucking, Leased Operators

POL 14/2014 Coverage – Directors
1.16 Coverage – Volunteer Firefighters (POL 04/2006)

Document Date 10 January 2006

Purpose To provide coverage for volunteer firefighters.

DEFINITION

Volunteer Firefighter means a volunteer registered with a Saskatchewan municipality for the purpose of fighting fires. Volunteer firefighters are normally unpaid but may receive an honorarium.

BACKGROUND

1. Section 2(1)(ii) of The Workers’ Compensation Act, 2013 (the “Act”) defines a member of a municipal volunteer fire brigade as a worker.

2. Under Section 3(gg) of The Workers’ Compensation Act Exclusion Regulations, 2014 (the “Exclusion Regulations”) volunteers are excluded except those who are members of a municipal fire brigade.

3. The Workers’ Compensation Board (WCB) in Board Directive 25/74 restricted coverage to “regular members of a brigade documented as such in a municipality’s records” and to “persons who are conscripted by an individual qualified to do so.” Board Directive 25/74 also stipulated wage loss benefits under the previous Act and needs to be updated to establish wage loss benefits under the current Act.

POLICY

1. Coverage under the Act is restricted to volunteer firefighters who are registered with a Saskatchewan municipality.

2. Under the authority of Section 20(2)(b) of the Act, the WCB determines that volunteer firefighters sponsored by a Saskatchewan municipality are in the course of employment while performing firefighting duties.

Terms and Conditions

3. Volunteer firefighters must be registered with their respective Saskatchewan municipality.

4. Coverage shall be in effect from the time of notification of a fire and includes travel from the individual’s residence or location to the site of the fire and return provided there are no deviations for personal reasons. Coverage is also in effect while attending volunteer firefighter training.
5. Any remuneration, excluding expense reimbursement, over $1,000.00 paid to volunteer firefighters by a Saskatchewan municipality to provide firefighting services is to be reported as assessable earnings.

6. If there is loss of earnings the calculation of wage loss benefits for any claims arising out of this policy will be based on:
   a. All earnings from a volunteer firefighters employment in industries covered by the Act;
   b. Where there are no covered earnings, the provincial minimum wage for a forty-hour workweek for the first 24 months of demonstrated earnings loss;
   c. Where wage loss benefits have been paid for a period exceeding 24 consecutive months, two-thirds of the average weekly wage as of June in the year immediately preceding the year in which the loss of earnings or ability to earn occurs; and,
   d. In the event of a fatality, benefits to the dependent spouse will be based on the provisions under Section 81 of the Act.

7. The costs of claims arising out of this policy are to be applied directly to the cost experience of the respective Saskatchewan municipality in which the volunteer firefighter is registered.

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**Act Sec #**  
2(1)(ii)(ii), 20(2)(b), 81  
*The Workers’ Compensation Act Exclusion Regulations, 2014* 3(gg)

**Effective Date**  
01 February 2006

**Amended**  
References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*  
References updated 01 May 2015 in accordance with *The Workers’ Compensation Act Exclusion Regulations, 2014*

**Application**  
Claims for volunteer firefighters from Saskatchewan municipalities.

**Supersedes**  
Board Directive 25/74 Coverage – Volunteer Fire Brigade

**Complements**  
**POL 08/2007** Compensation Rate – Where no earnings at disablement or death  
**PRO 04/2006** Coverage – Volunteer Firefighters
DEFINITION

**Dependant** means a member of the family of a worker who is wholly or partly dependent upon the worker’s earnings at the time of death or injury of the worker or who, but for the incapacity due to the injury, would have been so dependent.

**Migrant workers** are defined as individuals whose permanent home is not Canada, but receive a job offer from a Canadian employer defined under the worker’s compensation legislation of that jurisdiction to work for a defined temporary period of time, and who meet the definition of worker under the workers’ compensation legislation in the jurisdiction in which they are working.

BACKGROUND

1. Section 2(1)(l) of *The Workers’ Compensation Act, 2013* (the “Act”) directs that an ‘employer’ includes any person, association or body having in its service any worker engaged in any work in, about or in connection with an industry.

2. Section 2(1)(ii) of the Act directs that a ‘worker’ means a person who has entered into or works under a contract of service or apprenticeship, written or oral, express or implied, whether by way of manual labour or otherwise, and includes:
   a. A learner.
   b. A member of a municipal volunteer fire brigade.
   c. An executive officer of an employer, if that executive officer is carried on the employer’s payroll, and
   d. Any other person who, pursuant to this Act or any direction or order of the board, is deemed to be a worker.

3. Section 36 of the Act states that if a worker who is entitled to compensation ceases to reside in Saskatchewan, the WCB may do all or any of the following:
   a. Direct the worker to attend periodically before the authority administering the payment of compensation in the jurisdiction in which the worker is residing or before some other authority or institution for an assessment of the worker’s claim;
b. Direct the worker to complete any documents that the board considers necessary;

c. Suspend the payment of compensation to that worker until a direction mentioned in clauses (a) or (b) is complied with.

4. Citizenship and Immigration Canada advises that a migrant worker accessing services from the WCB will not result in deportation or adversely affect the worker’s status in Canada.

5. In February 2008, the Association of Workers’ Compensation Boards of Canada endorsed the following principles for each Canadian jurisdiction to follow when adjudicating injury claims involving migrant workers:

a. Provide migrant workers with the maximum extent of service possible under the entitlement provisions of each jurisdiction, before they leave Canada, keeping in mind that there will be cases where their work permit has expired;

b. Migrant workers are entitled to fair and reasonable benefits;

c. Migrant workers are provided translation services;

d. Migrant workers are provided expedited assessments and clinical services similar to any other injured worker in or outside of the noted province;

e. Migrant workers and employers are provided with information explaining coverage and claims information;

f. Dependants of fatally injured migrant workers who are entitled to receive survivor benefits are provided with the appropriate benefits similar to other dependants of fatally injured workers; and

g. Each jurisdiction to target communication strategies towards sectors or employers hiring migrant workers.

POL and PRO 05/2010, Coverage – Migrant Workers adheres to these principles.

POLICY

1. All Saskatchewan workers, regardless of citizenship and residency status, are covered by the WCB if their employer is an employer as defined under Section 2(1)(l) of the Act.

2. Workers’ entitlements and employers’ obligations under the Act apply whether the worker is a Canadian citizen, landed immigrant, or migrant worker.

3. Once a migrant worker arrives in Saskatchewan and begins employment for an employer as defined under Section 2(1)(l) of the Act, the migrant worker is viewed as a worker as defined under Section 2(1)(ii), and therefore is covered under the Act.
Reporting an Injury

4. All workers who suffer work-related injuries have the responsibility and right to report their injury to the WCB.

5. Section 163 of the Act directs that every agreement between a worker and his or her employer to waive or forego any of the compensation to which the worker or the worker’s dependants are or may become entitled pursuant to the Act is void. Employers and workers have an obligation to report work-related injuries to the WCB. An employer cannot, directly or indirectly, attempt to impede a worker, or the worker’s dependant, from reporting an injury to the WCB.

Entitlement to the Migrant Worker

6. The WCB may explore opportunities to place the migrant worker in modified work with the pre-injury employer where the conditions of the work permit allow.

7. In cases where the migrant worker wishes to return to their home country immediately following the work-related injury, and the effects of the injury will be short-term (less than four weeks duration), the WCB may issue the migrant worker a complete payment for the estimated period of impairment. Where medical treatment is required, the WCB will devise an appropriate plan that will meet the needs of the migrant worker.

8. Where the effects of the injury are not short-term (more than four weeks duration) and the worker leaves Canada, reports will be obtained from the worker’s health care professionals in their home country. The worker has the responsibility to advise health care professionals to forward all applicable medical reports to the Saskatchewan WCB. These reports will define the extent of injury and govern the worker’s ongoing entitlement. Where there is a delay in obtaining reports verifying ongoing disability, benefits may be suspended (POL 07/2014, Suspension of Benefits).

9. Where the migrant worker leaves Saskatchewan without notifying the WCB, payments entitled to the migrant worker may be suspended or terminated.

10. Benefits entitled to the migrant worker and all medical expenses associated with the claim (e.g., caregiver services, appliances, prescription drugs) will be paid either through a physical cheque or electronic funds transfer (upon the request of the migrant worker). In accordance with current banking processes, clients who request electronic funds transfer as their payment option will be required to maintain a bank account domiciled in Canada into which WCB benefits will be electronically deposited. All payments are to be issued in Canadian funds and are not to exceed Saskatchewan rates. Where the WCB arranges medical treatment, actual costs will be paid.
11. Travel expenses incurred by the migrant worker are to be paid as directed by POL 39/2010, Expenses – Travel and Sustenance – General. Expenses should not be considered in excess of what would be reasonable had the client been required to travel within Saskatchewan to obtain medical care.

Entitlement to Dependants

12. In the event the migrant worker dies as the result of a work-related injury, and the WCB is able to contact the worker’s dependent spouse, benefits are to be based on the provisions of Section 81 of the Act. Similarly, the provisions for dependent children under the Act will also apply.

13. In accordance with Section 86 of the Act, the WCB may recognize persons other than a dependent spouse or children as dependants to whom entitlement may be awarded. The WCB will determine the amount and type of payment most suitable given the circumstance.

Act Sec # 2(1)(l), 2(1)(ii), 36, 81, 86, 105, 163, 164, 183, 185
Effective Date 01 May 2010
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All migrant workers working in Saskatchewan on and after the effective date
Supersedes n/a
Complements PRO 05/2010 Coverage – Migrant Workers
PRO 04/2012 Translation Services
PRO 08/2010 Return to Work – Temporary Helper
POL 39/2010 Expenses – Travel and Sustenance – General
POL 07/2014 Suspension of Benefits
POL 07/2007 Voluntary Relocation Outside Canada
1.18 Alternative Assessment Procedure for the Interjurisdictional Trucking and Transport Industry (AAP) (POL 24/2014)

Document Date 10 December 2014

Purpose To outline the process for interjurisdictional trucking and transport employers participating in the AAP.

DEFINITION

Interjurisdictional Agreement on Workers’ Compensation (IJA) means an agreement between Canadian jurisdictions that helps:

- Ensure the effective, efficient and timely administration and resolution of interjurisdictional issues.
- Workers who work in more than one jurisdiction report injuries and get benefits.

Alternative Assessment Procedure for the Interjurisdictional Trucking and Transport Industry (AAP) means an elective assessment procedure under which employers in industries included in the AAP pay premiums for workers to the assessing board in the jurisdiction where the worker resides.

Assessing Board means the workers’ compensation boards or commissions in the jurisdiction that the workers reside and to which the employer pays premiums under the AAP.

Registering Board means the workers’ compensation boards or commissions, other than the Assessing Board, in the jurisdiction that the employer operates or travels through.

BACKGROUND

1. The Workers' Compensation Act, 2013 allows the Saskatchewan WCB to participate in the Interjurisdictional Agreement on Workers’ Compensation (IJA). The IJA allows workers to file claims in either (Section 33):
   a. Their home jurisdiction, or
   b. The jurisdiction where the injury occurred.

2. The Alternative Assessment Procedure for the Interjurisdictional Trucking and Transport Industry (AAP) is part of the IJA.

3. Beginning January 1, 2015, commercial bus operators can participate in the AAP.
POLICY

1. Trucking and transport employers who travel between jurisdictions can:
   a. Pay premiums based on kilometres driven in each jurisdiction, or
   b. Participate in the AAP and pay premiums to Assessing Boards.

2. To participate in the AAP, all individuals operating trucks or commercial buses in more than one jurisdiction in Canada, including the proprietor, any partners or directors, must have coverage.

3. The AAP does not apply to:
   a. Drivers that travel outside Canada (POL 08/1999, Coverage – Out of Province/Country).
   b. Local drivers, repair staff, garage staff, warehouse staff, and administrative staff. Employers will report earnings for these workers to the jurisdiction which they are employed.

4. If the Saskatchewan WCB is designated as a Registering Board, the employer will not have to pay the minimum annual assessment.

5. The AAP does not alter the worker’s right to claim benefits from either the Assessing or Registering Board. Workers can file a claim in either their home jurisdiction or the jurisdiction where they were injured (POL 08/2013, Interjurisdictional Agreement on Workers’ Compensation).

ATTACHMENTS

Interjurisdictional Agreement on Workers’ Compensation

<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>Effective Date</th>
<th>Application</th>
</tr>
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<tbody>
<tr>
<td>20, 33, 34, 35</td>
<td>01 January 2009 – Saskatchewan participation in AAP</td>
<td>Interjurisdictional trucking employers and commercial bus operators as per the above noted effective dates.</td>
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<td></td>
<td>01 January 2014 – Section 12 revisions</td>
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<tr>
<td></td>
<td>01 January 2015 – Inclusion of commercial bus operators</td>
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</table>

Supersedes  POL 12/2011 Alternative Assessment Procedure for the Interjurisdictional Trucking Industry

Complements PRO 24/2014 Alternative Assessment Procedure for the Interjurisdictional Trucking and Transport Industry

POL 08/2013 Interjurisdictional Agreement on Workers’ Compensation

POL 08/1999 Coverage, Out of Province/Country

POL 07/2011 Minimum Annual Assessment
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# 2.0 EMPLOYER ACCOUNTS

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- **2.2.5** Disaster Reserve (POL 12/2014) .................................................................................. 53
2.1 Registration, Classification & Premiums
2.1.1 Employer Coverage and Registration (POL 11/2011)

Document Date 17 October 2011

Purpose To provide general information on the guidelines for employer registration and coverage.

DEFINITION

Employer means any person, association or body that hires one or more workers on a full-time, part-time, casual, or contract basis.

Worker means a worker as defined by The Workers’ Compensation Act, 2013 (the “Act”).

Proprietorship means a business owned and operated by one person.

Partnership means a business owned and operated by two or more individuals.

Corporation means a legal entity that is separate and distinct from its owners.

Director means an individual chosen to control or govern the affairs of a corporation, including executive officers, who are registered as a director of that corporation.

Principal means a person or business who hires a contractor to perform work or services.

Contractor means a person or business that is hired under contract by another person or business to perform work or services. A contractor is also referred to as a subcontractor.

Clearance means a letter from the WCB that authorizes a principal to make payment to a contractor for work completed as of the date of the clearance. A clearance protects the principal from having to pay any overdue premiums the contractor owes.

Assessable earnings means a worker's gross earnings before deductions for income tax, Employment Insurance, Canada Pension Plan, and other similar deductions up to the maximum assessable amount for the calendar year being reported.

BACKGROUND

1. Section 3(1) of the Act, states that the “Act applies to all employers and workers engaged in, about or in connection with any industry in Saskatchewan except the farming or ranching industry, and those industries, employers or workers excluded” pursuant to The Workers’ Compensation Act Exclusion Regulations, 2014 (the “Exclusion Regulations”).
2. Section 20(2) provides the Workers' Compensation Board (WCB) exclusive jurisdiction to determine whether any industry or worker is within the scope of the Act.

3. Section 3(3) of the Act states that “an industry, employer or worker excluded from this Act may apply to the board to be brought within the scope of this Act.”

4. Section 164 restricts an employer from deducting from the wages of a worker any sum that the employer is liable to pay to the WCB as premiums, except in cases where the contractor owns and operates equipment or hires another person to operate that equipment as stipulated in Section 8 of the Act.

POLICY

Coverage – Mandatory

1. All employers operating in an industry covered under the Act who hire workers are required to register with the WCB within 30 calendar days of commencing business. Coverage will be effective the date the employer first employs workers.

2. Employers are required to report assessable earnings for all full-time, part-time, casual, or contract workers.

3. When a director of a corporation is carried on the payroll, they are considered a worker under the scope of the Act.

4. Where an out of province employer sends workers into Saskatchewan, account eligibility will be determined in accordance with POL 07/2002, Coverage within Saskatchewan – Out of Province Employers.

5. Volunteers are not considered workers under the scope of the Act with the exception of volunteers in mine rescue work, members of the Emergency Measures Organization, volunteer firefighters, and first responders.

Principal/Contractor Relationships

6. Contractors who hire workers are required to register as an employer with the WCB.

7. Contractors who do not hire workers are considered a worker of the principal unless they are eligible for and have purchased personal coverage. POL 15/2000, Coverage – Independent Worker, determines when a contractor is eligible for personal coverage.

8. Where a contractor is working for a principal that is not in a mandatory industry, coverage is not provided for the contractor.
9. Where a principal hires a contractor that is not in a mandatory industry, the workers of the contractor will not be considered workers of the principal.

10. When a contractor is considered a worker of the principal, they are classified at the principal’s industry rate code and the principal is required to pay premiums for the contractor based on the labour portion of the contract.

11. A principal company is required to obtain a clearance before paying any contractor they hire to ensure they are not responsible for the contractor’s overdue premiums.

Coverage – Optional

12. The WCB may approve two types of optional coverage: voluntary coverage and personal coverage.
   a. Voluntary coverage may be applied for by employers in excluded industries.
   b. Personal coverage may be purchased by:
      i. proprietors and their spouses;
      ii. partners and their spouses;
      iii. directors of a corporation not on the payroll;
      iv. elected officials of a city, town or village; and
      v. members of the governing body of a non-profit corporation or organization.

Cancellation of Coverage

13. An employer’s coverage in an industry that is mandatory under the Act will only be cancelled when the business no longer employs workers or is no longer in operation. The effective date of cancellation will be the date the employer ceased to employ workers or ceased operating the business.

14. If optional coverage has been purchased, coverage will remain in effect until the employer requests in writing that coverage be cancelled or until the WCB cancels it for one of the following reasons, which include, but are not limited to:
   a. non-payment of premiums;
   b. failure to provide the required payroll information;
   c. providing false or misleading information to the WCB;
   d. mail is returned and an alternate address cannot be found; or
   e. any other instance where the WCB determines coverage should be terminated.
Act Sec # 2(1)(i), 2(1)(ii), 3, 4, 5, 8, 20, 32(1), 37, 43, 116, 119, 121, 122, 123, 124, 131, 132, 134, 137, 139, 148, 152, 153, 158(1), 158(2), 164; The Workers’ Compensation General Regulations 3, 4, 5, 8, 12 and 14(1); The Workers’ Compensation Act Exclusion Regulations, 2014.

Effective Date 01 November 2011
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
References updated 01 May 2015 in accordance with The Workers’ Compensation Act Exclusion Regulations, 2014

Application All employers and workers.

Supersedes n/a

Complements POL 21/2014 Coverage – Voluntary
POL 07/2015 Maximum Assessable Wage Rate
POL 14/2014 Coverage – Directors
POL 02/2011 Coverage – Contracts Involving Equipment
POL 04/2006 Coverage – Volunteer Firefighters
POL 12/2012 Coverage – Students in Work-Based Learning Assignments
POL 07/2002 Coverage within Saskatchewan – Out of Province Employers
POL 07/2004 Assessable Labour Portion of Contracts
POL 07/2005 Coverage – First Responders
POL 09/2011 Failure to Register a Business
POL 07/2011 Minimum Annual Assessment
POL 08/1999 Coverage – Out of Province/Country
POL 15/2000 Coverage – Independent Worker
POL 24/2010 Assessable Earnings
POL 22/2014 Employer Accounts - Clearances and Letters of Good Standing
2.1.2 Classification, Change of (POL 09/2007)

Document Date 21 August 2007

Purpose To provide assessment guidance regarding the (re)classification of businesses.

BACKGROUND

1. Under Section 20 of The Workers’ Compensation Act, 2013 (the “Act”), The Workers’ Compensation Board (WCB) has exclusive jurisdiction to determine whether any industry or any part, branch or department of any industry is within the scope of this Act and the class to which it is assigned.

2. Further, under Section 119 of the Act, WCB may establish any classes or grouping of industries, as well as rearrange those classes or groups.

POLICY

1. WCB will change an employer’s industry classification where:
   a. The nature of the business changes and the current industry classification is no longer appropriate; or
   b. The nature of the business has not changed but the firm is misclassified.

2. Where the nature of the business has changed, requiring a change in classification:
   a. The effective date of the classification change will be the date the nature of the business changes or January 1 of the year in which the decision to change the classification of the business occurred, whichever is later;
   b. Where there is a gradual change in the nature of the business and the date of change cannot be determined, the effective date will be January 1 of the year that WCB is informed of the change.

3. Where the nature of the business has not changed but the firm is misclassified, the effective date of the change will be as follows:
   a. Where the change results in a premium decrease, January 1 of the year the review is requested by the employer or WCB reviews the employer’s business;
   b. Where the change results in a premium increase, January 1 of the year following the review.

4. Where an employer misrepresents or fails to disclose the details of the business and this failure results in an industry classification with a lower premium rate being
assigned, WCB will backdate the classification change for up to six years prior to the year in which the classification was reviewed.

Act Sec # 20, 119
Effective Date 01 September 2007
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All future changes in classification.
Supersedes POL 05/83 Classification of Industries
Complements PRO 09/2007 Classification, Change of Classification
POL 09/2011 Failure to Register a Business
2.1.3 Classification of Industries – 2016 Premium Rates (POL 06/2015)

Document Date 26 November 2015

Purpose To establish the 2016 premium rates.

BACKGROUND

1. In October 2015, provisional premium rates were established using the rate setting model of the Workers’ Compensation Board (WCB).

2. These rates were discussed with employer representatives and members of trade and safety associations during meetings held October 20 and 21. Taking into consideration the feedback received from these meetings, the WCB established the 2016 premium rates.

POLICY

1. The WCB hereby directs the 2016 premium rates for the following industry classifications:

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Rate Code Description</th>
<th>2016 Premium Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>A11</td>
<td>Light Agricultural Operations</td>
<td>2.98</td>
</tr>
<tr>
<td>A21</td>
<td>Farming and Ranching</td>
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</tr>
<tr>
<td>A31</td>
<td>Grain Elevators and Terminals</td>
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<tr>
<td>B11</td>
<td>Construction Trades</td>
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<td>B12</td>
<td>Residential Construction</td>
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<td>Commercial, Industrial Construction</td>
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<td>Light Commodity Marketing</td>
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<td>C32</td>
<td>Grocery, Department Stores, Hardware</td>
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<td>C33</td>
<td>Wholesale, Chain Stores</td>
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<td>C41</td>
<td>Co-Operative Associations</td>
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<td>C51</td>
<td>Lumber Yard, Builders’ Supplies</td>
<td>2.32</td>
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<td>C61</td>
<td>Automotive and Implement Sales and Service</td>
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<td>C62</td>
<td>Automotive Service Shops, Towing</td>
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<td>D32</td>
<td>Operation of Oilwells</td>
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<tr>
<td>D41</td>
<td>Oilwell Servicing</td>
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<td>D51</td>
<td>Service Rigs and Water Well Drilling</td>
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<td>Rate Code</td>
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<td>Seismic Drilling</td>
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<td>Cities, Towns, Villages and Rural Municipalities</td>
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<td>Manufacturing, Pipeline Operations</td>
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<td>Refineries and Upgrader</td>
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<td>M41</td>
<td>Dairy Products, Soft Drinks</td>
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<td>M42</td>
<td>Bakeries, Food Preparation and Packaging</td>
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<td>Mills, Semi Medium Manufacturing</td>
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<td>Caretaking, Park Authorities</td>
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<td>U31</td>
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**Act Sec #** 119, 134, 146(1); *The Workers’ Compensation General Regulations*

**Effective Date** 01 January 2016

**Application** All industries listed above.

**Supersedes** POL 19/2014 Classification of Industries – 2015 Premium Rates

**Complements**
- POL 07/2011 Minimum Annual Assessment
- POL 05/2015 Rate Setting Model
2.1.4 Rate Setting Model (POL 05/2015)

Document Date 03 November 2015

Purpose To outline the actuarial based model used to set annual industry premium rates.

DEFINITION

Industry rate code means a collective liability grouping comprised of employers with a similar industrial undertaking or injury experience. All employers with the same rate code pay the same industry premium rate.

Industry premium rate means the rate applied to all employers within a rate code expressed as a dollar amount for every $100 of assessable payroll.

BACKGROUND

1. Section 134(1) of The Workers’ Compensation Act, 2013 (the “Act”) states “subject to subsection (4), in every year, the board shall levy an assessment on the employers in each class of industries an amount based on any percentage of the employers’ payrolls or on any other rate, or an amount specified by the board, that, allowing for any surplus or deficit in the class, the board considers sufficient to pay:
   (a) the compensation with respect to injuries to workers in the businesses within the class;
   (b) the expenses of the administration of this Act; and
   (c) the cost of the administration of the occupational health and safety program for that year.”

2. Section 134(4) of the Act states “if, in any year, the board proposes to levy an assessment on the employers in a class of industries that exceeds the assessment levied on those employers in the preceding year by more than 10.5%:
   (a) the board shall, before making the assessment:
       (i) send a notice of the proposed assessment to the employers in the class; and
       (ii) cause the notice to be published in The Saskatchewan Gazette; and
   (b) the employers in the class may, within 30 days after the date of publication of the notice in The Saskatchewan Gazette, make representations to the board with respect to the proposed assessment.”
POLICY

1. The WCB uses an actuarial rate setting model that is based on the principle of collective liability.

2. Industry premium rates are set annually based on the collective claims experience of all employers within each industry rate code. This ensures that today’s employers pay the costs of today’s injuries.

3. The rate setting model uses historical claims costs and trends to project the number of claims expected in the next year and the future costs associated with those claims. The model then converts these future costs to a net present value revenue requirement.

4. Fatality costs are averaged and charged to all rate codes.

5. Assumptions approved by the Board Members annually, with respect to the benefits liability, are also applied to the actuarial rate setting model.

6. Industry payroll projections are determined by examining historical payroll information and industry trends within each industry rate code.

7. Industry premium rates are determined by dividing the revenue required by the projected payroll for each industry rate code.

8. Employers in industry rate codes with safety associations fund their safety association through a portion of their premium rates.

9. Administration costs associated with the operation of the compensation system are allocated to each rate code based on the payroll and claims costs incurred within each rate code.

10. Administration will ensure that the WCB website contains up to date information with respect to the actuarial rate setting model and how premium rates are set.
2.1.5 Maximum Assessable Wage Rate – 2016 (POL 07/2015)

Document Date 26 November 2015

Purpose To establish the maximum assessable wage rate for 2016.

BACKGROUND

Section 137(2) of The Workers’ Compensation Act, 2013 directs the Workers’ Compensation Board to set a maximum assessable wage rate for each year.

POLICY

1. Effective January 1, 2016, the Board Members have determined that the maximum assessable wage rate will be $69,242.

2. In subsequent years, the maximum assessable wage rate will be adjusted in accordance with the increases to the maximum wage rate.

Act Sec # 37, 137(2), and 182
Effective Date 01 January 2016
Application All employers.
Supersedes POL 18/2014 Maximum Assessable Wage Rate – 2015
Complements POL 24/2010 Assessable Earnings
2.1.6 Employer Accounts – Clearances and Letters of Good Standing (POL 22/2014)

Document Date 10 December 2014

Purpose To outline the process for issuing clearances and letters of good standing.

DEFINITION

Principal means a person or business who hires a contractor to perform work or services.

Contractor means a person or business that is hired under contract by another person or business to perform work or services. A contractor is also referred to as a subcontractor.

Clearance means a letter from the Workers’ Compensation Board (WCB) that authorizes a principal to make payment to a contractor for work completed as of the date of the clearance. A clearance protects the principal from having to pay any overdue premiums the contractor owes.

Letter of good standing means a letter requested before a contract begins which indicates whether a contractor has a WCB account and whether their premiums are paid.

BACKGROUND

1. In accordance with Section 131 of The Workers’ Compensation Act, 2013 (the “Act”), a contractor is considered to be a worker of the principal unless they are eligible for and choose to purchase optional personal coverage.

2. Where a principal has not obtained a clearance from the WCB prior to making payment to a contractor, Section 132 of the Act allows the WCB to hold the principal liable for outstanding premiums owing to the WCB with respect to that work.

3. Under Section 17 of The Workers’ Compensation General Regulations, 1985 (the “General Regulations”), the principal shall withhold any payment to a contractor until the WCB confirms that the contractor has fulfilled all obligations under the Act.

POLICY

1. A principal may request a letter of good standing prior to hiring a contractor to inquire about the contractor’s WCB status. The letter of good standing does not replace the need for a clearance letter prior to releasing payment.
2. A clearance letter must be obtained prior to a principal releasing any payment to a contractor, including any advance, progress, or final payment.

3. If a clearance letter is not obtained prior to making payment to a contractor and that contractor has not paid their WCB premiums, the principal will be liable to the WCB for the premiums relating to the labour portion of the contract.

4. If a contractor is not registered with the WCB, they will be considered a worker of the principal and the principal will be responsible for paying premiums on behalf of the contractor.

5. A clearance letter is only valid for the date shown on the letter and only applies to work performed in Saskatchewan.

6. Clearances are not required when a business is only supplying goods regardless of whether a delivery charge is included.

7. Clearances are not required when a homeowner, who has not applied for voluntary coverage, hires contractors for the purpose of construction or renovations to their residence.

**Act Sec #**

8, 20, 131, 132, 148, 159, 164; *The Workers’ Compensation General Regulations 17; The Workers’ Compensation Act Exclusion Regulations, 2014 3 (e)(i-iii).*

**Effective Date**

01 January 2015.

**Application**

All principals and contractors.

**Supersedes**

POL 25/95 Clearance, Letters of

**Complements**

PRO 22/2014 Employer Accounts – Clearances and Letters of Good Standing

POL 07/2002 Out-of-Provincial Employers – Coverage Within Saskatchewan

POL 03/2014 Coverage – Personal

POL 21/2014 Coverage – Voluntary
2.1.7 New Accounts, Opening of and Carry-forward of Cost Histories after Reorganization in Business (POL 01/98)

Document Date 22 January 1998

Purpose To establish guidelines for opening a new account and when to carry forward cost histories after there is a re-organization in a business.

DEFINITION

1. After a reorganization, a business will be considered to have “continued substantially the same”, if it involves predominately the same undertaking, executive officers (e.g. President, Secretary, Treasurer, Directors), and management, with consideration also given to whether or not there is substantial continuity in the workers, plant and equipment.

2. A “related” person is anyone with whom a person does not deal at arm’s length.

BACKGROUND

1. Section 138 of the Act permits the board to set the assessments of employers at different amounts in relation to the hazard of each employer or its activities.

2. Section 139 of the Act permits the board to adopt a system of merit rating.

3. In addition to relevant provisions in The Workers’ Compensation Act, 2013, Board policy regarding opening of new accounts and carrying forward of cost histories has been developed in light of the general legal framework relating to business organizations.

4. When ownership of an employing firm or business changes through a restructuring or sale and purchase of the business so that workers in the business have a new employer, the new employer is not generally responsible for the liabilities or obligations of the former employer, except by agreement. The nature of the agreement between the former and new employers must be considered when deciding whether or not the new employer should be permitted to open a new Workers’ Compensation Board account.

5. When after a business reorganization the business is continued substantially the same, it is reasonable to expect the business to have a similar risk of injuries to workers as before the reorganization.
POLICY

Whether to Open a New Account:

1. Certain business changes do not amount to a change in the identity of the employer, and therefore will not involve opening a new account. These include:
   a. a change in the name of the employer;
   b. a change in the shareholding of a corporate employer;
   c. an amalgamation of a corporate employer;
   d. a continuation of a partnership with additional or fewer partners.

2. A new account will be opened where the new entity is not legally responsible for nor entitled to the liabilities and assets of the former account holder; and
   a. Subject to 2(b), examples of when to open a new account are when a business reorganizes:
      i. from a proprietorship to a partnership or corporation;
      ii. from a partnership to a proprietorship or corporation;
      iii. from a corporation to a proprietorship or partnership; or
      iv. from one proprietorship, partnership or corporation to another;
   b. However, the existing account will be maintained (and renamed as necessary) if the new entity is entitled to and liable for the workers’ compensation account of the former entity. This may occur through:
      i. a general assignment of assets and liabilities from the former entity to the new entity; or
      ii. a specific agreement relating to the workers’ compensation account.

Whether a Cost History will be carried forward after a reorganization:

3. The cost history of a former account will be applied to the new account where the business to which the account relates is continued substantially the same.
   a. When the cost history is carried forward, it will be used to calculate the new account’s premiums, as well as any merits or surcharge.
   b. Examples of situations where a business will generally be considered to be substantially the same are the following:
      i. Where a corporation is established to carry on a business formerly carried on by a sole proprietor and the corporation is in fact controlled by the former proprietor either alone or together with related persons;
      ii. Where a corporation is established to carry on a business formerly carried on by a partnership and the corporation is in fact controlled by one or more of the former partners either alone or together with related persons;
iii. Where a person carries on as proprietor a business formerly carried on by a corporation that was in fact controlled by the person alone or together with related persons;

iv. Where a partnership carries on a business formerly carried on by a corporation that was in fact controlled by one or more of the partners alone or together with related persons;

v. Where a proprietor carries on a business formerly carried on by a partnership in which the proprietor was a partner;

vi. Where a partnership carries on a business formerly carried on by one of the partners as a sole proprietorship.

c. Examples of situations where a business will generally not be considered to be substantially continued are the following:

i. Where a proprietor, partnership or corporation sells a business as a going concern to persons who are not related;

ii. Where there is a sale of shares by controlling shareholder or shareholders of a corporation sufficient to result in a change in the control and management of the corporation to persons who are not related to the selling shareholder or shareholders.

| Act Sec # | 138 and 139 |
| Effective Date | 01 February 1998 |
| Amended | References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013 |
| Amended | ADM 03/2000 - 10 January 2000 |
| Application | To all employer accounts |
| Supersedes | n/a |
| Complements | n/a |
2.1.8 Minimum Annual Assessment (POL 07/2011)

Document Date 16 August 2011

Purpose To establish the minimum annual assessment.

BACKGROUND

Section 7 of *The Workers’ Compensation General Regulations, 1985* (the “General Regulations”) states that unless otherwise specified by the board, the minimum annual assessment for an employer is $25.

POLICY

A minimum annual assessment of $100 will apply to all employers registered with the WCB.

Act Sec # *The Workers’ Compensation General Regulations* 7
Effective Date 01 January 2012
Amended References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*
Application All registered employers covered under the Act.
Supersedes POL 05/2001 Minimum Annual Assessment
Complements POL 06/2015 Classification of Industries – 2016 Premium Rates
POL 01/2007 Experience Rating Program
POL 11/2011 Employer Coverage and Registration
2.1.9 Interest on Employer Accounts Refunds (POL 07/2001)

Document Date 04 September 2001

Purpose To establish guidelines on providing interest on employer account refunds.

DEFINITION

Situations that may result in a “credit balance” on an employer’s account include, but are not limited to:

a. A request from an employer to review the account in regards to classification issues, wage reporting or personal coverage issues.

b. The sale or closure of the business.

c. The application of a refund.

BACKGROUND

1. As per Section 152, of The Workers’ Compensation Act, 2013 (the “Act”), Regulation 8 of The Workers’ Compensation General Regulations, 1985 (the “General Regulations”), an employer operating in a mandatory industry and making payment of assessments to the Board after 30 calendar days from initial billing, is assessed a late payment penalty. In effect, the employer is charged interest on the amount owing.

2. In order to be accountable and provide fair and timely service to the employers of Saskatchewan, interest should be provided to employers where applicable, as outlined in this policy.

POLICY

1. Situations resulting in an employer having to wait longer than 30 calendar days for a requested refund on his/her account with the WCB will result in interest being paid in addition to the applicable refund in accordance with the following:

a. Interest is payable only on refunds initiated by a written request from an employer or their representative.

b. Interest will be issued only when the delaying factor in providing the employer with a refund can be solely attributed to internal administrative delays.

c. Interest will bear a rate equal to the Board’s financial institution’s prime rate at the date payment is issued.

d. Interest will be payable from the 31st calendar day after the request for refund or review is received within the Board’s office (either Saskatoon or Regina), up to
and including the date that the refund is made. Interest payments will be made only on refund amounts exceeding $5.00.

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<td>Application</td>
<td>All requests for refund and/or file review which may result in a refund or credit to Saskatchewan employers.</td>
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<td>n/a</td>
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<tr>
<td>Complements</td>
<td>POL 05/2003 Interest on Benefits Accruing From Successful Appeals</td>
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<td>PRO 56/2015 Default in Assessment Payment</td>
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<td>POL 06/2011 Employer Accounts – Cancellation of Penalties and Interest</td>
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</table>
2.1.10 Assessable Labour Portion of Contracts (POL 07/2004)

Document Date 12 October 2004
Purpose To provide guidelines for determining and assessing the labour portion of contracts.

DEFINITION

Principal means the employer in a mandatory industry in Saskatchewan who contracts for work with a contractor/subcontractor.

Contractor/Subcontractor means the person or business performing the work, or the person or business receiving the contract.

Contract means any work within the scope of the Act undertaken by a contractor or subcontractor for a principal.

BACKGROUND

1. Under Section 122 of The Workers’ Compensation Act, 2013 (the “Act”) and Regulation 4 of The Workers’ Compensation General Regulations, 1985 (the “General Regulations”), every employer in a mandatory or covered industry shall, register with the Workers’ Compensation Board (the WCB) by submitting a statement of payroll when starting operations and annually thereafter.

2. When a principal hires a contractor or subcontractor, the principal pays the contractor/subcontractor a negotiated contract amount for the work performed, which generally includes the contractor’s wages and overhead (equipment, materials, tools, etc.). Since compensation benefits are payable only on the actual wages, only the labour portion of the contract is considered as assessable earnings.

3. Where a principal or primary contractor hires a non-registered contractor or subcontractor, the Act states that the contractor or subcontractor is deemed to be a worker of the principal unless the contractor or subcontractor hired is assessed as an employer in his or her own right and is therefore individually liable for payment of WCB premiums.

4. Where the WCB considers contractors or subcontractors to be workers, the principal must report the total labour portion of the contract on their employer payroll statement. Where this does not occur, the WCB uses a schedule developed in consultation with industry representatives for determining the assessable labour portion of a contract. The labour percentage applied is based on the contractor or subcontractor’s trade or industry as outlined in the schedule.
5. Finally, the Act forbids an employer from deducting from the wages of a worker any sum that the employer is liable to pay to the WCB as premiums, except in cases where the contractor or subcontractor owns and operates equipment or hires another person to operate that equipment as stipulated in Section 8 of the Act.

POLICY

1. A Saskatchewan principal who contracts for services with a contractor/subcontractor must report the total labour amount of the contract on their annual employer’s payroll statement.

2. Where the actual labour portion of the contract has not been provided, the labour amount of the total contract will be based on the applicable industry percentage as set out in the Assessment Schedule for Contract Labour attached to PRO 07/2004. If the industry is not listed in the Assessment Schedule, the labour percentage shall be calculated on the basis of the most similar industry in the Schedule.

Act Sec # 8, 122, 131, and General Regulation 4
Effective Date 01 November 2004
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All principals and subcontractors
Supersedes n/a
Complements PRO 07/2004 Assessable Labour Portion of Contracts
POL 02/2011 Coverage – Contracts Involving Equipment
PRO 02/2011 Coverage – Contracts Involving Equipment
POL 08/2011 Coverage – Trucking, Leased Operators
2.1.11 Failure to Register a Business (POL 09/2011)

Document Date  16 August 2011

Purpose  To establish guidelines when employers fail to register with the WCB as required.

BACKGROUND

1. In accordance with Section 3 of The Workers’ Compensation Act, 2013 (the “Act”), all employers and workers in Saskatchewan will be subject to the Act, except those engaged in the farming or ranching industry and those industries excluded by The Workers’ Compensation Act Exclusion Regulations, 2014.

2. Under Regulation 4 of The Workers’ Compensation General Regulations, 1985 (the “General Regulations”), an employer in a mandatory industry is required to register with the Saskatchewan Workers’ Compensation Board (WCB) within 30 calendar days of commencing or recommencing business. If registration is not received within 30 calendar days, the employer may be assessed an additional five percent of the premium assessed. In accordance with General Regulation 5, this penalty will not be less than $5, nor greater than $500.

3. Under section 124(1), WCB has authority to estimate the probable payroll and assess employers who fail to register as required.

4. Under section 148(1) of the Act, where for any reason an employer who should be assessed is not assessed in any year, the employer shall be liable to pay the WCB the amount for which he/she should have been assessed.

5. In accordance with Section 153(2) of the Act, in the event of a work-related injury, employers who fail to meet their reporting requirement shall be held liable for the total cost of the injury. Under Section 153(3), “if the board is satisfied that failure to make or transmit any payroll statement, return or other statement was not intentional and that the employer honestly desired to furnish an accurate statement, it may relieve the employer in whole or in part from liability”.

6. Section 170 permits the WCB to issue an order for the payment of money owed under the Act and such order “may be filed with the local registrar of the Court of Queen’s Bench and, when filed, may be enforced as a judgment of that court.”

POLICY

1. Employers in a mandatory Saskatchewan industry are required to register with the WCB within 30 calendar days of employing workers.
2. Where an employer fails to register their business as required, the WCB will limit the employer’s liability to the premiums due for the current plus preceding three years that the business should have been registered.

3. Where an employer intentionally avoided registration or where a work-related injury has occurred, the employer’s liability will not be limited to the current plus previous three years and will be as follows:
   a. The employer will be liable to pay the premiums due for all years they should have been registered.
   b. The employer file will be referred to Internal Audit who will determine if the employer has breached the Criminal Code.
   c. Where a work-related injury has occurred and registration was intentionally avoided, the employer file will be referred to the Board members to determine whether the employer should be held liable for the total cost of all injuries that occurred prior to registration.

4. When registration is greater than 30 calendar days from the date of employing a worker, the employer will also be charged an additional 5% of the premium assessed for each year the WCB has determined the employer should have been registered. The penalty will not be less than $5, nor greater than $500 for each year of non-compliance.

5. Where the employer does not provide the payroll information, WCB will estimate the employer’s assessable payroll to calculate the required premiums. The employer will be bound by that assessment until they provide the actual payroll information.

6. Employers who have not registered as required are not eligible for the Experience Rating Program until the year following their registration. POL 01/2007, Experience Rating Program, will apply.
| Act Sec # | 3, 20, 122, 123, 124, 139, 148, 152, 153, 155, 158, 159, 170, 180; The Workers’ Compensation General Regulations 3, 4 and 5; The Workers’ Compensation Act Exclusion Regulations, 2014; The Limitations Act; The Criminal Code. |
| Effective Date | 01 September 2011 |
| Application | All employers. |
| Supersedes | POL 07/2010 Failure to Register a Business |
| Complements | PRO 09/2011 Failure to Register a Business |
| | POL 11/2011 Employer Coverage and Registration |
| | POL 07/2002 Coverage Within Saskatchewan – Out of Province Employers |
| | POL 01/2007 Experience Rating Program |
| | POL 14/2014 Coverage - Directors |
2.1.12 Assessable Earnings (POL 24/2010)

Document Date 26 August 2010

Purpose To determine the types of earnings used to assess employer’s premiums.

DEFINITION

Assessable earnings are workers’ gross earnings before deductions for income tax, Employment Insurance, Canada Pension Plan, and other similar deductions up to the maximum assessable amount for the calendar year being reported.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has exclusive jurisdiction under Section 20(2)(h) of The Workers’ Compensation Act, 2013 (the “Act”) to determine whether any industry or any part, branch or department of any industry is within the scope of the Act and the class to which it is assigned. Under Section 20(2)(i), WCB may also determine whether any worker is within the scope of the Act.

2. Section 3(1) makes application of the Act mandatory to all “employers and workers engaged in, about or in connection with any industry in Saskatchewan”, except the farming or ranching industry in Saskatchewan and those industries, employers or workers that are specifically excluded pursuant to The Workers’ Compensation Act Exclusion Regulations, 2014.

3. Subject to Section 122 of the Act and Regulation 4 of The Workers’ Compensation General Regulations, 1985, employers must report the earnings of all workers in their employ.

4. Under Section 134(1) of the Act, “the board shall levy an assessment on the employers in each class of industries an amount based on any percentage of the employers’ payrolls or on any other rate, or an amount specified by the board, that, allowing for any surplus or deficit in the class, the board considers sufficient to pay: the compensation with respect to injuries to workers in the businesses within the class”.

5. Section 137(2) of the Act states WCB will annually set a maximum assessable wage rate.

POLICY

1. All employers covered under the Act are required to report to WCB the assessable earnings of their full-time, part-time, casual and contract workers.
2. Employers must report all assessable earnings for each worker up to the maximum assessable amount per calendar year being reported.

3. Assessable earnings include all employment income reported on the Canada Revenue Agency’s T4 income tax slips and any other taxable allowances or benefits as listed below.

4. Assessable earnings include, but are not limited to:
   a. Salaries and wages;
   b. Director’s earnings when included in the payroll of the business;
   c. Management fees (as reported on T4A);
   d. Labour portion of contract earnings or piecework;
   e. Overtime pay;
   f. Commissions;
   g. Bonuses;
   h. Vacation pay;
   i. Tips and Gratuities (as reported on T4);
   j. Honorariums and Financial awards;
   k. Gifts (as reported on T4);
   l. Advances of future earnings (as reported on T4);
   m. Pay in lieu of notice;
   n. Paid leave (e.g., sabbatical, maternity);
   o. Salary continuance;
   p. Maternity or paternity “top up” benefits;
   q. “Top up” of WCB benefits;
   r. Taxable benefits such as:
      i. Housing, board & room, lodging;
      ii. Personal or living allowances;
      iii. Car Allowance;
      iv. Loans;
      v. Employer paid premiums on group life insurance, provincial medical services, disability plans;
      vi. Stock Options; and
      vii. Travel allowances;
   s. Profit Sharing Plan (distribution of profits reported on income tax form T4 or T4A);
t. Share Purchase Plan; and
u. Registered Retirement Saving Plans (if paid by the employer).

Assessable earnings also include any other remuneration or allowance WCB determines is assessable.

5. Employers are not required to report earnings that WCB excludes from assessments such as (but not limited to):
   a. WCB benefits;
   b. Severance/Retiring Allowance;
   c. Dividends;
   d. Shareholder loans;
   e. Jurors’ fees;
   f. Pension and retirement benefits; and
   g. Reimbursement of travel expenses.


Effective Date 01 September 2010

Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
References updated 01 May 2015 in accordance with The Workers’ Compensation Act Exclusion Regulations, 2014

Application All applicable employers.

Supersedes n/a

Complements POL 14/2014 Coverage – Directors
POL 08/1999 Coverage, Out of Province/Country
POL 07/2004 Assessable Labour Portion of Contracts
POL 07/2015 Maximum Assessable Wage Rate
2.1.13 Employer Accounts – Cancellation of Penalties and Interest (POL 06/2011)

Document Date 16 August 2011

Purpose To establish guidelines for when the Workers’ Compensation Board (WCB) may cancel penalties and interest charges applied to employers’ accounts.

BACKGROUND

The Workers’ Compensation Act, 2013 (the “Act”) and The Workers’ Compensation General Regulations, 1985 (the “General Regulations”) authorize the WCB to charge penalties and interest to employers who fail to register their business, provide payroll information, or remit premiums promptly.

POLICY

1. A penalty or an interest charge may only be cancelled in limited situations where:
   a. the penalty or interest is charged after:
      i. the assignment date for bankruptcy or receivership; or
      ii. the notification to terminate an employer’s account due to a business ceasing operations;
   b. the penalty or interest resulted from an administrative error by the WCB;
   c. the penalty or interest resulted from extraordinary circumstances including:
      i. death or severe illness of a proprietor, partner, family member, or accountant within the last remittance period;
      ii. the loss, destruction, or theft of payroll records within the last three (3) months prior to the penalty being applied;
   d. the penalty or interest resulted from an issued cheque failing to arrive, which can be supported by a copy of the general ledger or cheque stubs;
   e. the penalty or interest is the only cost on a closed account with a balance less than five (5) dollars; or
   f. in exceptional cases for any other reason as determined by the WCB.

2. The receipt of post-dated cheques to cover overdue amounts will not constitute sufficient cause to relieve an employer of penalties or interest. Penalties or interest will continue to accrue until the account is paid in full.
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<th>Act Sec #</th>
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<td>All employer accounts.</td>
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2.1.14 Employer Classification (POL 14/2011)

Document Date 23 November 2011

Purpose To provide guidelines on the industry classification structure.

DEFINITION

**Industrial Undertaking** means the work, trade, or service in which an employer is engaged (i.e., the primary business activity of the employer).

**Industry Classification** means the major industrial sector that best reflects an employer’s industrial undertaking or primary business activity.

**Industry Rate Code** means a collective liability grouping comprised of employers with a similar industrial undertaking or injury experience. All employers with the same rate code pay the same industry premium rate.

**Industry Premium Rate** means the rate applied to all employers within a rate code expressed as a dollar amount for every $100 of assessable payroll.

BACKGROUND

1. Section 20 of *The Workers’ Compensation Act, 2013* (the “Act”) provides the WCB exclusive jurisdiction to determine whether any industry or worker is within the scope of the Act and the class to which it is assigned.

2. Section 119(1) of the Act authorizes the WCB to “establish any classes of industries that it considers necessary for the purposes of this Act.”

3. Section 19 of *The Workers’ Compensation General Regulations, 1985* (the “General Regulations”) establishes that an employer who operates in more than one industry may be registered in more than one rate group.

4. Section 5 of *The Workers’ Compensation Act Exclusion Regulations, 2014* (the “Exclusion Regulations”) states:

   Unless the employer applies to the board in the manner set out in the Act, the Act does not apply to work performed in the operation mentioned in clause (b) if an employer is carrying on both:

   (a) an operation that is within the scope of the Act; and

   (b) an operation that is not within the scope of the Act.
5. Section 138 of the Act states:
   
   (1) It is not necessary that the assessment levied on the employers in a class or subclass of industries be uniform.

   (2) The board may fix the assessment on an employer in relation to the hazard found in the type of work or in relation to the hazard in any of the businesses included in the class or subclass.

POLICY

Classification – General

1. The Workers’ Compensation Board classifies employers based on the nature of their industrial undertaking. Each industry classification includes all occupations within the industry.

2. The following factors shall be considered in determining an employer’s classification:
   
   a. the nature of the service or product provided;
   
   b. the process involved in providing the service or manufacturing the product;
   
   c. the customers and competitors of the business;
   
   d. any other information the WCB requires to gain a complete understanding of the business.

3. Employers are assigned the industry rate code that best represents the industrial undertaking of the employer. All employers with similar industrial undertakings are classified in the same industry rate code since they are generally exposed to similar risks and hazards.

4. Where an industry rate code is not clearly or easily determined, the WCB will assign the rate code that most closely represents the industrial undertaking of the employer.

5. Where the industrial undertaking of a business is such that it does not align with other classifications, or the group of employers with the same industrial undertaking is not large enough to support its own rate code, injury experience may be considered and the employer(s) may be classified with other employers with a similar risk profile.

6. Where two or more legal entities contribute to one business in the production of goods and services, the WCB will assign the same classification to each firm, regardless of ownership.

Employers Operating in More than One Industry

7. The WCB will only consider providing more than one industry classification to an employer where the business operations are distinct and independent. This means:
a. the industrial activity is not an extension of or incidental to the employer's other business, and is not provided primarily to benefit the other business;

b. each industrial activity is independently viable with distinct sources of revenue; and

c. staff or personnel, excluding administrative staff, are not working in both businesses at the same time and the earnings paid to each worker are distinguishable for each business.

8. Where the above conditions are not met, the WCB will assign a single industry classification based on the business with the highest industry premium rate.

9. Where an additional classification is assigned, the employer will be required to prorate the earnings of the administrative staff between the businesses. The proration is to be based on the payroll size of each business.

Premium Rates

10. Industry premium rates are set annually at the rate code level based on the collective claims experience of all employers within an industry rate code.

Act Sec # 2(1)(l), 2(1)(q), 3, 20, 119, 138
The Workers’ Compensation General Regulations 19;

Effective Date 01 January 2012
For all existing employer accounts with multiple rate codes, any changes to classification will be effective January 1st of the year following the review of the employer’s account.

Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
References updated 01 May 2015 in accordance with The Workers’ Compensation Act Exclusion Regulations, 2014

Application All employers.

Supersedes n/a

Complements POL 09/2007 Classification, Change of
POL 05/2015 Rate Setting Model
POL 01/2007 Experience Rating Program
POL 06/2015 Classification of Industries – 2016 Premium Rates
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2.2 Cost Relief
2.2.1  Experience Rating Program (POL 01/2007)

Document Date  17 January 2007

Purpose  To provide guidelines for experience rate setting that will establish qualification for a discount or surcharge to employer accounts.

DEFINITION

Rate Code means a collective liability grouping comprised of businesses with a similar industrial undertaking or injury experience.

Base Premium means the premium required for a specific industry group.

Experience Rate means the net result of the base premium rate and the experience driven discount or surcharge.

Application Year means the year in which the experience rate is charged to the employer line of business.

Calculation Year means the year in which the calculation of the experience rate occurs. Since this is a prospective program, the calculation year is the year preceding the application year.

Evaluation Window means the years of data used in order to determine an employer’s experience rate. This is the three complete years immediately preceding the calculation year.

Participation Factor means the degree to which an employer participates in experience rating based on their total base premium. Employer discounts and surcharges are limited by their participation factor.

Eligibility Factor means the weighting applied for each consecutive year in which premiums were paid.

Total Costs means the costs paid on all claims in the last one, two or three consecutive years regardless of the date the claim was initiated.

Weighted Loss Ratio means the ratio of weighted costs to weighted premiums.

BACKGROUND

1. The purpose of the Workers’ Compensation Board (WCB) is to provide no fault insurance that protects workers and employers from the result of workplace injuries.
2. In a larger context, WCB has a role in preventing injuries before they occur, thereby reducing the associated costs and human suffering related to injuries. The Prevention Department provides on-site educational seminars and WCB supports employer Safety Associations that initiate programs to prevent or reduce workplace injuries within their industry classification, and to accommodate injured workers in returning to employment.

3. In 1980, the Merit Program was introduced to recognize employers with a positive injury experience in relation to the industry standard. The Surcharge Program was introduced in 1988 to motivate the small number of employers in each industry responsible for upward pressure in the premium rates. The two programs were combined in 1992, to form a single initiative to encourage all employers to provide a safe work environment for their employees.

4. In January 2003, WCB began a comprehensive review of the Merit Surcharge Program in order to ensure that it:
   a. Fairly and equitably represents employers’ individual claims experience.
   b. Provides adequate incentive for employers to implement workplace injury prevention programs.
   c. Advances closer relationships between employers and workers in establishing workplace safety initiatives.

   The review involved detailed research into best practices in terms of experience rating programs across the country as well as thorough consultation with various stakeholder groups.

5. The review led to further consultation through a focused stakeholder committee composed of equal representation from workers and employers in the province as well as an independent chair. The committee delivered recommendations concerning each of following principles:
   a. Program Integration – The Experience Rating Program should be run at the same time as the annual rate setting process to provide integrated and comprehensive communication to employers regarding their total due premiums.
   b. Accounting for Employer Size – Approximately 23,000 employers pay less than $15,000 in premiums over a three-year window. On average, these employers have one time loss claim every 10.5 years. Therefore, basing their experience solely on total costs could be unfairly punitive and unnecessarily complicated. A frequency-based approach for these employers is more appropriate, while a cost based approach is more relevant for employers with sufficient cost experience.
   c. Widened Range – The existing Merit Surcharge Program had a maximum merit of 25% and a maximum surcharge of 40%. These do not provide sufficient incentive for employers to implement safety programs.
d. Participation Factor – This principle assumes that employers that pay more in premiums have a larger impact on setting their industry’s base premium rates; therefore they should be held to a higher level of accountability.

e. Weighted Cost Experience – In order to make a revised program more responsive, cost and premium experience will be weighted according to most recent years. This will allow for a quicker reaction in the program to improved prevention/safety strategies.

f. Eligibility Criteria – Under the Merit Surcharge program employers were not eligible for merit until they had three consecutive active years. This eligibility allows for the awarding of discounts to firms with fewer than three active years.

g. Protection Against Extraordinary Circumstance - A claim’s cost in a given year will be limited to an amount equal to the maximum assessable wage in order to protect employers from the effects of a single claim.

h. Fatalities – No employer with a fatality in the current or previous year will be eligible for a discount.

i. Revenue/Cost Neutral - The program ought to be revenue or cost neutral or self-funding and to the extent that it isn’t, the difference will be built into the base rate.

6. In December 2005, WCB received feedback from stakeholders in regards to the 2006 changes to the Experience Rating Program. As a result, the Board Members requested the Experience Rating Review Committee to reconvene to review and provide recommendations for changes to the program. The Committee’s recommendations for the program will be implemented in 2007.

POLICY

1. The Experience Rating Program is based on analysis of an employer’s claim history over a three-year evaluation window. The analysis includes total costs, premiums, payroll and time loss claim count as they appear at the time the program is run.

2. The experience rate is calculated at the time of the annual rate setting process in the 4th quarter of every year and applied to the employer’s base industry premium rate for the following year. Only an employer paying premiums in the application year will be eligible for a discount or a surcharge. The amount of that discount or surcharge is relative to the amount of premiums paid in the application year. Surcharges are due at the same time as premiums.

3. Each employer’s line of business, designated by the assignment of a separate industry sub code, will be independently evaluated.

4. The total cost per claim (for experience rating purposes) in a given year will be limited to an amount equal to the maximum assessable wage applicable in the year the costs were incurred (POL 07/2015, Maximum Assessable Wage Rate).
5. Employers are not eligible for a discount if they have failed to comply with Section 122 of *The Workers’ Compensation Act, 2013* (the “Act”) and have been arbitrarily assessed in the calculation year.

6. Employers are not eligible for a discount if they have had a fatality that has occurred and been accepted within either the calculation year or the year previous. This excludes any fatality arising from occupation disease or other circumstances where the exposure occurred many years prior to the acceptance of the fatality claim.

7. Employers are not eligible for a discount if they, or any of their employees, have been convicted of a criminal offence under Section 217.1 of the Criminal Code of Canada within either the calculation year or the year previous.

8. The Experience Rating Program is divided into two separate components, Standard and Advanced Program, based on the level of impact employers have on the overall compensation system.

9. The maximum surcharge amount for the Standard Program is 75%. The maximum surcharge for the Advanced Program is 200%.

10. In the event that an employer receives a surcharge on any line of business, no discount certificate will be issued on any of that employer’s lines of business.

11. Where one employer is responsible for 90% or more of a rate code’s payroll, it is deemed representative of the entire industry average and therefore, not eligible for the Experience Rating Program.

**Standard Program**

12. All lines of business with less than $15,000 base premiums over the evaluation window are included in the Standard Program.

13. To qualify for a discount or surcharge, the employer must have paid a minimum base premium per year over the evaluation window, equal to the minimum annual assessment.

14. The Standard Program is based on Time Loss claims frequency. The number of accepted time loss claims determines the discount or surcharge within the evaluation period.

15. The discount or surcharge is as illustrated below:

<table>
<thead>
<tr>
<th># of TL Claims</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>25% Discount</td>
</tr>
<tr>
<td>1 to 2</td>
<td>No Discount, No Surcharge</td>
</tr>
</tbody>
</table>
# of TL Claims

<table>
<thead>
<tr>
<th># of TL Claims</th>
<th>Surcharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>4</td>
<td>50%</td>
</tr>
<tr>
<td>5 or more</td>
<td>75%</td>
</tr>
</tbody>
</table>

### Advanced Program

16. All lines of business with $15,000 or more in base premiums over the evaluation window are included in the Advanced Program.

17. The Advanced Program includes the following additional elements in the determination of the discount or surcharge applied to the employer’s industry rate. The discount or surcharge is the product of these three elements:

a. Eligibility Factor - The eligibility factor is based on the number of consecutive years an employer has paid premiums:

<table>
<thead>
<tr>
<th>Years of Experience</th>
<th>Eligibility Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>33%</td>
</tr>
<tr>
<td>2</td>
<td>67%</td>
</tr>
<tr>
<td>3</td>
<td>100%</td>
</tr>
</tbody>
</table>

b. Participation Factor - The participation factor for the advanced program is as follows:

<table>
<thead>
<tr>
<th>Participation Factor</th>
<th>Base Participation</th>
<th>Increments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>37.5%</td>
<td>1% per $1500 premium</td>
</tr>
<tr>
<td>Maximum Participation (premium $)</td>
<td>$108,750</td>
<td></td>
</tr>
</tbody>
</table>

c. Weighted Loss Ratio - The Advanced Program is based on a comparison of an individual employer’s weighted loss ratio and the industry’s weighted loss ratio. The weighted loss ratio applies more weight to the current year as follows:

<table>
<thead>
<tr>
<th>Evaluation Year</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most recent year</td>
<td>50%</td>
</tr>
<tr>
<td>Second most recent year</td>
<td>33%</td>
</tr>
<tr>
<td>Third most recent year</td>
<td>17%</td>
</tr>
</tbody>
</table>
For every 3.33% the employer's weighted loss ratio is better than that of the industry, the employer receives up to 1% of potential discount. For every 1.5% the employer's weighted loss ratio is worse than that of the industry, the employer receives up to 1% of surcharge. If the employer's weighted loss ratio is equal to that of the industry, no discount or surcharge is applicable.

d. The maximum discount is 30%. The maximum surcharge is 200%.

Cost Relief

18. A firm may receive relief of the cost of a claim due to the following circumstances:
   a. Application of Second Injury cost relief (Second Injury and Re-employment Reserve), application of the Occupational Disease Reserve cost relief or application of the Disaster Reserve;
   b. Third party recovery of cost (subrogation);
   c. Transfer of claim costs to another employer or claim;
   d. Any other consideration as directed by WCB.

19. Where cost relief has been granted under Point 18 above, the credit is applied to the employer's account in the year in which cost relief was granted. The effect of these credits will be to offset claim costs used for the calculation of the experience rate over the next three years.

20. Where cost relief has been granted under Point 18 above, employers may request to have their previous years' experience rating reviewed. In these cases, consideration will be given to the recalculation of their experience rating for the current and previous two years only.

Appeals

21. Employers may formally appeal any WCB decision regarding their experience rating in writing.

Statistical Information

22. To facilitate the development of workplace safety programs, statistical information regarding surcharged employers is provided to WCB’s Prevention Department, the Occupational Health and Safety Division (OH&S) of Saskatchewan Labour and WCB sponsored industry Safety Associations. As prescribed by POL 15/2013, Privacy of Information, all third parties who receive WCB information are required by agreement to ensure that the information is to be used only by the parties to the agreement, solely for the purposes intended and based on understanding that all reasonable security and confidentiality measures are to be taken.
### Act Sec #
121(1), 121(2), 122, 139

### Effective Date
01 January 2007

### Amended
References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

### Application
All employers

### Superseded
- POL 05/2006 Experience Rating Program
- PRO 01/2007 Experience Rating Program
- POL 20/2013 Appeals - Employer Accounts
- POL 21/2013 Appeals – Claims
- POL 15/2013 Privacy of Information
- POL 21/2010 Second Injury and Re-Employment Reserve
- POL 05/2014 Occupational Disease Reserve
- POL 12/2014 Disaster Reserve

### Complements
- POL 20/2013 Experience Rating Program
- POL 21/2013 Appeals – Claims
- POL 15/2013 Privacy of Information
- POL 21/2010 Second Injury and Re-Employment Reserve
- POL 05/2014 Occupational Disease Reserve
- POL 12/2014 Disaster Reserve
2.2.2 Administrative Error – Cost Relief (POL 25/2010)

Document Date 27 August 2010
Purpose To establish guidelines for providing cost relief due to administrative error.

DEFINITION

Administrative Error means a clerical or calculation error committed by a member of the staff of the Workers’ Compensation Board (WCB) when determining compensation payments to clients.

Additional costs, for the purpose of this policy, means increases to an employer’s premium rate and/or adverse impact to an employer’s cost experience as the result of an administrative error.

BACKGROUND

1. In accordance with Section 20(5) of The Workers’ Compensation Act, 2013 (the “Act”), the WCB has the jurisdiction to reconsider any matter arising under the Act and may rescind, alter or amend any decision or order it originally made.

2. The WCB considers it appropriate and fair to remedy an administrative error that adversely impacts the costs charged to an employer and which affects the employer’s experience rate.

POLICY

1. Where an administrative error has created an overpayment in compensation to an injured worker, recovery efforts will be in accordance with POL 38/2010, Overpayment Recovery – Compensation.

2. Where an administrative error has resulted in additional costs charged to an employer’s cost experience, the employer shall receive cost relief.

3. Cost relief may only be ordered by the Board Members, the Appeals Department, the Executive Director of Operations or the Assistant Director of Operations.

4. Where the employer is granted cost relief, the additional costs will be charged to the Second Injury and Re-employment Reserve (POL 21/2010).

5. Where cost relief has been granted, employers may request to have their experience rating reviewed in accordance with POL 01/2007, Experience Rating Program.
Act Sec #  
20(5), 120

Effective Date  
03 February 2012 (effective as of implementation date of new claims system).

Amendment  
References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013

Application  
Employers entitled to cost relief where a WCB administrative error results in additional costs.

Supersedes  
POL 14/94 Administrative Error – Cost Relief

Complements  
POL 38/2010 Overpayment Recovery – Compensation
POL 01/2007 Experience Rating Program
POL 21/2010 Second Injury & Re-Employment Reserve
2.2.3 Second Injury and Re-Employment Reserve (POL 21/2010)

Document Date 24 August 2010

Purpose To establish guidelines for the Second Injury and Re-Employment Reserve.

BACKGROUND

1. Section 145 of The Workers’ Compensation Act, 2013 (the “Act”) provides for the setting aside of a special fund to meet loss “arising from any disaster or other circumstance the liability for which would, in the opinion of the board, unfairly burden the employers in any class.”

2. The Second Injury and Re-Employment Reserve (the “Reserve”) was established to provide employers with cost relief on claims attributed to earlier injuries and to assist in facilitating return to work.

3. Supernumerary return-to-work programming was initially introduced to help small employers who had limited ability to bring injured workers back to alternate work. Employers, who accommodated the injured workers while hiring additional staff to assist with the duties of the injured worker, were provided with partial cost relief on claims.

4. With effective return-to-work programs in place, as well as experience rating incentives, employers are now accommodating injured workers more effectively and efficiently. To ensure a fair process among all employers and to recognize the importance of prevention strategies and effective return-to-work programs, cost relief for supernumerary programming is being eliminated.

5. POL 01/2014, Funding Policy establishes the size of the Reserve at 1% of benefit liabilities as actuarially determined.

POLICY

Cost Relief

1. Whenever the Reserve is utilized, the cost experience of the injury employer and the industrial classification to which the claim costs were charged will be granted corresponding relief, and the employer will be so advised.

Second Injuries

2. The Reserve will be charged with all the costs of claims where a work injury is caused by a pre-existing condition unrelated to the worker's employment (e.g.,
seizure, fainting). However, in all cases the Workers’ Compensation Board (WCB) assumes no responsibility for the worker’s pre-existing condition.

3. The Reserve will be charged with additional claim costs:
   a. Directly related to an injury that was solely caused by a prior work-related condition (e.g., where the failure of a prosthetic device prescribed for a previous work injury was the sole cause of an additional injury, regardless of whether the event occurred in the course of employment);
   b. Where the period of disability from a work injury is prolonged or the effect of a work injury is enhanced because of a prior or pre-existing condition. The WCB assumes no responsibility for pre-existing conditions that are not work related;
   c. Where the work injury is caused by, or the period of disability from a work injury is prolonged because of, past workplace exposure, POL 05/2014, Occupational Disease Reserve, may also apply;
   d. Where the award for permanent functional impairment (PFI) or loss of earning capacity is enhanced because of a prior measurable impairment (e.g., amputation, loss of joint movement, loss of vision); and,
   e. Where the award for PFI or loss of earnings is the result of the acceleration of a prior measurable impairment; and,
   f. Where workplace exposures contributed to a respiratory disease (e.g., asthma, emphysema, lung cancer) and there is sufficient evidence to indicate smoking as a partial cause, fifty (50) percent of the claim’s costs will be charged to the Reserve.

Injury Following Re-employment

4. The Reserve will be charged with all the costs of claims arising out of the following circumstances:
   a. Where a worker has a new injury that arises out of and in the course of a return-to-work (RTW) program as defined in POL 08/96, Return-to-Work Plans, with an employer or training facility, and the RTW program was approved and financially sponsored by the WCB.
   b. Where a worker suffers a new injury similar to the subject of the original claim within one year of his/her return to alternate or accommodated employment.

Supernumerary

5. Through supernumerary RTW programming, the WCB pays full benefits while an injured worker returns to the pre-injury workplace. Currently, employers receive 75% cost relief on the costs of supernumerary claims during the period of time that the worker is at work. However, starting in 2011, the WCB will be phasing out cost relief for supernumerary programming over a two-year period as follows:
Year | Percentage (Cost Relief)
--- | ---
2011 | 50%
2012 | 0%

Other

6. The Reserve will also be charged with additional claim costs arising out of the following circumstances:
   
a. Under POL 07/2014, Suspension of Benefits, extension of wage loss benefits and any additional costs incurred from the cancellation or early cessation of a rehabilitation (medical or RTW) program, where the client has withdrawn from the program with good reason as defined in that policy.

b. Under POL 01/2008, Suspension of Benefits – Pregnancy, extension of wage loss benefits and any additional costs incurred from the cancellation or early cessation of a rehabilitation program, where the client has withdrawn from the program due to pregnancy.

c. Injury occurring to a worker while travelling to or from treatment or RTW programming, for which WCB has paid the travel expenses, or while undergoing treatment for which WCB is responsible.

d. For interest as directed under POL 05/2003, Interest on Benefits Accruing from Successful Appeals.
2.2.4 Occupational Disease Reserve (POL 05/2014)

Document Date 29 April 2014

Purpose To establish guidelines for the Occupational Disease Reserve.

DEFINITION

Latent Occupational Disease means a disease or disorder that appears several years after exposure at work. The cause and effect link between the exposure and disease will be:

a. Known at the time of exposure, or
b. Shown by scientific evidence some time after exposure.

BACKGROUND

1. Under Section 20 of The Workers’ Compensation Act, 2013 (the “Act”), the Workers’ Compensation Board (WCB) will determine:
   a. Whether a condition or death was a result of an injury, and
   b. Whether an injury has arisen out of or in the course of employment.

2. Section 145 of the Act allows the WCB to create a fund to help meet the demands of any disaster or other circumstances that might unfairly burden employers. The Occupational Disease Reserve serves this purpose.

POLICY

1. The Occupational Disease Reserve covers the high costs for latent occupational diseases. The amount of the Occupational Disease Reserve is set under POL 01/2014, Funding.

2. There are latent occupational diseases that have a cause and effect link to work known at exposure. The WCB will charge all or a portion of the costs to the Occupational Disease Reserve when:
   a. The disease results from exposure at work:
      i. With an employer who no longer reports to the WCB.
      ii. With two or more employers, where one is reporting to the WCB, or
      iii. In an industry under the Act, but there is no confirmation of the employer, or
   b. The disease is partly caused by exposure at work under the Act and the work exposure was combined with:
      i. Exposure at work not covered by the Act.
      ii. Exposure at work covered by other jurisdictions, or
iii. Non-work exposure.

3. There are latent occupational diseases that do not have a cause and effect link to work known at exposure. Rather, the link establishes from future scientific evidence. The WCB will charge all costs for these claims to the Occupational Disease Reserve.

Conditions

4. The WCB will charge costs to the Occupational Disease Reserve after considering:
   a. Recoveries (for example, Third party recoveries), or
   b. Relief under the Second Injury and Re-employment Reserve.

Experience Rating

5. When the WCB provides cost relief, an employer may request to have their previous years’ experience rating reviewed (POL 01/2007, Experience Rating Program).

<table>
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<tr>
<th>Act Sec #</th>
<th>Effective Date</th>
<th>Application</th>
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<tbody>
<tr>
<td>2(1)(r)(iii), 2(1)(aa), 20, 145</td>
<td>01 December 2014</td>
<td>All new injury claims on or after the effective date.</td>
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<thead>
<tr>
<th>Supersedes</th>
<th>Complements</th>
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<tbody>
<tr>
<td>POL 10/1999 Disaster and Occupational Disease Reserve</td>
<td></td>
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<tr>
<td>PRO 05/2014 Occupational Disease Reserve</td>
<td></td>
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<tr>
<td>POL 21/2010 Second Injury and Re-Employment Reserve</td>
<td></td>
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<tr>
<td>PRO 21/2010 Second Injury and Re-Employment Reserve</td>
<td></td>
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<tr>
<td>POL 01/2014 Funding</td>
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<tr>
<td>PRO 02/2013 Funding</td>
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<tr>
<td>POL 11/2003 Injuries – Occupational Disease</td>
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<td>POL 12/2014 Disaster Reserve</td>
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<td>PRO 12/2014 Disaster Reserve</td>
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<tr>
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</table>
2.2.5 Disaster Reserve (POL 12/2014)

Document Date 02 September 2014

Purpose To establish guidelines for the Disaster Reserve.

BACKGROUND

1. Under Section 20 of The Workers’ Compensation Act, 2013 (the “Act”), the Workers’ Compensation Board (WCB) will determine:
   a. Whether a condition or death was a result of an injury, and
   b. Whether an injury has arisen out of or in the course of employment.

2. Section 145 of the Act allows the WCB to create a fund to help meet the demands of any disaster or other circumstances that might unfairly burden employers. The Disaster Reserve serves this purpose.

POLICY

1. The Disaster Reserve has two parts:
   a. Part 1 covers the less severe disasters that would fall under Point 3(a).
   b. Part 2 covers the rare severe disasters that would fall under Point 3(b).

2. Each part of the Disaster Reserve is set at 1 percent of benefit liabilities (POL 01/2014, Funding).

3. The WCB will charge a portion of a claim’s costs to the Disaster Reserve.
   a. For one claim:
      The WCB will charge the portion of costs exceeding 10 times above the maximum wage rate at the time of injury to the Disaster Reserve.
   b. For an incident resulting in injury to two or more workers of the same employer:
      The WCB will calculate the total costs of the claims. The WCB will then charge the portion of costs 20 times above the maximum wage rate at the time of injury to the Disaster Reserve.

4. The WCB will provide the maximum amount of cost relief to the employer. When the calculation under Point 3(b) does not benefit the employer, the WCB will consider cost relief for the individual claims.

Conditions

5. The WCB will charge costs to the Disaster Reserve after considering:
a. Recoveries (for example, third party recoveries), or

b. Relief under the Second Injury and Re-employment Reserve or the Occupational Disease Reserve.

Exceptions

6. An industry or rate group may incur costs that are less than those in 3(a) or (b). The industry or rate group can apply for cost relief. If accepted, the WCB will assign the costs to the Second Injury and Re-Employment Reserve.

Experience Rating

7. When the WCB provides cost relief, an employer may request to have their previous years’ experience rating reviewed (POL 01/2007, Experience Rating Program).

<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>Effective Date</th>
<th>Application</th>
<th>Supersedes</th>
<th>Complements</th>
</tr>
</thead>
<tbody>
<tr>
<td>20, 145</td>
<td>01 December 2014</td>
<td>All new injury claims on or after the effective date.</td>
<td>POL 10/1999 Disaster and Occupational Disease Reserve</td>
<td>PRO 12/2014 Disaster Reserve</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>POL 01/2014 Funding</td>
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<td></td>
<td></td>
<td></td>
<td>PRO 02/2013 Funding</td>
<td>PRO 05/2014 Occupational Disease Reserve</td>
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<tr>
<td></td>
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<td>POL 05/2014 Occupational Disease Reserve</td>
<td>POL 01/2007 Experience Rating Program</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PRO 01/2007 Experience Rating Program</td>
<td>PRO 01/2007 Experience Rating Program</td>
</tr>
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</table>
# 3.0 INJURIES

## 3.1 Type of Injury

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.1</td>
<td>Injuries – Communicable Disease (POL 02/2010)</td>
<td>5</td>
</tr>
<tr>
<td>3.1.2</td>
<td>Injuries – Hearing Loss (POL 11/2012)</td>
<td>8</td>
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<tr>
<td>3.1.4</td>
<td>Injuries – Psychological (POL 01/2009)</td>
<td>12</td>
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<tr>
<td>3.1.5</td>
<td>Injuries – Heart Attack (POL 05/2013)</td>
<td>16</td>
</tr>
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## 3.2 Circumstance of Injury

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3.1 Type of Injury
3.1.1 Injuries – Communicable Disease (POL 02/2010)

Document Date 17 February 2010

Purpose To establish guidelines for communicable disease injury claims.

DEFINITION

**Communicable disease** means a disease that can be transmitted, or transferred by contact from one person to another.

**Compulsory immunization** means that a worker is required, either directly or indirectly, by the employer to be immunized. An example of an indirect requirement is where an unimmunized worker is directed by the employer that they are not allowed to work (with no pay) in the event of a communicable disease of pandemic proportions.

**Voluntary immunization** means an immunization that is provided by the employer as part of a broad program, and is received on a voluntary basis by the worker. Voluntary immunization is not a condition of employment.

**Arising out of employment** means the injury must be related to some hazard, which results from the nature, conditions or obligations of employment. It must be linked to, originate from, or be the result of, in whole or in part, an activity or action undertaken for employment (origin and cause).

**In the course of employment** means the injury must happen at a time and place, and in circumstances consistent with and reasonably incidental to employment. It is the direct result of an activity, action, procedure or conduct undertaken related to employment (time, place and circumstance).

BACKGROUND

1. Section 2(1)(r) of *The Workers’ Compensation Act, 2013* (the “Act”) specifies that an injury means all or any of the following arising out of and in the course of employment:
   i. The results of a wilful and intentional act, not being the act of the worker;
   ii. The results of a chance event occasioned by a physical or natural cause;
   iii. A disabling or potentially disabling condition caused by an occupational disease;
   iv. Any disablement.

2. Section 20(1)(b) of the Act directs that the Workers’ Compensation Board (WCB) has exclusive jurisdiction to examine, hear and determine all matters and questions arising pursuant to this Act and any other matter with respect to which a power,
authority or discretion is conferred on the WCB. Section 20(2)(b) of the Act adds that without limiting the generality of Section 20(1), the WCB has exclusive jurisdiction to determine whether any injury has arisen out of and in the course of an employment.

POLICY

Each communicable disease injury claim will be judged on its own merits with consideration to relevant medical information, the nature of the occupation and the extent of exposure.

General Adjudication Guidelines

1. As a requirement of the definitions of injury (Section 2(1)(r) of the Act) and communicable disease, the development of a claim must include gathering the necessary information to determine whether the communicable disease has arisen out of and in the course of employment (POL 12/2013, Arising Out Of and In The Course Of Employment).

2. The WCB may consider a communicable disease to have arisen out of and in the course of employment where all of the following conditions are met:
   a. There is confirmed exposure to the disease in the workplace.
   b. The time period when the worker contracts the disease is in close proximity to the confirmed workplace exposure, and
   c. The nature of employment increases the exposure risk of contracting the disease as compared to the general population.

3. Where a communicable disease is considered by the WCB to have arisen out of and in the course of employment, in general the determination of compensability will be made on the basis of a known medical diagnosis provided in a medical report.

Preventative Measures Against Communicable Disease

4. The WCB will not accept claims from workers who elect to stay away from the workplace to avoid exposure to the communicable disease, or are symptom free when quarantined or sent home as a precautionary measure by the employer. In such a case, no injury has occurred and time loss is not compensable.

5. Where immunization is required by the employer for the prevention of a communicable disease, and as a result of an adverse reaction (e.g., allergic) to this compulsory immunization the worker is medically required to be absent from employment, the WCB will consider the reaction and its consequences to be compensable.

6. Where the employer provides voluntary immunizations as part of a broad program, but does not require workers to be immunized as a condition of employment, the
WCB will consider any adverse reaction to voluntary immunizations as non-work-related. Therefore, any injury resulting from voluntary immunization is not compensable.

Reporting Communicable Disease Injury Claims

7. Where there is confirmed exposure to a communicable disease in a workplace, the employer must submit an Employer’s Report of Injury (E1) form for each staff member that has fallen ill due to the disease. Each E1 form should include a description of the diagnosed illness and a statement outlining the nature and extent of exposure occurring in the workplace.

8. The date of injury for communicable disease claims is deemed to be the date the worker initially:
   a. sought medical care for the injury
   b. informed the employer of the injury, or
   c. reported the injury to the WCB
   whichever occurs first (POL 04/2013, Date of Injury).

Act Sec # 2(1)(r), 20, 23, 49
Effective Date 01 April 2010
Amendment References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All communicable disease injury claims on and after the effective date
Supersedes n/a
Complements PRO 02/2010 Injuries – Communicable Disease
          POL 11/2003 Injuries – Occupational Disease
          PRO 13/2007 Injuries – Occupational Disease
          POL 12/2013 Arising Out Of And In The Course Of Employment
          POL 03/2012 Benefit of the Doubt
          POL 04/2013 Date of Injury
3.1.2 Injuries – Hearing Loss (POL 11/2012)

Document Date 13 November 2012

Purpose To provide guidelines for the adjudication of traumatic and occupational noise induced hearing loss claims, as well as Permanent Functional Impairment (PFI) awards.

DEFINITION

Decibel means a unit of measurement expressing the relative intensity (loudness) of sound.

Hertz means a unit of frequency equal to one cycle per second and is related to the pitch of the sound.

Decibel sum of the hearing threshold levels (DSHL) means the sum of the minimum volumes detected during hearing tests, measured in decibels using a pure tone audiometer. For the purpose of assessing PFI awards, hearing tests are done at four frequency levels (500, 1,000, 2,000 and 3,000 Hertz).

Exchange rate means the maximum amount sound levels may increase above the specified criterion level if exposure time is cut in half.

Presbycusis means sensorineural hearing loss as a result of aging.

Sensorineural means hearing impairment due to damage to the cochlea (hair cells) or the cochlear (auditory) nerve.

Conductive means hearing loss due to a physical dysfunction of the sound collecting apparatus, either the bones or eardrum, but the auditory nerve is not affected.

Tinnitus means a subjective whistling, ringing, roaring or buzzing sound in the ear for which there is no objective measurement.

BACKGROUND

1. The purpose of this policy is to provide guidelines for the adjudication of traumatic and occupational noise induced hearing loss claims and PFI awards. The most current version of the American Medical Association: Guides to the Evaluation of Permanent Impairment (AMA Guide) is the Workers’ Compensation Board’s (WCB) rating schedule. These guides are used to establish the degree of hearing loss and the amount to be awarded.

2. The WCB regards occupational hearing loss as an injury and not an occupational disease.
POLICY

1. Occupational hearing loss may be traumatic (acoustic trauma), noise induced, or both. The date of injury for noise induced hearing loss is the earlier of the dates the worker initially sought medical attention for the condition, or reported to the WCB. For acoustic trauma, the actual date of the injury is to be used.

2. Traumatic hearing loss is usually sudden or acute and traceable to a specific work-related incident (e.g., exposure to a loud burst of sound, excessive pressure levels or injury such as basal skull fracture). The hearing impairment may be sensorineural, conductive or both.

3. Noise induced hearing loss is gradual and due to prolonged occupational exposure of excessive noise levels over a period of years (causing sensorineural impairment). To be eligible for a claim, there must be evidence of continuous occupational noise exposure for two or more years at the decibel levels and durations outlined in the chart below (taking into consideration normal time away for rest breaks), and the occupational noise exposure must be the predominate cause. In accordance with the Canadian Center for Occupational Health and Safety equivalent noise exposure standards, for every increase in noise of three decibels (Saskatchewan three decibel exchange rate) above 85 decibels, the required daily exposure time (over two or more years) required to result in lasting impairment will be reduced by half.

<table>
<thead>
<tr>
<th>Allowable Level Decibels (Three Decibel Exchange Rate)</th>
<th>Max Permitted Daily Duration (Hours)</th>
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<td>97</td>
<td>0.5</td>
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<tr>
<td>100</td>
<td>0.25</td>
</tr>
</tbody>
</table>

4. Actual noise readings at the worksite are not essential, provided confirmation of exposure from the employer, industry or other valid source is available to the WCB.

5. Hearing impairment is evaluated and based on DSHL. A DSHL totalling 125 or greater in one ear qualifies for a PFI award. A DSHL totalling 105 or greater in each of both ears qualifies for a PFI award. A DSHL totalling 367 in one ear is considered to be a total loss of hearing in that ear.

6. To qualify, a noise induced hearing loss claim must be a result of hearing loss predominantly from work exposure in a high noise industry.
a. The WCB will determine the extent of noise induced hearing loss from work-related exposure by reviewing the worker’s audiogram completed while employed or within five years of leaving employment in a high noise industry. Noise induced hearing loss does not progress when noise exposure from work ceases. Therefore, an audiogram completed while employed or within five years of leaving employment would provide an accurate work exposure reading.

b. If no audiogram is available from while the worker is employed or in the immediate five years from leaving employment, the WCB will review the worker’s current audiogram. The WCB will consider audiogram patterns and standard occupational hearing loss calculators when determining the amount of noise induced hearing loss resulting from work-related exposure. However, the claim will not qualify if it is determined by the WCB that the hearing loss recorded on the current audiogram is predominately age related (presbycusis).

7. Hearing loss claims that are accepted as being predominately noise induced will not have a presbycusis factor deducted in determining the level of the PFI award.

8. A possible side effect of noise induced hearing loss is tinnitus. This condition will qualify a worker for a PFI award provided there is documented medical evidence that tinnitus has been long-standing, distressing, and continuous for at least two years. Where tinnitus has been caused by a work-related injury or occupational hearing loss, a rating of up to five percent may be added to the worker’s binaural hearing impairment (hearing impairment of both ears) rating.

9. All hearing loss claims are to be prorated to provide coverage for only the portion of hearing loss caused by exposure in a Saskatchewan industry, except where an interprovincial agreement for occupational noise induced hearing loss exists.

10. PFI awards for hearing loss will not be considered when establishing entitlement to independence allowance.
| Act Sec # | 20 |
| Effective Date | 01 February 2013 |
| Amended | References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013* |
| Application | All new hearing loss claims on and after 01 February 2013 |
| Supersedes | POL 01/2010 Injuries – Hearing Loss |
| Complements | PRO 11/2012 Injuries – Hearing Loss |
| | POL 23/2010 Permanent Functional Impairment (PFI) – General |
| | PRO 23/2010 Permanent Functional Impairment (PFI) – General |
| | POL 11/2003 Injuries – Occupational Disease |
| | PRO 13/2007 Injuries – Occupational Disease |
| | PRO 50/2015 Medical Fees – Hearing Services |
| | POL 05/2014 Occupational Disease Reserve |
| | POL 27/2010 Allowance – Independence |
| | POL 04/2013 Date of Injury |
3.1.4 Injuries – Psychological (POL 01/2009)

Document Date 10 March 2009

Purpose To establish guidelines for psychological injury claims.

DEFINITION

**Acute** means a specific, dramatic and sudden incident. Acute cause claims will have entitlement determined under Points 1 to 3.

**Chronic** means a series of events or incidents over time. Chronic cause claims will have entitlement determined under Points 4 to 7.

**Mental Health Assessment**, for the purposes of this policy, means a psychological or psychiatric evaluation completed for the worker, including a diagnosis, a treatment plan and a return-to-work plan. The diagnosis, completed by a doctoral psychologist or psychiatrist, will be in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM IV).

BACKGROUND

1. Section 2(r) of *The Workers’ Compensation Act, 2013* (the “Act”), specifies that an injury means certain acts, events or disablements which arise out of and in the course of employment.

2. Under Section 20(1) of the Act, the Workers’ Compensation Board (WCB) has exclusive jurisdiction to determine, among other things, whether any condition or death was caused by an injury and whether any injury arose out of or in the course of employment.

POLICY

Psychological injury claims are classified into two categories based on cause: Acute Cause or Chronic Cause.

**Acute Cause Criteria**

1. Generally, for acute cause claims to be accepted all three of the following criteria must be met:
   a. There is a specific, dramatic or sudden event which the worker personally witnessed and/or was involved in;
   b. The event will be unexpected for the type of employment concerned and generally accepted to be traumatic (shocking, horrific, involving risk of harm to self or others); and,
c. The onset of the effect is often immediate or close in time to the event.

2. In cases of acute cause claims with delayed onset (not immediate or close in time to the event) of injury, a DSM IV diagnosis will be required and the worker will be referred for a complete Mental Health Assessment.

3. Acute cause type claims are adjudicated in the same manner as claims with physical injury from specific events; that being, the WCB determines if an injury occurred and whether it arose out of and in the course of employment.

**Chronic Cause Criteria:**

**Traumatic Event Jobs**

4. Generally for chronic cause claims to be accepted for those workers employed in jobs involving events considered traumatic to the general population all of the following criteria must be met:
   a. A series of events, each in itself are not considered significantly traumatic or to cause the effect as in an acute cause, and the events are expected for the type of employment but may have a cumulative effect;
   b. For the series of events there should exist objective facts to support the claim;
   c. An onset of the effect which is generally gradual and delayed and can become evident at the time of an event or become evident sometime after the series of events;
   d. The trauma from the series of events is the predominant cause of the diagnosed disability; and,
   e. Chronic psychological injury claims generally will require a confirmed Mental Health Assessment including a DSM IV diagnosis by a doctoral psychologist or psychiatrist.

**Non-Traumatic Type Jobs**

5. Generally for chronic cause claims to be accepted for those workers employed in jobs with events not considered traumatic to the general population, all of the following criteria will be met:
   a. A series of events, each in itself are not considered significantly traumatic to cause the effect as in an acute cause, and the events are beyond the normal scope and/or typical expectation in maintaining employment and/or outside the normal and foreseeable relationships expected between the worker, co-workers and employer of that employment as defined under Point 6;
   b. For the series of events there should exist objective facts to support the claim;
c. An onset of the effect which is generally gradual and delayed and can become evident at the time of an event or become evident sometime after the series of events;

d. The trauma from the series of events is the predominant cause of the diagnosed disability; and,

e. Chronic psychological injury claims generally will require a confirmed Mental Health Assessment including a DSM IV diagnosis by a doctoral psychologist or psychiatrist.

Non-Traumatic Event Definitions

6. For workers employed in jobs involving non-traumatic events, chronic cause claims generally arise out of three categories: work relations, work load, and interpersonal conflicts. Points a, b, and c define the categories and the parameters for what will or will not be considered as a series of events under Point 5(a).

a. Work Relations: The employer’s right to manage in terms of staff management, which includes decisions around work actions, hiring employees, performance evaluations, staff assignments, transfers, promotions or demotions, disciplinary action, transfers, termination/dismissal, lay-off, restructuring and re-organization, will not be considered for a psychological claim.

b. Work Load: Psychological claims relating to the tasks to be performed in the workplace, such as work overload, work under pressure, work environment, assignment modifications, etc., will not be considered for a psychological claim unless they exceed the normal scope of the work. The assignments must differ significantly from the usual tasks, either quantitatively or qualitatively. It must be demonstrated that the worker has little or no control, little or no support, and the situation has been in effect for significant periods of time.

c. Interpersonal Conflicts: Interpersonal conflicts which arise out of work requirements between superiors, co-workers, subordinates or customers will not be considered for a psychological claim unless the conflicts generate an unusual and unacceptable behaviour that is clearly dangerous, abusive, threatening within the interpersonal relations or conflicts, or discriminatory. Interpersonal conflicts occurring in employment, which do not arise out of work requirements, generally are not considered to have arisen out of employment.

7. The resolution of work relations, workload or interpersonal conflict issues will not be a considered factor in determining entitlement.

Permanent Functional Impairment (PFI)

8. Accepted psychological claims will be considered for entitlement to a Permanent Functional Impairment award as outlined in PFI – General policy (POL 23/2010).
Act Sec #  2, 20, 26, 49
Effective Date  01 May 2009
Amended References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*
Application All psychological injury claims
Supersedes POL 02/92 Claims for Chronic Stress – Adjudication and Procedure Guidelines
Complements POL 11/2003 *Injuries – Occupational Disease*
POL 23/2010 *Permanent Functional Impairment (PFI) – General*
PRO 01/2009 *Injuries – Psychological*
3.1.5 Injuries – Heart Attack (POL 05/2013)

Document Date 29 October 2013

Purpose To establish adjudication guidelines for heart attack claims.

DEFINITION

**Unusual physical exertion or strain** means the exertion or strain is unusual when compared to:

a. An individual’s normal work duties, and
b. Their active lifestyle outside of work.

**Acute** means a specific, dramatic and sudden incident.

**Emergency response** means those circumstances where firefighters attend a crisis situation as part of their duties. Examples include a fire or car crash.

**Pre-existing condition** means a non-work-related medical condition that existed prior to the work-related injury.

BACKGROUND

Under Section 20 of *The Workers’ Compensation Act, 2013* (the “Act”), the Workers’ Compensation Board (WCB) will determine:

a. Whether a condition or death was a result of an injury, and
b. Whether an injury has arisen out of or in the course of employment.

POLICY

1. Heart attack claims are work injuries when one of the following has occurred:

   a. The worker performed unusual physical exertions or strains within a few hours of the onset of heart attack symptoms. For example, an office worker who spends most of their time at a desk is required to move heavy office furniture.

   b. The worker experienced an acute emotional shock within a few hours of the onset of heart attack symptoms (POL 01/2009, Injuries – Psychological).

   c. The worker received an injury as a result of occupational hazards that placed unusual stress on the heart. For example:

      i. An electric shock.
      ii. Chest injury, or
iii. The inhalation of harmful gases such as carbon monoxide, hydrogen sulfide or methane.

d. The worker had heart problems during medical treatment for a work injury. For example, reaction to anesthetic.

2. Heart attack claims will typically require detailed file development. This will involve obtaining:
   a. All relevant medical information. This includes records of prior heart problems, and
   b. Details of the circumstances leading up to the initial onset of symptoms and the diagnosis of a heart attack.

3. In certain instances a worker may not recognize the initial symptoms as an indicator of heart problems. This can cause a delay in the diagnosis. Coverage may be provided if:
   a. The diagnosis occurred within 24 hours of an unusual physical exertion or acute emotional shock, and
   b. The worker experienced symptoms within a few hours of the work event.

Firefighters

4. When a firefighter has a heart attack within 24 hours of attending an emergency response, the WCB will determine the claim under POL 06/2012, Injuries – Firefighters.

Pre-Existing Conditions

5. Factors such as pre-existing conditions and lifestyle may contribute to heart disease. As a result, each heart attack claim will be considered on its own merits. Review by a WCB Medical Consultant may be required (POL 01/2000, Pre-Existing Conditions – Section 49).

Fatalities

6. When a worker is found dead at a worksite, the WCB will determine the claim under POL 04/2014, Fatalities, Presumption.
### Act Sec #
20, 23, 28, 29; *The Workers’ Compensation General Regulations*  
22.3

### Effective Date
01 December 2013

### Amended
References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

### Application
All heart attack claims on or after the effective date.

### Supersedes
POL 12/2007  *Injuries – Cardiac*

### Complements
POL 05/2013  *Injuries – Heart Attack*  
POL 11/2003  *Injuries – Occupational Disease*  
PRO 13/2007  *Injuries – Occupational Disease*  
POL 06/2012  *Injuries – Firefighters*  
POL 01/2000  *Pre-Existing Conditions – Section 49*  
POL 01/2009  *Injuries – Psychological*  
POL 04/2014  *Fatalities, Presumption*

Document Date 12 November 2003

Purpose To establish guidelines for occupational disease injuries.

DEFINITION

Arising out of employment means the injury must be related to some hazard, which results from the nature, conditions or obligations of employment. It must be linked to, originate from, or be the result of, in whole or in part, an activity or action undertaken for employment (origin and cause).

In the course of employment means the injury must happen at a time and place, and, in circumstances consistent with and reasonably incidental to employment. It is the direct result of an activity, action, procedure or conduct undertaken related to employment (time, place and circumstance).

BACKGROUND

1. The definition of occupational disease requires two conditions to be met before it is considered an injury under The Workers’ Compensation Act, 2013 (the “Act”). Subsection 2(1)(aa) defines occupational disease as:

   “a disease or disorder that arises out of and in the course of employment and that results from causes or conditions that are:
   
   (i) peculiar to or characteristic of a particular trade, occupation or industry; or

   (ii) peculiar to a particular employment.”

2. The definition of injury under Paragraph 2(1)(r)(iii) includes as part of the definition “a disabling or potentially disabling condition caused by an occupational disease”. It also requires the act, event or disablement to have arisen out of and in the course of employment.

3. Under Section 20 of the Act, the Workers’ Compensation Board (WCB) has the exclusive jurisdiction to examine, hear and determine all matters arising pursuant to the Act, including under subsection 2(a) “whether any condition or death with respect to which compensation is claimed was caused by an injury” and subsection 2(b) “whether any injury has arisen out of or in the course of employment.”

4. Many trades, occupations, or industries may have environments which cause specific occupational diseases, however, there will often be non-work causes that can also contribute to these types of disease. These non-work causes include such things as; hobbies, medical conditions and exposure in employment not covered by...
the Act. The WCB therefore must ensure that an occupational disease has arisen out of and in the course of employment before acceptance of a claim.

5. A work related disease or condition normally refers to an injury which results from exposure to a causative agent in a work environment, or one that manifests itself following a latent period after exposure to a causative agent. Though it normally results from numerous exposures, it can relate to one, though this will usually be traumatic, where it is easier to identify the cause.

6. In addition to this general adjudication process, specific occupational diseases confirmed by medical/scientific evidence are published as complementary policies or appendices attached to PRO 13/2007.

POLICY

1. In addition to the following general adjudication guidelines, where the causal link for an occupational disease is confirmed by the medical/scientific community (i.e., asbestos related cancer), WCB publishes the established guides specific to that disease in complementary policy.

General Adjudication Guidelines

2. As a requirement of both the definition of injury and occupational disease, the development of a claim must include gathering the necessary information to determine whether the condition or disease has arisen out of and in the course of employment.

3. When a number of claims are submitted for a disease or condition from the same trade, occupation, industry, or employer, and the employment environment provides exposure to a causative agent, a record of these trades, occupations, industries, and employers will be kept in a database and referenced for future claims of the same disease or condition (the database is published to WCB’s website and available upon request).

4. When assessing the cause or origin of the disease or condition and whether it has occurred as the result of exposure or incident in employment, staff will determine if it is one that is peculiar to any trade, occupation, industry or employer.

5. Where the worker’s exposure to a causative agent is peculiar to a trade, occupation, industry or employer, staff shall make inquiries to determine if any non-work causes exist and if none are present, the claim shall be accepted.

6. Where there are both work and non-work causes, staff will assess the degree of exposure or effect on the disease by both and determine, based on such things as the latency, progression and nature of the disease, degree of exposure and medical support of the cause, whether to accept a claim.
7. In cases where entitlement is determined on or after 01 January 1980 and where injury is not traumatic in nature such as disease, the date of occurrence is to be deemed to be the date the worker initially sought medical care for the injury or the date the worker's injury was initially reported to the Board, whichever occurs first.

8. Employers may be provided cost relief if the circumstances of a claim meet the criteria defined under either the Occupational Disease Reserve or the Second Injury and Re-employment Reserve.

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<th>Effective Date</th>
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<td>01 December 2003</td>
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<td>8 August 2004 - ADM 03/2004</td>
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<td>Application</td>
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<td>All claims for Occupational Disease</td>
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<td>Supersedes</td>
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<td>POL 23/2010 Permanent Functional Impairment (PFI) – General</td>
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3.1.7 Injuries – Firefighters (POL 06/2012)

Document Date 19 June 2012

Purpose To provide guidelines for the adjudication of cancer and cardiac claims for firefighters.

DEFINITION

Firefighter, for the purpose of this policy, means a full-time, active member of an urban fire department regularly exposed to the hazards of a fire scene, other than a forest fire scene, for the minimum periods of employment prescribed in The Workers’ Compensation General Regulations, 1985 (the “General Regulations”). Volunteer or forest firefighters are not included in this definition.

Fire department means a fire department as defined in The Fire Safety Act and belonging to a municipality incorporated under The Urban Municipality Act, 1984 or The Cities Act.

Primary site cancer means the originating site of the cancer in the body.

Emergency response means those circumstances where firefighters attend at a crisis situation including but not limited to a fire, car crash, or other incident as part of their active firefighter duties.

BACKGROUND

1. Professional firefighters in an urban setting are believed to be at a higher risk for developing certain primary site cancers.

2. Section 28 of The Workers’ Compensation Act, 2013 (the “Act”), stipulates that, unless the contrary is proven, where a full-time member of a fire department regularly exposed to the hazards of a fire scene, other than a forest fire scene, suffers from a presumptive listed disease, “that disease is presumed to be an occupational disease, the dominant cause of which is the employment as a firefighter.”

3. Section 28 of the Act and Section 22.3 of the General Regulations also stipulate that where a full-time member of a fire department suffers a cardiac injury within 24 hours after attendance at an emergency response, it is presumed to be an occupational disease, unless the contrary is shown.

4. Section 22.3 of the General Regulations provides the minimum periods of employment (i.e., the time between exposure and diagnosis) required before a
firefighter may be presumed to have an occupational disease listed under Section 28 of the Act.

5. Section 22.4 of the General Regulations prescribes the minimum periods before the date of injury during which a firefighter must have been a non-smoker (based on the criteria set out in Section 22.4(a)) in order for primary site lung cancer to be presumed an occupational disease.

6. In 2011, Bill 174 amended Section 28 of the Act to include esophageal cancer among the listed presumptive occupational diseases for firefighters. An Order in Council amended Section 22.3 of the General Regulations by:
   a. changing the minimum period of employment for testicular cancer from 20 years to 10 years; and
   b. establishing a minimum period of employment of 25 years for esophageal cancer.

   The presumption for esophageal cancer came into effect on May 27, 2011.

POLICY

1. Primary site brain, bladder, kidney, ureter, testicular, colorectal, esophageal, or lung cancers, non-Hodgkin’s lymphoma, or leukemia will be considered compensable as an occupational disease (unless the contrary is shown) when the following conditions apply:
   a. There is a history of full-time employment as a firefighter with regular exposure to combustion gases. The presumption will not apply to volunteer or forest firefighters.
   b. The minimum interval of uninterrupted employment between first exposure and the diagnosis of the primary site cancer is:
      i. 10 years for brain cancer.
      ii. 15 years for bladder cancer.
      iii. 20 years for kidney cancer.
      iv. 20 years for primary non-Hodgkin’s lymphoma.
      v. 5 years for leukemia.
      vi. 15 years for ureter cancer.
      vii. 15 years for colorectal cancer.
      viii. 15 years for lung cancer (non-smoking firefighters).
      ix. 10 years for testicular cancer, and
      x. 25 years for esophageal cancer.
2. In the case of primary site lung cancer, a firefighter with a history of smoking will be excluded from the presumption unless the firefighter was a non-smoker prior to the date of the injury for the minimum period listed in the General Regulations.

3. Where a firefighter has smoked in their lifetime:
   a. less than 365 cigarettes
   b. less than 365 cigars
   c. less than 365 pipes
   d. less than 365 cigarettes, cigars, and pipes, or
   e. on average less than seven cigars or pipes per week
   there will be no minimum period of non-smoking.

4. The minimum period of non-smoking for a firefighter who has smoked cigarettes is:
   a. six years if the firefighter smoked on average less than seven cigarettes per week
   b. six years if the firefighter smoked on average one to nine cigarettes per day
   c. 13 years if the firefighter smoked on average 10 to 19 cigarettes per day
   d. 18 years if the firefighter smoked on average 20 cigarettes per day
   e. 23 years if the firefighter smoked on average 21 to 39 cigarettes per day, or
   f. 28 years if the firefighter smoked on average 40 or more cigarettes per day.

5. The minimum period of non-smoking for a firefighter who has smoked cigars or pipes is eight years if the firefighter smoked on average one or more cigars or pipes per day.

6. Where a firefighter smoked cigarettes in combination with cigars and/or pipes, the minimum period will be determined in accordance with Point 4 with one cigar or pipe counting as a cigarette.

7. Where a firefighter suffers a cardiac injury that manifests within 24 hours after attendance at an emergency response, it is presumed to be an occupational disease, unless the contrary is shown. No minimum period of employment will be required. POL 05/2013, Injuries – Heart Attack, will apply.

8. During the adjudication process, full file development will be required for all claims, regardless of whether they meet the criteria set out in Points 1 and 2 above.

9. In accordance with POL 11/2003, Injuries –Occupational Disease, a claim for a listed presumptive occupational disease:
   a. not meeting the minimum interval of uninterrupted employment, or
b. diagnosed prior to the applicable effective date for the presumptive clause; will be judged on its own merit and justice. A claim may be accepted if the gathered medical information favours a causal relationship between the listed presumptive occupational disease and the workplace.

10. Where smoking is a factor in an accepted work-related lung cancer claim, cost relief may be provided to the employer under POL 21/2010, Second Injury and Re-Employment Reserve.

11. Medical Services will be consulted before a claim for one of the listed presumptive occupational diseases is denied.

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Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013

Application All claims for presumptive illnesses, diagnosed after the effective dates, related to exposure to the hazards of firefighting.

Supersedes POL 11/2007 Injuries – Firefighters

Complements POL 03/2012 Benefit of the Doubt
POL 05/2013 Injuries – Heart Attack
PRO 13/2007 Injuries – Occupational Disease
POL 21/2010 Second Injury and Re-Employment Reserve
3.2 Circumstance of Injury
DEFINITION

Emergency situation for the purpose of this policy means a single occurrence resulting in (potential) serious harm to others that workers encounter in the course of employment and offer their assistance.

BACKGROUND

1. Section 20(2)(b) of The Workers’ Compensation Act, 2013 (the “Act”) provides the Workers' Compensation Board (WCB) with the exclusive jurisdiction to determine “whether any injury has arisen out of or in the course of employment.”

2. The WCB recognizes that workers may encounter emergency situations (e.g., car collisions) in the course of their employment and that their natural response is to act as “Good Samaritans” and assist those who may be exposed to (potential) serious harm.

3. The reason the worker happens to be in that particular time and place arises out of and in the course of employment (POL 12/2013). As a result, there is a tenable link between the risk and the worker’s employment duties.

POLICY

1. Workers who are injured while assisting at an emergency situation encountered in the course of employment will be entitled to compensation benefits under the Act. An example of an emergency situation is provided below:

   Example:
   A truck driver is driving along his trucking route and encounters a high speed car collision. He stops and assists to extricate the occupants from the vehicle(s) but in the process suffers an injury. In this situation, the truck driver’s injuries would be compensable.

2. Workers who encounter non-emergency situations in the course of employment and choose to remove themselves from the course of employment to offer assistance will not be covered. An example of a non-emergency situation is provided below:
Example:
A taxi driver is travelling to pick up her next fare when she notices a man trying to lift packages out of the trunk of his car. Instead of remaining on the direct route to pick up her next fare, the taxi driver drives toward the man struggling with the packages. The taxi driver stops, exits her cab and walks toward the man to provide assistance. In the process of lifting packages out of the man’s car, the taxi driver suffers an injury. As this is not a situation where the person requiring assistance is at risk of (potential) serious harm and the taxi driver deviated from the course of employment to provide assistance, the injury is not compensable.

3. Coverage is not restricted to normal hours of work so long as the worker encounters the emergency situation in the course of employment.

Act Sec # 2(1)(r), 20(2)(b)
Effective Date 01 November 2009
Amended References updated 01 January 2014 in accordance with *The Workers' Compensation Act, 2013*
Application Workers responding to emergency situations on and after the effective date
Supersedes n/a
Complements POL 12/2013 *Arising Out Of And In The Course Of Employment*
POL 28/77 *Injuries, Responding to Emergency*
3.2.2 Injuries, Responding to Emergency (POL 28/77)

Document Date 12 June 1977

Purpose To establish guidelines for claims for injuries sustained by workers responding to emergency situations.

POLICY

1. Workers who suffer personal injury while immediately responding to an emergency arising out of employment shall be considered in the course of employment and covered under the legislation.

2. Coverage in these situations is not dependent upon remuneration nor restricted to normal hours of work but shall be in effect from notification and includes, by means reasonable for the circumstances, use of the individual’s premises and/or travel between lodgings and emergency site, providing there is no deviation.

Act Sec # 2(1)(r)
Effective Date 12 June 1977
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All workers
Supersedes n/a
Complements POL 12/2013 Arising Out Of and In the Course of Employment
POL 07/2009 Injuries, Workers Acting as Good Samaritans
3.2.3 Injuries, Recreational Activities in Remote Camps (POL 29/82) (Amended by 08/95)

Document Date 14 June 1982

Purpose To establish guidelines for determining entitlement for injuries sustained while participating in recreational activities in remote camps.

BACKGROUND

1. By legislation, compensation is payable for injuries arising out of and in the course of employment.

2. The legislation covers “employment” injuries rather than just “work” injuries, and therefore can encompass other activities related to employment.

3. Not infrequently, recreational injuries occur while employees are off work on their spare time.

4. The employer, in an isolated camp situation, has control over what sort of activities the work force engages in during their off hours.

POLICY

1. Each case will be considered on its own merits having regard for such factors as serious and wilful misconduct, or knowingly undertaking a task which is excessively perilous.

2. Recreational injuries, whether employer-sponsored or employee-sponsored, will be considered as injuries arising out of and in the course of employment.
   a. This includes an injury occurring on the employer’s isolated property when the worker is engaging in reasonable activity associated with employment or with normal life activities.

3. Injuries not covered as those involving an imported hazard (see POL 12/2013), and those involving purely personal acts on the part of a worker which do not involve a hazard of the premises and which occur at a time when the worker is not engaged in employment.
**Policy Manual**

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3.2.4 Injuries – Travelling for or Attending Medical Aid or Return-to-Work Programming (POL 04/2011)

Document Date: 01 March 2011

Purpose: To establish guidelines for claims where injuries are sustained while travelling for or attending medical aid or return-to-work programming as required by a work injury.

DEFINITION

Return-to-Work Programming, in this context, means Workers’ Compensation Board (WCB) sponsored programs aimed at assisting an injured worker in a return to suitable employment. These may include, but are not limited to, academic or technical training, work assessment, training on the job, job search programs, or employment skills development workshops.

Resident Community means the limits of the city, town, or village in which the worker’s permanent place of residence is located.

BACKGROUND

1. Section 20(2)(b) of The Workers’ Compensation Act, 2013 (the “Act”) directs that the WCB shall have exclusive jurisdiction to examine, hear and determine all matters and questions arising under this Act and any other matter in respect of which a power, authority or discretion is conferred upon the board and, without limiting the generality of the foregoing, the WCB shall have exclusive jurisdiction to determine whether an injury has arisen out of or in the course of employment.

2. Section 103 of the Act states:
   (1) Every worker who is entitled to compensation or who is disabled only on the day of the injury is entitled without charge to:
   a. any medical aid that may be necessary as a result of the injury;
   b. any other treatment by a health care professional;
   c. any prosthetics or apparatus that may be necessary as a result of the injury, and to have any prosthetic limbs and eyes and any surgical appliances such as belts, braces, supports and orthopaedic shoes repaired, maintained and renewed when necessary by reason of accident or ordinary wear and tear; and
   d. any transportation or sustenance occasioned by the medical aid.
   (2) The board shall furnish or arrange medical aid in any manner that it may approve.
3. Section 111 of the Act states that the WCB “may take any measures that it considers necessary or expedient:
   a. to assist an injured worker in returning to work;
   b. to assist in lessening or removing any barriers resulting from the worker’s injury;
   or
   c. to encourage a dependent spouse of a deceased worker to become self-sufficient.”

4. Due to a work injury, a worker may be required to:
   a. Travel for medical aid and attend a treatment centre (i.e., a hospital, a secondary or tertiary assessment/treatment centre, a counselling centre, a rehabilitation centre, a work hardening centre, etc.); or
   b. Travel for and attend return-to-work (RTW) programming at a work site or academic/technical training institution.

   This travel and attendance can place the worker at additional risk, which can be considered part of the effects of a work injury.

5. In determining entitlement, the WCB considers there to be a parallel between:
   a. Travel for the purposes of employment and travel for medical aid or RTW programming as required by a work-related injury; and
   b. Injuries that occur on the work site and those that happen on the premises where medical aid or RTW programming is being received for a work-related injury.

POLICY

1. The WCB will provide coverage for injuries arising in the course of travel for medical aid where the worker is:
   a. Injured while being immediately transported from the work site to a hospital or other place of treatment after a work injury;
   b. Travelling for medical aid in an ambulance or air ambulance; or
   c. Travelling for medical aid outside of the resident community, and the travel exceeds the worker’s normal pre-injury travel requirement for getting to and from work.

2. The WCB will provide coverage for injuries arising in the course of travel for RTW programming where the worker is:
   a. Pre-authorized a WCB travel allowance to travel outside the resident community; and
b. The travel exceeds the worker’s normal pre-injury travel requirement for getting to and from work.

3. The WCB will not provide coverage for injuries arising in the course of travel for medical aid or RTW programming where:
   a. Medical aid or RTW programming is sought in the worker’s resident community;
   b. Travel does not exceed the worker’s normal pre-injury travel requirement for getting to and from work; or
   c. The worker deviates from the most practical route for personal reasons.

4. The WCB may provide coverage for injuries a worker sustains on the premises where the worker is attending medical aid or RTW programming for a work injury. In respect of RTW programming, this will include academic/technical training institutions or an employer’s premises.

5. Transition from WCB to Saskatchewan Government Insurance (SGI) benefits will be considered if a worker, while in receipt of WCB benefits, sustains an injury as a result of a motor vehicle accident. Where it is determined coverage is not valid, POL 06/2009, Benefits – Clients in Transition from WCB to SGI Benefits – will apply.

6. Cost relief will be considered if injuries that arise in the course of travel for medical aid or RTW programming result in additional claim costs. POL 21/2010, Second Injury and Re-Employment Reserve, will apply.

Act Sec # 20(2)(b), 103, 111
Effective Date 01 April 2011
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All claims on and after the effective date.
Supersedes POL 15/87 Injury Occurring While Travelling for Medical Aid and at the Place of Treatment
POL 12/90 Injury Occurring While Travelling in Connection with and/or Participating In Board Sponsored Vocational Rehabilitation Programs
Complements POL 39/2010 Expenses – Travel and Sustenance – General
POL 06/2009 Benefits – Clients in Transition from WCB to SGI Benefits
POL 21/2010 Second Injury and Re-Employment Reserve
3.2.7 Fatalities, Presumption (POL 04/2014)

Document Date 29 April 2014

Purpose To establish guidelines for applying presumptive clauses in fatalities.

DEFINITION

**Found dead** refers to the situation where there are no witnesses to the occurrence or circumstances of a death. Finding a person a few minutes after being seen alive would normally not constitute being “found.”

BACKGROUND

1. Section 29 of *The Workers’ Compensation Act, 2013* (the “Act”) states “unless the contrary is proven, if a worker is found dead at a place where the worker had a right to be in the course of his or her employment, it is presumed that the worker’s death was the result of injury arising out of and in the course of his or her employment.”

2. The rebuttal clause in Section 29 means that if the cause of death proves not to be work-related, the WCB will not provide coverage.

POLICY

1. If a worker is found dead at the worksite, the WCB will determine:
   a. If the worker was a worker as defined under the Act.
   b. If the worker was in a place the worker had a right to be in the course of employment, and
   c. The worker’s cause of death.

2. The WCB will presume that the death arose out of and in the course of employment unless the contrary is shown. Strong evidence is required to rebut this presumption. Grounds sufficient to rebut the presumption include:
   a. Worker’s employment duties or circumstances could not have contributed to the medical cause of death, and
   b. Investigation conclusively reveals the actions leading to the worker’s death had no connection to the worker’s employment.

   In the absence of such strong evidence, allowing for rebuttal of the presumption, the WCB will accept the claim.

3. If a worker is found in a comatose state at the worksite and subsequently dies and no one saw what led to the worker’s collapse, where evidence permits, the WCB will
Injuries – Circumstance of Injury

presume that the death arose out of and in the course of employment unless the investigation proves otherwise.

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4.1 Benefit Calculations
4.1.1 Establishing Initial Wage Base (POL 29/2010)

Document Date 07 September 2010

Purpose To establish the initial wage base for workers.

DEFINITION

**Average weekly earnings**, as determined by Section 70(1) of *The Workers’ Compensation Act, 2013* (the “Act”), means the greater of:

a. One fifty-second of the worker’s earnings for the 12 months preceding the commencement of the worker’s loss of earnings resulting from the injury; and

b. The rate of daily, weekly, monthly or other regular gross earnings that the worker was receiving at the commencement of the worker’s loss of earnings resulting from the injury converted, in the case of a daily, monthly or other rate that is not a weekly rate, to a weekly amount.

**Gross earnings** means the worker’s earnings from all sources of employment, before all deductions, within an industry under the scope of the Act or for which coverage has been elected.

**Average gross earnings** means the worker’s gross earnings, divided by the number of weeks in a particular period of time.

**Regular gross earnings** means the daily, weekly, monthly or other gross earnings a worker normally received prior to the commencement of the loss of earnings (e.g., agreement of hire typically requires the worker to work and be paid for 40 hours per week at $25.00 an hour).

BACKGROUND

1. Sections 37 of the Act stipulates that the worker’s eligible gross earnings will be subject to the maximum wage rate applicable at the time of the injury.

2. Section 68(1) of the Act directs that if an injury to a worker results in a loss of earnings beyond the day of the injury, the board shall determine the loss of earnings resulting from the injury and shall ensure compensation to the worker:

a. In the case of a worker who sustained an injury before September 1, 1985, in an amount equal to 75 percent of that loss of earnings;

b. In the case of a worker who sustained an injury on or after September 1, 1985, in an amount equal to 90 percent of that loss of earnings.
3. Section 68(2) of the Act states that compensation pursuant to subsection (1) is payable for as long as the loss of earnings continues, but the compensation is no longer payable when the worker reaches the age of 65.

4. Section 2(1)(k) of the Act directs that for the purposes of this Act, “earnings” means:
   a. In the case of a worker who sustained an injury before September 1, 1985, the worker’s gross earnings from employment; or
   b. In the case of a worker who sustained an injury on or after September 1, 1985, the worker’s gross earnings from employment less the probable deductions for:
      i. The probable income tax payable by the worker calculated by using only the worker’s earnings from employment as his or her income, and using only the worker’s basic personal exemption, exemption for dependants and employment-related tax credits, as at the date of the worker’s injury and each anniversary date, as the worker’s deductions;
      ii. The probable Canada Pension Plan premiums payable by the worker; and
      iii. The probable unemployment insurance premiums payable by the worker.

POLICY

1. Upon the commencement of earnings loss resulting from an injury, the worker will qualify for wage loss benefits.

2. Wage loss benefits will be based on the worker’s gross earnings prior to the commencement of loss of earnings and will not exceed the maximum wage rate under the Act.

3. The WCB will use the worker’s regular gross earnings at the commencement of earnings loss or an average of the worker’s gross earnings for the 52 weeks prior to the commencement of loss, whichever is greater.

4. There may be situations where using the 52-week period prior to the commencement of earnings loss to calculate the worker’s wage rate would be inequitable. Therefore, the WCB will ensure that each claim is adjudicated on its own merits to calculate an equitable wage rate. Consideration will be given to the worker’s employment history and pattern, employment status and gross earnings over a period of time that more appropriately reflects the worker’s loss of earnings.

5. Where the worker has worked for a period of less than 52 weeks prior to the commencement of earnings loss or there is insufficient information to determine the worker’s regular gross earnings, the WCB will calculate wage loss benefits based on the following:
   a. Where the worker has regular daily, weekly, or monthly gross earnings prior to the commencement of earnings loss, but has been employed for a period less than 52 weeks, the WCB may use a period less than 52 weeks but greater than
13 weeks to calculate the worker’s average gross earnings. The number of weeks used will be a sufficient period of time to demonstrate that the calculated average gross earnings is an equitable representation of the worker’s gross earnings. To determine wage loss benefits, the WCB will use the calculated average gross earnings or the regular gross earnings at the commencement of earnings loss, whichever is greater;

b. Where there is insufficient information to determine the worker’s regular gross earnings (e.g., the worker’s employment is casual in nature and or the worker has been employed by the injury employer for less than 13 weeks), the worker’s average gross earnings will be calculated based on the actual period of time over which those gross earnings were earned.

6. Where the worker was not available for employment for the full period of 52 weeks preceding the commencement of earnings loss, or the casual nature of the employment makes it inequitable to determine the worker’s average gross earnings, consideration may be given to using the average gross earnings of a worker regularly employed in the same grade of employment. POL 35/2010, Compensation Rate – Casual and Seasonal Employment – Section 70(4), will apply.

7. Where the worker is employed by two or more employers at the commencement of loss of earnings, the gross earnings will be based on the combined wage base from those employers.

8. Where the worker has applied for, and been granted personal coverage, the wage loss benefits will be based on the level of coverage purchased or confirmed. Section 12 of The Workers’ Compensation General Regulations, 1985 will apply. Where the worker is engaged under other employment arrangements (e.g., contractor, learner), gross earnings will be based upon the applicable coverage guidelines.

9. The worker’s net earnings will be calculated based on gross earnings from employment. POL 03/2007, Calculation of Net Compensation Payable, will apply.

10. The worker will be entitled to wage loss benefits equal to 90 percent of their net earnings.

11. Where disablement or death resulting from an injury is delayed (e.g., due to an exposure causing an occupational disease) and there are no gross earnings, POL 08/2007, Compensation Rate - Where No Earnings at Disablement or Death, will apply.
| Act Sec # | 2(1)(a), 2(1)(k), 20, 37, 68, 69, 70(1), 70(4), 95; The Workers’ Compensation General Regulations 12 |
| Effective Date | 01 November 2010 |
| Amended | References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013 |
| Application | All claims. |
| Supersedes | n/a |
| Complements | PRO 29/2010 Establishing Initial Wage Base |
| | POL 08/2015 Maximum Wage Rates |
| | POL 08/2007 Compensation Rate – Where no earnings at disablement or death |
| | POL 35/2010 Compensation Rate – Casual and Seasonal Employment – Section 70(4) |
| | POL 28/2010 Compensation Rate - Minimum and Average Weekly Earnings |
| | POL 03/2007 Calculation of Net Compensation Payable |
| | PRO 59/2015 Calculation of Net Compensation Payable |
4.1.2 Determination of a Worker’s Daily Rate of Benefits (POL 34/2010)

Document Date 10 November 2010

Purpose To establish the process by which the WCB converts a worker’s weekly compensation rate to a daily compensation rate.

DEFINITION

Average weekly earnings, as determined by Section 70(1) of The Workers’ Compensation Act, 2013 (the “Act”), means the greater of:

a. One fifty-second of the worker’s earnings for a period of 12 months preceding the commencement of the worker’s loss of earnings resulting from the injury; and

b. The rate of daily, weekly, monthly or other regular gross earnings that the worker was receiving at the commencement of the worker’s loss of earnings resulting from the injury converted, the case of a daily, monthly or other rate that is not a weekly rate, to a weekly amount.

Daily rate of benefits means the weekly rate of benefits divided by the number of days worked in a seven day period.

Irregular rest days occur when a worker’s days off fluctuate from week to week, or month to month.

Regular rest days occur when a worker receives the same days off every week (e.g., every week the worker works from Monday to Friday, and Saturday and Sunday are the worker’s rest days).

Repeating cycle rest days occur when the number of days off repeat during the worker’s normal work cycle (e.g., 3 weeks on, 1 week off).

BACKGROUND

1. Section 20 of the Act directs that the Workers’ Compensation Board (WCB) shall have exclusive jurisdiction to examine, hear and determine all matters and questions arising under this Act and any other matter in respect of which a power, authority or discretion is conferred upon the WCB and, without limiting the generality of the foregoing, the WCB shall have exclusive jurisdiction to determine “the average earnings.”

2. Section 68(1) of the Act states that where injury to a worker results in a loss of earnings beyond the day of the injury, the WCB shall determine the loss of earnings resulting from the injury and shall ensure compensation to the worker.
3. Section 69(1) of the Act directs that the calculation of the loss of earnings for the purposes of subsection 68(1) and Sections 71 and 72 must be based on the difference between:
   a. The worker’s average weekly earnings at the commencement of the worker’s loss of earnings resulting from the injury, increased annually by the percentage increase in the Consumer Price Index; and
   b. The weekly earnings that the worker is receiving from employment.

4. Section 69(3) states that any adjustments are subject to the maximum wage rate for that year.

**POLICY**

1. When the WCB provides earnings loss benefits to a worker based on the worker’s average weekly earnings, the WCB will pay a daily rate for every missed work day resulting from the injury. To pay a daily rate, the WCB will determine the number of days worked in a seven day period, and whether the rest days are regular, repeating cycle or irregular.

2. The daily rate of earnings loss benefits will be determined by dividing the weekly rate by the number of days worked in a seven day period.

<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>Effective Date</th>
<th>Amended</th>
<th>Application</th>
<th>Supersedes</th>
<th>Complements</th>
</tr>
</thead>
<tbody>
<tr>
<td>20, 68, 69, 70, 71 and 72</td>
<td>01 January 2011</td>
<td>References updated 01 January 2014 in accordance with <em>The Workers’ Compensation Act, 2013</em></td>
<td>All claims on and after the effective date.</td>
<td>n/a</td>
<td>PRO 34/2010 Determination of a Worker’s Daily Rate of Benefits POL 35/2010 Compensation Rate – Casual and Seasonal Employment – Section 70(4) POL 28/2010 Compensation Rate – Minimum and Average Weekly Earnings</td>
</tr>
</tbody>
</table>
4.1.3 Determination of Long-Term Loss of Earnings (POL 15/2014)

Document Date 15 October 2014

Purpose To establish the process for determining long-term earnings loss benefits.

DEFINITION

Client means an injured worker, or surviving dependent spouse.

Earning capacity means the amount of income a client could be expected to generate, post injury, through the performance of suitable productive employment, given the physical restrictions and the unique vocational profile of that client.

Long-term earnings loss benefits means a client’s earnings loss benefits after the completion of a vocational rehabilitation program. These benefits are also known as long-term earnings replacement.

Suitable productive employment means work that:

- The client can do given their employability assessment and transferable skills analysis.
- The client can functionally perform, given the restrictions imposed by the work injury and existing at the time of the injury.
- Will not endanger the health and safety of the client or others.
- Contributes meaningfully to the operation of the business.

Vocational rehabilitation program means a program that is intended to return clients to positions of independence in suitable productive employment. As part of this program, the WCB will, in consultation with the client, develop an individualized vocational plan.

BACKGROUND

The Workers’ Compensation Act, 2013 (the “Act”) requires clients to take steps to mitigate their loss of earnings and authorizes the WCB to suspend or reduce earnings loss payments (Sections 51 and 101).

POLICY

1. The WCB will determine a client’s earning capacity if a vocational rehabilitation program is unable to return the client back to suitable productive employment that
To eliminate all earnings loss. This allows the WCB to determine the amount of long-term earnings loss benefits the client should receive.

2. The WCB will reduce a client’s long-term earnings loss benefits by the greater of the client’s:
   a. Determined earnings capacity, or
   b. Actual earnings.

3. The client’s earning capacity will normally be the same as their actual earnings. The WCB may consider the client’s earning capacity to be greater than their actual earnings if the client:
   a. Does not accept an offer for suitable productive employment.
   b. Does not participate in a medical or vocational rehabilitation program.
   c. Does not acquire suitable productive employment after completing a vocational rehabilitation program.
   d. Accepts a job offer that pays lower than what they could receive from other suitable productive employment.
   e. Leaves suitable productive employment, but not because of the injury.

4. The WCB will only adjust a client’s earning capacity when the:
   a. Client accepts an employment offer that pays more than the starting or staged wage increases (e.g., annual increases) of the determined suitable productive employment.
   b. WCB determines that the client is able to acquire suitable productive employment that receives staged wage increases,
   c. Client’s medical condition related to the injury changes and the amount of long-term earnings loss benefits no longer accurately reflects the client’s earning capacity.

5. The WCB may not reduce or eliminate future earnings loss benefits if:
   a. A client’s earnings loss benefits are based on actual earnings, and
   b. The client experiences a short-term increase in earnings that is not expected to result in a sustained change in their earning capacity.
<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>Effective Date</th>
<th>Application</th>
<th>Supersedes</th>
<th>Complements</th>
</tr>
</thead>
<tbody>
<tr>
<td>51, 81, 101</td>
<td>01 December 2014</td>
<td>All clients.</td>
<td>POL 26/2010</td>
<td>Determination of Long-Term Loss of Earnings</td>
</tr>
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<td>PRO 15/2014</td>
<td>Determination of Long-Term Loss of Earnings</td>
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<td></td>
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<td></td>
<td>POL 02/2014</td>
<td>Vocational Rehabilitation – Moving Allowance</td>
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<td></td>
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<td>POL 07/2014</td>
<td>Suspension of Benefits</td>
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<td></td>
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<td>POL 01/2011</td>
<td>Vocational Rehabilitation – Programs and Services</td>
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<td>Vocational Rehabilitation – Programs and Services</td>
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<td>POL 39/2010</td>
<td>Expenses – Travel &amp; Sustenance – General</td>
</tr>
<tr>
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<td></td>
<td>POL 26/90</td>
<td>Provincial Minimum Wage, Effect of Increase</td>
</tr>
</tbody>
</table>
4.1.4 Estimating Earning Capacity – Commissioned Sales and Self-Employment (POL 09/2013)

Document Date 27 November 2013

Purpose To establish guidelines for estimating the earning capacity of workers in commissioned sales or self-employment.

DEFINITION

**Average weekly wage** is determined by the Workers’ Compensation Board (WCB) for a calendar year. The average weekly wage is Saskatchewan’s industrial composite wage published by Statistics Canada as of June of the preceding year (Section 2).

**Earning capacity** means the amount of income a worker could be expected to generate, post injury, through the performance of suitable employment, given the physical restrictions and the unique vocational profile of that worker.

**Suitable productive employment** means a position or occupation in which the worker is employable, given the worker’s employability assessment and transferable skills analysis, the restrictions imposed by the work injury, and any non-compensable restriction that existed prior to the injury, and that contributes meaningfully to the operation of the business, thereby providing purposeful tasks to the worker.

BACKGROUND

1. Section 69(1) of *The Workers’ Compensation Act, 2013* (the “Act”) states “calculation of the loss of earnings for the purposes of subsections 32(2) and 68(1) and sections 71 and 72 must be based on the difference between:

(a) the worker’s average weekly earnings at the commencement of the worker’s loss of earnings resulting from the injury, adjusted annually by the percentage increase in the Consumer Price Index; and

(b) the weekly earnings that the worker is receiving from employment.”

2. The first and foremost objective of vocational rehabilitation is to return the worker to pre-injury employment.

3. In some instances, a worker’s return to suitable productive employment may lead to a career in commissioned sales or self-employment. Self-employment will only be approved where all other conventional re-employment objectives have been exhausted (PRO 11/2014, Self-Employment – Individualized Vocational Plan, will apply).
4. The WCB recognizes that initially when workers start in commissioned sales or self-employment, workers may not be able to earn regular or consistent income. To enable a successful transition into commissioned sales or self-employment, the WCB may need to provide a stabilized level of support. This requires a structured schedule of staged earnings loss payments.

POLICY

1. Where the worker is not able to earn regular or consistent income through commissioned sales or self-employment, the WCB will provide estimated earnings loss benefits that are based on the difference between the worker’s earnings at the commencement of loss (Consumer Price Index adjusted to date) and an estimation of the worker’s earning capacity.

2. The WCB will estimate the worker’s earning capacity using the average weekly wage published by Statistics Canada as of June in the year immediately preceding the year in which the loss of earnings occurs. Subject to Point 3, the worker’s earning capacity will be:
   a. Zero for the balance of the month when the return-to-work begins plus six full months thereafter;
   b. 50 percent of the average weekly wage for the following 12 months of working;
   c. 75 percent of the average weekly wage for the following 12 months of working;
   d. 100 percent of the average weekly wage for the following 12 months of working;
   e. 125 percent of the average weekly wage for the following 12 months of working; and
   f. 150 percent of the average weekly wage thereafter.

3. Earnings loss benefits will end when:
   a. The worker’s estimated earning capacity exceeds earnings at the commencement of loss (Consumer Price Index adjusted to date); or
   b. The worker demonstrates the ability to generate actual earnings equal to or in excess of the earnings at the commencement of loss (Consumer Price Index adjusted to date) for a period of time sufficient to reasonably predict future earnings (typically two to four months).
<table>
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<th>Act Sec #</th>
<th>32, 68, 69, 71, 72</th>
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<tr>
<td>Effective Date</td>
<td>01 January 2014</td>
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<tr>
<td>Application</td>
<td>Claims on and after the effective date</td>
</tr>
<tr>
<td>Supersedes</td>
<td>POL 14/89 Estimating Earning Capacity – Commission and Self-Employed</td>
</tr>
<tr>
<td>Complements</td>
<td>PRO 09/2013 Estimating Earning Capacity – Commissioned Sales and Self-Employment</td>
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<td></td>
<td>POL 01/2011 Vocational Rehabilitation – Programs and Services</td>
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<td>PRO 01/2011 Vocational Rehabilitation – Programs and Services</td>
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<td></td>
<td>POL 07/2013 Consumer Price Index (CPI) – Annual Indexing</td>
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<td>POL 15/2014 Determination of Long-Term Loss of Earnings</td>
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<td>PRO 15/2014 Determination of Long-Term Loss of Earnings</td>
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<td>POL 17/2010 Termination of Compensation Benefits – Notice</td>
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<td>PRO 17/2010 Termination of Compensation Benefits - Notice</td>
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<td></td>
<td>PRO 11/2014 Vocational Rehabilitation – Self-Employment Plans</td>
</tr>
</tbody>
</table>
4.1.5 Compensation Rate – Apprentices and On-The-Job Training (POL 25/2014)

Document Date 10 December 2014

Purpose To establish guidelines for compensating workers who are injured while undergoing training or instruction.

DEFINITION

Undergoing training or instruction that the Workers’ Compensation Board (WCB) is satisfied should be recognized, as referenced in Section 50 of The Workers’ Compensation Act, 2013 (the “Act”), means the worker is:

a. Registered in an apprenticeship contract for a designated trade under The Apprenticeship and Trade Certification Act, 1999, or

b. Participating in a specified or contractual On-the-Job training program.

BACKGROUND

Section 50 of the Act provides that where a worker suffers a compensable injury while undergoing training or instruction the Workers’ Compensation Board (WCB) may review the amount of compensation payable and increase the compensation to an amount the worker would have received had they completed training or instruction.

POLICY

1. A worker injured while in an apprenticeship or on-the-job training program is only eligible for a Section 50 increase in benefits if:

   a. There is a signed agreement between the worker, the employer, and the Saskatchewan Apprenticeship and Trade Certification Commission (SATCC) in effect at the time of the injury.

   b. The work injury occurred while the worker was participating in an apprenticeship or on-the-job training program under the direction of the sponsoring employer.

   c. The worker’s employment history and participation in training demonstrates an intent to actively pursue advancement and completion of the apprenticeship program in a reasonable amount of time, and

   d. The work injury permanently prevented the worker from completing the apprenticeship or on-the-job training program.

2. Compensation benefits will initially be based on the worker’s earnings at the time of injury and will be subject to the maximum wage rate.
3. The worker’s benefit increases and intervals will replicate the apprenticeship or on-the-job training program agreement effective at the time of the commencement of loss of earnings and will be based on the probable wages the worker would have received for each applicable stage of the program.

4. Section 50 adjusted earnings will be subject to the Consumer Price Index (CPI) adjustments required under Section 69 of the Act. The worker’s benefits will be based on the greater of the Section 50 increases or the original CPI-adjusted earnings (including any applicable CPI adjustments).

5. Increases to the worker’s benefits, as determined by the probable wages, will cease on the projected date of completion for the apprenticeship or on-the-job training program.

6. After the projected date of completion of the apprenticeship or on-the-job training program, the Section 50 adjusted earnings will be increased annually by the percentage increase of the CPI. Compensation adjusted for annual CPI percentage increases is not to exceed the maximum wage rate at the time of calculation.

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**Act Sec #** 50, 69  
**Effective Date** 01 January 2015  
**Application** All workers injured while participating in an apprenticeship or on-the-job training program.  
**Supersedes** POL 21/2001 Compensation Rate – Apprentices and On-the-Job Training  
**Complements**  
POL 07/2013 Consumer Price Index (CPI) – Annual Indexing  
POL 08/2015 Maximum Wage Rates
4.1.6 Compensation Rate – Excluded Earnings (POL 18/87)

Document Date 08 April 1987

Purpose To establish guidelines for use of earnings from excluded employment.

BACKGROUND

1. The Board interprets the Act to prohibit the use of earnings from industries and occupations excluded by the Act and Regulations, in the calculation of compensation benefits.

2. The Board further believes that present practice of using excluded earnings but not income, as in the case of a farmer injured in covered employment, is unfair.

POLICY

1. Earnings earned in Saskatchewan industries and occupations not subject to the Act may not be used in calculating compensation entitlement.

2. However, earnings earned in another Canadian jurisdiction may be used if the industry or occupation in which these are earned is subject to both workers’ compensation legislation in the jurisdiction and Saskatchewan.

Act Sec # 70
Effective Date Entitlement Commencing on or after 01 January 1986
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All Claims
Supersedes POL 60/85 Earnings from Excluded Industries and Occupations
Complements POL 35/2010 Compensation Rate – Casual and Seasonal Employment – Section 70(4)
4.1.7 Compensation Rate – Where No Earnings at Disablement or Death (POL 08/2007)

Document Date 21 August 2007

Purpose To establish guidelines for payment of benefits where there are no earnings at disablement or death.

DEFINITION

Recurrence for the purpose of this policy occurs when a worker who stopped work previously and received compensation for earnings loss resulting from a work injury, returns to full employment and becomes disabled again as the result of the original injury. The worker’s return to work following the previous disablement must be for a sufficient period of time to reflect that the worker was able to return to work within the capacity identified at recovery. This period will normally be greater than one month.

Early Retirement for the purpose of this policy occurs when a worker ceases employment for reasons not related to a work injury prior to attaining the age of 65.

BACKGROUND

1. The Board interprets the intent of The Workers’ Compensation Act, 2013 (the “Act”) not to penalize the worker who persisted in employment initially, nor to deny benefits where the nature of the injury does not produce disability or death immediately.

2. Where a work injury results in disablement, the Act directs the payment of compensation for earnings loss to an injured worker or the surviving dependent spouse based on the earnings at the commencement of loss of those earnings.

3. There are circumstances, however, where there are no employment earnings at the time of disablement or death on which to base the calculation of compensation benefits (e.g., a latent occupational disease has become symptomatic or causes death after a worker is no longer involved in the workforce, a government-sponsored unpaid learner is injured, etc.).

4. Section 20 of the Act allows the Workers’ Compensation Board (WCB) to determine the average weekly earnings where there are no employment earnings on which to base the calculation of compensation benefits.

5. Sections 68(1) and (2) and Section 69(1) of the Act provide for the compensation payable at the commencement of the loss of earnings resulting from an injury and for annual reviews of those earnings. Section 69 of the Act also provides for the indexing of the average weekly earnings based on increases in the Consumer Price Index.
6. Section 72 directs the compensation payable in the case of a recurrence. Payments of benefits to injured workers is restricted from going beyond age 65, unless allowed under Section 71 where a worker is age 63 or older at the commencement of his or her loss of earnings.

7. Section 70(5)(b) of the Act sets out the minimum wage base for those claims where the wage loss imposed by a work injury extends beyond 24 consecutive months.

8. Section 81(1) of the Act defines the amount of allowances for dependent spouses, payable for five years or longer if there are dependent children, who survive an injured worker.

**POLICY**

Wage loss benefits will not be paid to a worker who is retired or early retired based on the above definition. Where a disability recurs or the retired worker suffers an occupational disease that becomes evident after retirement (and there is medical evidence to support that the disablement or death resulted from a work injury), wage loss benefits will be payable as follows:

1. Workers, under 65 years of age, who do not stop work initially but later become disabled from an injury where there are no earnings or any assessable earnings will be provided benefits based on their earnings at the time the injury occurred (or at the time the workers left employment following exposure causing an occupational disease), subject to any increases afforded under Section 69 of the Act. If it is impossible to confirm such earnings, Section 70(4)(a) of the Act will apply. Failing that, the average weekly earnings will be based on the provincial minimum wage for a forty-hour work week for the first 24 months of demonstrated earnings loss.

2. For unpaid workers who stop work at the initial time of injury (immediately disabled) and have no earnings or any assessable earnings (e.g., government-sponsored volunteers or learners in work placement programs), the average weekly earnings will be based on the provincial minimum wage for a forty-hour work week for the first 24 months of demonstrated earnings loss.

3. In cases where the loss of earnings resulting from an injury extends beyond 24 consecutive months, compensation is to be calculated based on not less than two-thirds of the average weekly wage in accordance with the provisions of Section 70(5) of the Act.

4. Where there are no earnings at the time of death resulting from a work injury, benefits to the dependent spouse will be paid for a period not exceeding five years or longer if there are dependent children and will be based on the provisions of Section 81(1) of the Act.
5. Consumer Price Indexing of average weekly earnings as defined above will occur annually (Section 69(3)).

6. Costs may be charged to the Occupational Disease Reserve where disablement under Points 1 and 2 relate to a latent occupational disease, or where benefits are paid to a dependent spouse as directed under Point 4.

<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>20, 68, 69, 69, 70(4)(a), 70(5), 72, 81, and 145</th>
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<tr>
<td>Effective Date</td>
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<tr>
<td>Amended</td>
<td>References updated 01 January 2014 in accordance with The Workers’ Compensation Act 2013</td>
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<tr>
<td>Application</td>
<td>All claims where there are no assessable earnings at disablement, delayed disablement and recurrence.</td>
</tr>
<tr>
<td>Supersedes</td>
<td>POL 08/2002 Compensation Rate – Where No Earnings at Disablement or Death</td>
</tr>
<tr>
<td>Complements</td>
<td>POL 02/2015 Compensation – Dependent Spouse After Initial Entitlement</td>
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<td>POL 05/2014 Occupational Disease Reserve</td>
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<td>POL 06/80 Compensation Rate – Recurrence</td>
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<td>POL 28/2010 Compensation Rate - Minimum and Average Weekly Earnings</td>
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<td>POL 09/2012 Termination – Age 63 &amp; Over, Age 65, and Retirement</td>
</tr>
<tr>
<td></td>
<td>POL 35/2010 Compensation Rate – Casual and Seasonal Employment – Section 70(4)</td>
</tr>
</tbody>
</table>
DEFINITION

Average weekly wage is determined by the Workers’ Compensation Board (WCB) for a calendar year. The average weekly wage is Saskatchewan’s industrial composite wage published by Statistics Canada as of June of the preceding year (Section 2).

BACKGROUND

1. Effective January 1, 2014, The Workers’ Compensation Act, 2013 (the “Act”), provides for an increase to the maximum wage rate for all current claims and for all new injuries (Section 37).

2. The maximum wage rate for a worker who sustains an injury prior to January 1, 2014 will be adjusted annually in accordance with the percentage change in Saskatchewan’s average weekly wage (Sections 37(1) and 182).

3. A decrease in Saskatchewan’s average weekly wage would result in a reduced maximum wage rate, which the Board considers to be unfair to the worker. Therefore, it is the Board’s intent that if the ratio between the average weekly wage for the current year and the average weekly wage for the previous year is less than 1.0, there will be no adjustment.

4. The maximum wage rate for a worker who sustains an injury on or after January 1, 2014 will be adjusted annually in steps that the Board considers appropriate so that the maximum wage rate per year for those workers is, in the fifth and subsequent years, equal to 165% of the product of Saskatchewan’s average weekly wage and 52 (Sections 37(2)(a) and 37(3)).

POLICY

1. Effective January 1, 2016, the Board directs the maximum wage rates to be as follows:

   a. For injuries sustained prior to January 1, 2014:

<table>
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<tr>
<th>Effective Date</th>
<th>Maximum Wage Rate</th>
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<tr>
<td>January 1, 2013</td>
<td>$55,000</td>
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<tr>
<td>January 1, 2014</td>
<td>$57,037</td>
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<tr>
<td>January 1, 2015</td>
<td>$58,941</td>
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</table>
b. For injuries sustained on or after January 1, 2014:

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Maximum Wage Rate</th>
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<tbody>
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<td>January 1, 2014</td>
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<tr>
<td>January 1, 2015</td>
<td>$65,130</td>
</tr>
<tr>
<td>January 1, 2016</td>
<td>$69,242</td>
</tr>
</tbody>
</table>

2. In accordance with Section 69, any adjustments in a worker’s average weekly earnings because of an increase in the maximum wage rates will occur on the anniversary date of the original commencement of loss and will be subject to the maximums noted above. POL 07/2013, Consumer Price Index (CPI) – Annual Indexing, will apply.

Act Sec # 2(1)(b), 2(1)(u), 37, 69, 72, 182
Effective Date 01 January 2016
Application All workers.
Supersedes POL 17/2014 Maximum Wage Rate
Complements POL 08/2015 Maximum Wage Rates
POL 07/2013 Consumer Price Index (CPI) – Annual Indexing
POL 07/2015 Maximum Assessable Wage Rate
POL 01/2007 Experience Rating Program
4.1.11 Compensation Rate – Minimum and Average Weekly Earnings (POL 28/2010)

Document Date 07 September 2010

Purpose To establish the guidelines for the application of Section 75 and Section 70(5) of The Workers’ Compensation Act, 2013 (the “Act”).

DEFINITION

Average weekly earnings, as determined by Section 70(1) of the Act, means the greater of:

a. One fifty-second of the worker’s earnings for the 12 months preceding the commencement of the worker’s loss of earnings resulting from the injury; and

b. The rate of daily, weekly, monthly or other regular gross earnings that the worker was receiving at the commencement of the worker’s loss of earnings resulting from the injury converted, in the case of a daily, monthly or other rate that is not a weekly rate, to a weekly amount.

Average weekly wage is determined by the Workers’ Compensation Board (WCB) for a calendar year. The average weekly wage is Saskatchewan’s industrial composite wage published by Statistics Canada as of June of the preceding year (Section 2).

Gross earnings means the worker’s earnings from all sources of employment, before all deductions, within an industry under the scope of the Act or for which coverage has been elected.

Totally unable to work, referred to in Section 75 of the Act, means that due to the workplace injury, the client is completely prevented from working and is unable to participate in a return-to-work plan, or part-time or supernumerary work. Absences for medical appointments are not considered being totally unable to work.

BACKGROUND

1. Section 68(1) of the Act directs that where injury to a worker results in a loss of earnings beyond the day of the injury, the WCB shall determine the loss of earnings resulting from the injury and shall ensure compensation to the worker:

   a. In the case of a worker who sustained an injury prior to September 1, 1985, in an amount equal to 75 percent of that loss of earnings; or

   b. In the case of a worker who sustained an injury on or after September 1, 1985, in an amount equal to 90 percent of that loss of earnings.
2. Section 68(2) of the Act states that compensation pursuant to subsection (1) is payable for as long as the loss of earnings continues, but the compensation is no longer payable when the worker reaches the age of 65.

3. Section 2(1)(k) of the Act directs that “earnings” means:
   a. In the case of a worker who sustained an injury before to September 1, 1985, the worker’s gross earnings from employment; or
   b. In the case of a worker who sustained an injury on or after September 1, 1985, the worker’s gross earnings from employment less the probable deductions for:
      i. The probable income tax payable by the worker calculated by using only the worker’s earnings from employment as his or her income, and using only the worker’s basic personal exemption, exemption for dependants and employment-related tax credits, as at the date of the worker’s injury and each anniversary date, as the worker’s deductions;
      ii. The probable Canada Pension Plan premiums payable by the worker; and
      iii. The probable employment insurance premiums payable by the worker.

4. Section 75 of the Act directs that the amount of compensation payable to a worker who is injured on or after January 1, 1980 and who is totally unable to work because of the injury must be:
   a. During the period commencing on January 1, 1980 and ending on December 31, 1982, not less than $580 per month or, if the worker’s average earnings at the time of the injury are less than $580 per month, the amount of those average earnings; and
   b. On and after January 1, 1983, not less than one-half of the average weekly wage as of June in the year preceding the year in which the review occurs respecting the worker’s compensation or, if the worker’s average earnings at the time of the injury are less than that amount, the amount of those earnings.

5. Section 70(5)(b) of the Act states if a worker is injured on or after January 1, 1980 and is in receipt of compensation for a period of at least 24 consecutive months, the worker’s average weekly earnings on and from January 1, 1983, are deemed to be not less than two-thirds of the average weekly wage as of June in the year preceding the year in which the review respecting his or her compensation occurs.

POLICY

1. Where a worker has a loss of earnings due to a workplace injury, in an industry under the scope of the Act, which extends beyond the day of injury, the worker will qualify for wage loss benefits. POL 29/2010, Establishing Initial Wage Base, will apply.
Minimum Compensation – Section 75

2. Where a worker is totally unable to work, the worker will be eligible for minimum compensation under Section 75 of the Act.

3. Injured workers totally unable to work, whose average weekly earnings are less than one-half of the industrial composite, will receive compensation equal to the amount of their gross earnings at the time of injury, free of any probable deductions.

4. Where a worker’s earnings are above the minimum outlined in Section 75 of the Act, and where the calculations called for in Section 68 of the Act would bring the benefit level below the minimum, those workers will receive one-half of the industrial composite.

5. Where the worker is able to return to some form of employment, the provision of Section 75 of the Act will not apply. If a worker is fit for any form of employment, compensation will be in accordance with Section 68 of the Act and POL 03/2007, Calculation of Net Compensation Payable.

Average Weekly Earnings – Section 70(5)

6. In accordance with Section 70(5) of the Act, where the injured worker has been in receipt of wage loss benefits on a single claim for 24 consecutive months, the workers average weekly earnings is to be not less than two-thirds of the industrial composite. A wage loss payment for a full or partial month will count towards the 24 consecutive months.

7. Where the average weekly earnings is less than two-thirds of the industrial composite, the worker’s average weekly earnings will be adjusted the first day of earnings loss in the 25th month. The worker will receive wage loss benefits increased annually by the percentage increase in the Consumer Price Index (CPI) or two-thirds of the industrial composite, whichever is greater. There will be no retroactive effect.

8. After the application of Section 70(5) of the Act if the calculations called for by Section 68 of the Act will reduce the rate of compensation below one half of the industrial composite, Section 75 will continue to apply. That is, where a worker is totally unable to work, the worker will receive one half of the industrial composite.

9. Periods of benefit suspension, subject to POL 07/2014, Suspension of Benefits, will not count towards the 24 consecutive months referenced in Point 7. However, once a benefit suspension ends, the count will resume and the months accumulated prior to suspension will be applied to the total number of consecutive months.

10. Where wage loss benefits are interrupted for reasons other than suspension and are subsequently reinstated, the months accumulated prior to the interruption will not be applied to the 24 month qualifying period.
11. Sections 70(5) and 75 of the Act do not apply to the calculation of average weekly earnings for a dependent spouse's compensation under Section 83 of the Act.

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<td>Application</td>
<td>All claims commencing after 1 January 1983</td>
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4.1.13 Offset of Canada or Quebec Pension Plan Disability Benefits (POL 24/2013)

Document Date 18 December 2013

Purpose To establish guidelines for deducting Canada or Quebec Pension Plan (CPP/QPP) Disability Benefits from loss of earnings benefits.

DEFINITION

Periodic Benefits means benefits relative to the death or injury of a worker that the worker or the worker’s surviving spouse is entitled to receive from Employment and Social Development Canada (ESDC – Service Canada) under the Canada Pension Plan or the Quebec Pension Plan (e.g., Disability Benefits, Survivor’s Pension).

Offset means deducting CPP/QPP Disability Benefits from loss of earnings (wage loss) benefits.

BACKGROUND

1. An injured worker or the worker’s surviving spouse may be entitled to both wage loss benefits under The Workers’ Compensation Act, 2013 (the “Act”) and CPP/QPP benefits under the Canada Pension Plan for the same period of entitlement.

2. In accordance with Section 95 of the Act, offset of CPP/QPP benefits is to be effective on the anniversary of the commencement of loss of earnings resulting from the injury. After this date, 50 percent of the worker’s or the worker’s surviving spouse’s periodic benefits are to be considered as wages that the worker is capable of earning for the purposes of:
   a. calculating the compensation to be paid by the WCB for loss of earnings; or
   b. determining the worker’s surviving spouse’s entitlement.

3. Sections 70(5), 74, 75, 77, and 81(1)(b) of the Act refer to minimum compensation benefits payable as a result of a work injury. WCB interprets these provisions to mean there should be a minimum level at which no offset of CPP/QPP benefits occurs. Where full offset reduces benefits to below the minimum compensation level, only a partial offset will occur.

4. Awards and allowances also exempt from any offset of CPP/QPP benefits include:
   a. Permanent functional impairments (Section 66).
   b. Independence allowance (Section 67).
   c. Dependent children allowance (Sections 83, 84, 85 and 89).
5. CPP/QPP benefits accrue separately to dependent children of an injured or deceased worker. The practice of both the Canada and Quebec Pension Plans are to pay children’s benefits to the worker or surviving spouse until the child reaches 18 years of age. Thereafter, CPP/QPP benefits are paid directly to the child.

6. CPP/QPP rate increases are calculated each January by ESDC using the Consumer Price Index (CPI). Wage loss benefits are adjusted during the annual benefit review on the anniversary date of the commencement of loss of earnings using the average percentage increase of the all-items Consumer Price Indices for Regina and Saskatoon (Sections 2(1)(i) and 69).

7. For workers or surviving spouses who were not eligible for a CPI adjustment to their wage base due to the maximum wage rate under the former Act, deducting an increased CPP/QPP offset would result in decreased benefits. The Board considers this reduction to be unfair to the worker. Therefore, it is the Board’s intent that for these workers, the CPP/QPP offset will continue at the level set prior to their annual review. The CPP/QPP offset will only increase if the worker or surviving spouse qualifies for an increase in their wage base due to an increase in the maximum wage rate.

POLICY

1. Canada or Quebec Pension Plan benefits (CPP/QPP benefits) will be considered wages the worker or the worker’s surviving spouse is capable of earning.

2. WCB will offset 50 percent of the CPP/QPP benefits a worker or the worker’s surviving spouse receives as a result of the work injury.
   a. For a worker, offset will be effective on the first anniversary of the commencement of loss of earnings.
   b. For the surviving spouse, offset will be effective on the first anniversary of the spousal benefits (POL 33/2010, Initial Entitlement and (Re)Employment Assistance – Dependent Spouses).

Indexing

3. Adjustments in the calculation of wage loss benefits because of an increase to the worker’s CPP/QPP benefits will occur during the worker’s or the worker’s surviving spouse annual benefit review. This review is completed on the anniversary date of the original commencement of loss of earnings.

4. Wage loss benefits indexed for annual CPI adjustments are not to exceed the maximum wage rate at the time of calculation (POL 08/2015, Maximum Wage Rates). Where the CPI adjustment is limited during the annual benefit review, partial offset of CPP/QPP benefits will occur.
5. In situations where the worker’s or the worker’s surviving spouse benefits were not subject to a full CPP/QPP offset at the previous review due to the maximum wage rate, the CPP/QPP offset will be adjusted at the current review to reflect only the latest CPP/QPP rate increase.

6. If a worker qualifies for CPP/QPP benefits and is in receipt of WCB estimated wage loss benefits (less than full benefits), the amount of CPP/QPP offset will be pro-rated.

**Minimum Compensation**

7. Wage loss benefits will not be subject to CPP/QPP offset where minimum compensation or actual earnings, if less, is payable. Partial offset will occur if full offset would reduce WCB benefits below minimum compensation.

**Dependents**

8. Only CPP/QPP benefits payable to the worker or worker’s surviving spouse may be offset. Any CPP/QPP benefits payable to dependent children are exempt.

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**Act Sec #** 2(1)(i), 66, 67, 69, 70(5), 74, 75, 77, 81(1)(b), 83, 84, 85, 89, 95

**Effective Date** 01 January 2014

**Application** All claims

**Supersedes**
- POL 01/2012 Offset of Canada or Quebec Pension Plan Benefits
- POL 05/2011 Maximum Earners – Consumer Price Index and Canada Pension Plan Benefits

**Complements**
- PRO 24/2013 Offset of Canada or Quebec Pension Plan Disability Benefits
- POL 08/2015 Maximum Wage Rates
- POL 03/2007 Calculation of Net Compensation Payable
4.1.15 Provincial Minimum Wage, Effect of Increase (POL 26/90)

Document Date 15 August 1990

Purpose To stipulate adjustment to earnings replacement due to increase in the provincial minimum wage.

POLICY

Any adjustment in the calculation of loss of earning capacity because of an increase in the provincial minimum wage will occur effective the date of that increase.

Act Sec # 69(1)
Effective Date 15 August 1990
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All Claims
Supersedes n/a
Complements n/a
4.1.16 Adjusting Original Wage – Injuries Before 1980 (POL 03/2015)

Document Date 16 March 2015

Purpose To show how to adjust the original wage base of a worker injured before 1980.

DEFINITION

Average weekly wage is determined by the Workers' Compensation Board (WCB) for a calendar year. The average weekly wage is Saskatchewan's industrial composite wage published by Statistics Canada as of June of the preceding year (Section 2). Original wage means the worker's wage at the time of injury.

BACKGROUND

Section 76 of The Workers’ Compensation Act, 2013 (the “Act”) allows the WCB to adjust a worker’s original wage if the worker:


b. Is under age 65 in 1983, and

c. Receives earnings loss benefits on or after January 1, 1983.

POLICY

1. From the year of injury to 1979, the WCB will increase the original wage by the percentage change in the average weekly wage.

2. On the date of injury each year after 1979, the WCB will increase the original wage by changes in the Consumer Price Index (CPI).

Act Sec # 2(1)(b), 69(2), 72, 76, 95
Effective Date 01 May 2015
Application Workers under the age of 65 on January 1, 1983, injured prior to January 1, 1980, that qualify for earnings loss entitlement after January 1, 1983 and are under the age of 65.

Supersedes POL 24/83 Annual Review of Former Act Workers
Complements PRO 03/2015 Adjusting Original Wage – Injuries Before 1980
PRO 60/2015 Consumer Price Index (CPI) – Annual Increase
POL 07/2013 Consumer Price Index (CPI) – Annual Indexing
POL 08/2015 Maximum Wage Rates
POL 24/2013 Offset of Canada or Quebec Pension Plan Disability Benefits

Benefits to Worker – Benefit Calculations Section 4 – Page 33
Doc # 4.1.16 Adjusting Original Wage – Injuries Before 1980 (POL 03/2015)
4.1.17 Permanent Disability Lump Sums, Deducting (POL 01/85)

Document Date 12 February 1985

Purpose To establish guidelines for deducting previous permanent disability awards from current entitlements.

BACKGROUND

Board Members do not interpret the Act to require bringing the dollar value of lump sums and pension commutations to current levels during the application of subsection (7) of Section 76.

POLICY

1. Only the actual dollar value of the lump sum or commutation at the time it is paid is to be deducted.

2. On affected claims, retroactive adjustment to the anniversary date in 1983 is to be made at the next annual review of entitlement provided for by subsection (7) or earlier if it is possible to identify them before that review.

Act Sec # 76(7)
Effective Date 12 February 1985
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All affected future claims
Supersedes n/a
Complements POL 11/2010 Pension Commutation
4.1.18 Payments Provided at Expense of Employer (POL 52/82)

Document Date 14 December 1982

Purpose To establish guidelines for treatment of disability insurance payments provided wholly at employer’s expense.

BACKGROUND

Some employers, wholly at their expense, provide disability insurance for their workers.

POLICY

The Board will continue to regard this as “or other allowance” and not duplicate payment for any period covered by the insurance.

Act Sec # 96
Effective Date Immediately
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act 2013
Application All Claims
Supersedes n/a
Complements n/a
4.1.19 Benefits – Clients in Transition from WCB to SGI Benefits (POL 06/2009)

Document Date 30 July 2009

Purpose To ensure workers continue to receive benefits from the Workers’ Compensation Board (WCB) after a non-work-related motor vehicle accident, until the worker can establish benefits with Saskatchewan Government Insurance (SGI).

BACKGROUND

1. Occasionally, workers receiving benefits from the WCB are involved in non-work-related motor vehicle accidents that result in injury. This situation may result in the worker being caught between the compensation systems of the WCB and SGI.

2. Section 202(7) of The Automobile Accident Insurance Act (the “AAIA”) outlines the responsibilities of both the WCB and SGI for the payment of benefits to workers.

3. Although there are no provisions in The Workers’ Compensation Act, 2013 (the “Act”), the WCB has the implied authority as a public corporation to enter into a Memorandum of Agreement for the Benefit Determination Process with SGI.

POLICY

Where WCB is First Payer

1. According to the Memorandum of Agreement for the Benefit Determination Process between SGI and the WCB, where a worker is receiving WCB benefits and sustains another injury as a result of a non-work-related motor vehicle accident, and due to that latter injury the worker becomes entitled to SGI benefits:

   a. SGI and the WCB will:
      i. Make a joint decision based on all medical information available regarding which injury is the primary disabling factor and, as a result, which agency will be responsible for issuing benefits; and
      ii. Pay compensation in proportion to the attribution of the worker’s injuries.

   b. Where the WCB has issued benefits to the worker as a result of the non-work-related injury, the WCB will request a refund from SGI where appropriate.

2. When required, the WCB will continue to be the first payer of benefits until a joint decision with SGI can be made.
Where SGI is First Payer

3. Where the worker sustains a work injury after being injured in a non-work-related motor vehicle accident, the worker’s claim for WCB benefits shall be adjudicated in accordance with POL 01/2000, Pre-Existing Conditions – Section 49.

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<td>01/09/2009</td>
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4.1.20 Compensation Rate – Casual and Seasonal Employment – Section 70(4) (POL 35/2010)

Document Date 17 November 2010

Purpose To establish the wage base for part-time, casual, and seasonal workers.

DEFINITION

**Average weekly earnings**, as determined by Section 70(1) of *The Workers’ Compensation Act, 2013* (the “Act”), means the greater of:

a. One fifty-second of the worker’s earnings for the 12 months preceding the commencement of the worker’s loss of earnings resulting from the injury; and

b. The rate of daily, weekly, monthly or other regular gross earnings that the worker was receiving at the commencement of the worker’s loss of earnings resulting from the injury converted, in the case of a daily, monthly or other rate that is not a weekly rate, to a weekly amount.

**Gross earnings** means the worker’s earnings from all sources of employment, before all deductions, within an industry under the scope of the Act or for which coverage has been elected.

**Average gross earnings** means the worker’s gross earnings, divided by the number of weeks in a particular period of time.

**Regular gross earnings** means the daily, weekly, monthly or other gross earnings a worker normally received prior to the commencement of the loss of earnings (e.g., agreement of hire typically requires the worker to work and be paid for 40 hours per week at $25.00 an hour).

**Casual worker** means a person who works full or part-time normally for a period of less than three months usually to meet peak or periodic demands. Those who work at holiday periods, during stocktaking or on call would qualify as casual workers.

**Part-time worker** means a person who regularly works less than 30 hours per workweek.

**Seasonal worker** means a person who works full or part-time for a period of more than three months but less than one year. This typically occurs in such industries as farming, forestry, oil drilling, construction and maintenance for municipalities, towns and villages that are busiest during periods of favourable weather.

**Persons regularly employed in the same grade of employment** means similar workers in the same industry working under the same terms and employment pattern as
the injured worker. In other words, workers in the same job classification working under the same conditions for the same pay and for sufficient time to accurately determine a typical annual gross earning level. Examples are seasonal woodcutters, seasonal grader operators and farm labourers.

**Inequitable**, in relation to Section 70(4) of the Act, means compensation benefits that do not accurately reflect the worker’s loss of earnings (e.g., seasonal positions where an average of the worker’s earnings over a short period of time does not accurately reflect the amount of long term earnings expected for the type of employment). An equitable earnings loss benefit rate is fair and reasonable in considering all the circumstances of a particular case (i.e., the worker’s employment history, pattern, employment status, etc.). Consequently, it is important that each case is judged on its own merit when determining an equitable compensation rate since many cases will not conform to usual circumstances.

**BACKGROUND**

1. Section 68(1) of the Act directs that if an injury to a worker results in a loss of earnings beyond the day of the injury, the Workers' Compensation Board (WCB) shall determine the loss of earnings resulting from the injury and shall ensure compensation to the worker:
   a. In the case of a worker who sustained an injury prior to September 1, 1985, in an amount equal to 75 percent of that loss of earnings; or
   b. In the case of a worker who sustained an injury on or after September 1, 1985, in an amount equal to 90 percent of that loss of earnings.

2. Section 70(4) of the Act states that in determining the average weekly earnings of a worker, the WCB shall take into consideration the average earnings, as determined by the WCB, that were earned by a person regularly employed in the same grade of employment if:
   a. The worker was not available for employment for the full period of 12 months preceding the commencement of his or her loss of earnings resulting from the injury; or
   b. In the opinion of the WCB, it is inequitable, by the casual nature or the terms of the worker’s employment, to compute the worker’s average weekly earnings in accordance with subsection (1).

3. Establishing a wage rate for part-time, casual and seasonal workers is a challenging process, as these workers are typically not employed for the full 12 months prior to commencement of earnings loss or recurrence of injury, which sometimes leads to inequitable earnings loss compensation. Therefore, a policy is required that clarifies the intent of the WCB to base compensation benefits on what will most fairly and accurately represent the worker's initial and long-term loss of earnings.
POLICY

Initial Compensation

1. Upon the commencement of earnings loss resulting from an injury, workers will qualify for wage loss benefits. These benefits will normally be based on the regular rate of pay or gross earnings that the worker was receiving over the 52-week period prior to the commencement of earnings loss or recurrence of injury. POL 29/2010, Establishing Initial Wage Base, will apply.

2. Where there are no regular gross earnings to establish earnings loss under Section 70(1) of the Act (e.g., commissioned sales persons who have worked only a few days or weeks and have no sales yet), Section 70(4) of the Act may be applied to establish an initial wage base that would more appropriately reflect the worker’s loss of earnings.

3. If the application of Section 70(4) of the Act supplies a lower rate of benefits than an average of the worker’s earnings over the period 52 weeks prior to the commencement of loss as called for by Section 70(1), the average of the 52-week period will apply.

4. There may be situations where using the rate of pay at the commencement of loss or the 52-week period prior to the commencement of earnings loss to calculate the worker’s wage rate would be inequitable. Therefore, the WCB will ensure that each claim is adjudicated on its own merit to calculate an equitable wage rate. Consideration will be given to the worker’s employment history and pattern, employment status with the injury employer and gross earnings over a period of time that more appropriately reflects to the worker’s loss of earnings.

Review of Compensation

5. Where the worker is employed in seasonal, casual or part-time work and has been in receipt of wage loss benefits for a total of 26 weeks (consecutive or cumulative), the WCB may adjust the initial wage rate to more fairly and accurately reflect the injured worker’s long-term regular gross earnings and employment pattern.

6. Where the initial earnings loss calculated using Section 70(1) of the Act is considered inequitable for calculating entitlement, benefits will be recalculated based on the provisions of Section 70(4) of the Act. Consideration may be given to the average gross earnings and employment pattern of a worker performing the same work with the same employer, or where there is no such person, a worker in the same class of employment in the same industry.

7. Where the wage rate is recalculated to reflect the worker’s long-term average gross earnings, the revised wage loss benefits will become effective the first workday of
the 27th week of wage loss benefits. Recalculation will not occur prior to advance notification.

Recurrence of Injury

8. Where a worker is employed in seasonal, casual or part-time work at the time of a recurrence, and the calculation of a wage rate using the provisions of Section 70(1) of the Act is considered inequitable, the wage rate used will be based on the provisions of Section 70(4) of the Act. If the wage rate established in conjunction with the initial commencement of loss supplies a higher rate, the initial wage rate will be used.

Act Sec # 18, 20, 23, 68, 70(1), 70(4)
Effective Date 01 January 2011
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All claims for casual, part-time and seasonal workers.
Supersedes POL 10/2003 Average Weekly Earnings – Section 70(4)
POL 29/2010 Compensation Rate – Casual and Seasonal Employment – Section 70(4)
POL 24/2013 Offset of Canada or Quebec Pension Plan Disability Benefits
POL 18/87 Compensation Rate – Excluded Earnings
POL 08/2007 Compensation Rate – Where no earnings at disablement or death
POL 08/2015 Maximum Wage Rates
PRO 58/2015 Minimum Average Weekly Earnings – Section 70(5)
PRO 57/2015 Minimum Compensation – Section 75
4.1.21 Consumer Price Index (CPI) – Annual Indexing (POL 07/2013)

Document Date 05 November 2013

Purpose To provide the process for adjusting compensation in accordance with annual CPI percentage increases.

BACKGROUND

1. Section 69(1) of The Workers’ Compensation Act, 2013 (the “Act”) states that the “calculation of the loss of earnings for the purposes of subsections 32(2) and 68(1) and Sections 71 and 72 must be based on the difference between:

(a) the worker’s average weekly earnings at the commencement of the worker’s loss of earnings resulting from the injury, adjusted annually by the percentage increase in the Consumer Price Index; and

(b) the weekly earnings that the worker is receiving from employment."

2. Section 69(2) of the Act states “for the purposes of subsection (1), the percentage increase in the Consumer Price Index must be the percentage increase for the 12 months ending on November 30 in each year, and that percentage increase must be applied to the average weekly earnings of the worker on the anniversary date of the commencement of the worker’s loss of earnings resulting from the injury in the year following the year in which the calculation is made.”

3. Section 69(3) of the Act states “notwithstanding subsections (1) and (2), if the result of an adjustment pursuant to clause (1)(a) is to make the worker's average weekly earnings for a year greater than one fifty-second of the maximum wage rate for that year, the worker's average weekly earnings must be set at one fifty-second of the maximum wage rate.”

4. Section 72 of the Act states that “if an injured worker returns to full employment and afterwards suffers a recurrence of the injury, the compensation payable to the worker must be based on the positive difference, if any, between:

(a) the amount that is the greater of:

(i) the worker’s weekly earnings at the time of the commencement of the worker’s loss of earnings resulting from the injury when the injury was initially sustained; and

(ii) the worker’s weekly earnings at the time of the worker’s loss of earnings resulting from the recurrence of the injury; and

(b) any compensation the worker is already receiving with respect to that injury.”
POLICY

1. The annual review date on claims made under legislation in effect prior to January 1, 1980 is always the anniversary of the date of injury. The annual review date on claims made under the Act is always the anniversary of the date of the original commencement of loss.

2. The applicable CPI percentage increase is as of November 30 in the year immediately preceding the annual review date.

3. Eligibility for a CPI percentage increase is not dependent on compensation being paid continuously with no interruptions throughout the 12 month period leading up to the first annual review date or subsequent review dates.

4. Suspension does not disqualify CPI adjustments if the annual review date occurs during the period of suspension. No compensation is paid during suspension, but the adjustment in compensation triggered by the annual CPI percentage increase is applied when compensation payments are recommenced.

5. Where an injured worker returns to full employment and thereafter is eligible for benefit reinstatement, compensation will be payable in accordance with Section 72 of the Act. Compensation payable to the worker will be the greater of the worker’s:
   a. Weekly earnings as of the date of injury (injury prior to January 1, 1980) adjusted for annual CPI percentage increases; or
   b. Weekly earnings as of the date of the original commencement of loss (injury on or after January 1, 1980) adjusted for annual CPI percentage increases; or
   c. Subject to POL 06/80, Compensation Rate – Recurrence, the average weekly earnings at the time of the most recent recurrence of the injury.

6. When workers have not been in receipt of a recurrent wage base for a full year prior to the annual review date, the CPI adjustment will be prorated. The proration will be based on the number of months between the date of recurrence and the annual review date. The number of months will be based on a full month calculation (not reduced to days within a month). The count begins with the month in which the recurrence takes place, whether it is the first day or any other day of that month, and excludes the month of the annual review date.

7. Adjustments to compensation benefits and other allowances that are based on the CPI increase can be implemented on the written instruction of the Chief Executive Officer.

8. Compensation adjusted for annual CPI percentage increases is not to exceed the maximum wage rate at the time of calculation (POL 08/2015, Maximum Wage Rates). Apart from increases called for by POL 08/2015, the maximum wage base is
not subject to indexing. The original wage base, adjusted to date, is to be compared with current maximums at the time of each review.

ATTACHMENTS

CPI Adjustment Example

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<td>POL 06/80 Compensation Rate – Recurrence</td>
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</tbody>
</table>
CPI Adjustment Example

01 Jan 1980  Original commencement of loss
01 May 1980  Return to full employment compensation ends
01 Sept 1980 Recurrence with greater than original earnings
01 Jan 1981  CPI review date.

The prorating count is September through December equalling 4/12 of the 1980 CPI percentage increase, which is to be applied to the recurrent earnings in order to arrive at the amount of recurrent earnings indexed. This amount is to be compared to the original wage base adjusted to date. Compensation payable to the worker is the greater of the worker’s:

- Weekly earnings as of the date of the original commencement of loss adjusted for annual CPI percentage increases; and
- Average weekly earnings at the time of the recurrence of the injury adjusted for annual CPI percentage increases.
**4.1.22 Compensation Rate – Recurrence (POL 06/80)**

**Document Date** 07 January 1980

**Purpose** To establish guidelines for setting wage base on recurrence.

**BACKGROUND**

Section 76(2) of *The Workers’ Compensation Act, 2013* states that “any workers receiving compensation pursuant to any former *Workers’ Compensation Act* are, on the coming into force of this Act, to receive all benefits pursuant to this Act other than those benefits pursuant to sections 66 and 73.”

**POLICY**

1. Benefits under Section 72 (recurrence) qualify in this respect.

2. When workers return to full employment and thereafter suffer a recurrence, they are entitled to the better of their earnings at the time of original injury or their earnings at the time of recurrence, less any compensation the worker is receiving in respect of that injury.

3. Workers are not able to qualify for a higher income ceiling merely by reporting to work for a very short while and filing for recurrence benefits. There must be a clear indication of returning to full employment and losing the new earnings level because of recurrence.

**Act Sec #** 66, 72, 73, 76

**Effective Date** 07 January 1980

**Amended** References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

**Application** All claims

**Superseded** n/a

**Complements** *POL 07/2013 Consumer Price Index (CPI) – Annual Indexing*
4.1.23 Benefits on Concurrent Claims (POL 22/2010)

Document Date 24 August 2010

Purpose To establish guidelines on how to provide compensation to workers that experience concurrent earnings loss claims.

DEFINITION

Earnings means the worker’s earnings from all sources of employment, prior to any deductions.

Average weekly earnings, as determined by Section 70(1) of The Workers’ Compensation Act, 2013 (the “Act”), means the greater of:

a. One fifty-second of the worker’s earnings for the 12 months preceding the commencement of the worker’s loss of earnings resulting from the injury; and

b. The rate of daily, weekly, monthly or other regular gross earnings that the worker was receiving at the commencement of the worker’s loss of earnings resulting from the injury converted, in the case of a daily, monthly or other rate that is not a weekly rate, to a weekly amount.

Adjusted earnings, for the purposes of this policy, means earnings used in the calculation of benefits, subsequent to increases called for by Section 70(5) or 69(2) of the Act.

Net earnings means earnings minus probable deductions called for by Section 2(1)(k) of the Act (i.e., income tax, Canada Pension Plan premiums, and employment insurance premiums).

BACKGROUND

1. The intent of creating policy directed towards concurrent earnings loss claims is to avoid instances of overcompensation where workers have two or more concurrent claims, one of which is subject to Section 70(5) or Section 69(2) of the Act.

2. Section 68(1) of the Act directs that where injury to a worker results in a loss of earnings beyond the day of the injury, the WCB shall determine the loss of earnings resulting from the injury and shall ensure compensation to the worker.

3. Section 69(2) of the Act requires that the percentage increase in the Consumer Price Index must be the percentage increase for the 12 months ending on November 30 in each year, and that percentage increase must be applied to the average weekly earnings of the worker on the anniversary date of the commencement of the
worker's loss of earnings resulting from the injury in the year following the year in which the calculation is made.

4. Section 69(3) states that any adjustment will be subject to the maximum wage rate for that year.

5. Section 70(5)(b) of the Act states if a worker is injured on or after January 1, 1980 and is in receipt of compensation for a period of at least 24 consecutive months, the worker's average weekly earnings on and from January 1, 1983, are deemed to be not less than two-thirds of the average weekly wage as of June in the year preceding the year in which the review respecting his or her compensation occurs.

POLICY

1. The sum of earnings loss benefits from all concurrent earnings loss claims are not to exceed the equivalent of full earnings loss benefits on the initial claim.

2. Where the worker has two or more concurrent earnings loss claims and has been in receipt of earnings loss benefits for 24 consecutive months on the most current claim, the earnings on that claim may be adjusted in accordance with Section 70(5) of the Act.

3. Where the adjusted earnings on the most current claim increases above the earnings deduction on the initial claim, either due to the application of Section 70(5) or Section 69(2) of the Act, earnings loss benefits on the initial claim will be based on the difference between 90 percent of the net adjusted earnings on the initial claim and 90 percent of the net adjusted earnings on the most current claim.

Act Sec #
2(1)(a), 2(1)(k), 68(1), 69(2), 69(3), 70(1), 70(5), 101
Effective Date
03 February 2012
Amended
References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application
Clients with two or more concurrent claims, one of which is subject to Section 70(5) or Section 69(2) of the Act, on and after the effective date
Supersedes
n/a
Complements
PRO 22/2010 Benefits on Concurrent Claims
4.2 Allowances
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4.2.1 Allowance – Personal Care (POL 10/2014)

Document Date 25 June 2014

Purpose To establish personal care allowances (PCA).

DEFINITION

Personal care means the care a worker needs in relation to:

- Hygiene.
- Dressing.
- Mobility.
- Feeding, and
- Supervision.

BACKGROUND

1. The Workers’ Compensation Act, 2013 allows the WCB to provide personal care allowances (PCA) to injured workers (Section 79).

2. The WCB can take any measures necessary to (Section 111):
   a. Help workers return-to-work.
   b. Lessen work-related disabilities.
   c. Help dependent spouses become self-sufficient.

3. The WCB may pay for any medical aid or treatment that the worker needs because of an injury (Section 115).

POLICY

1. The WCB provides PCAs to workers that have temporary or permanent physical or cognitive needs because of a work injury.

2. All decisions concerning PCA will be confirmed in writing.

3. If the worker’s personal care requirements are serious or unique enough, additional special care costs may be considered. If a family member of the injured worker is qualified to provide the needed care and the health care provider has no objection to this, the WCB will acknowledge them as able.
4. The WCB will annually adjust PCAs by yearly changes to the Consumer Price Index (CPI). POL 07/2013, CPI – Annual Indexing and PRO 60/2015, CPI – Annual Increase will apply.

5. If the worker is in the hospital, the WCB will suspend PCA if the worker stays for more than 30 consecutive days.

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<td>POL 15/2008</td>
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DEFINITIONS

Additional expense is an out-of-pocket expense incurred by a worker for the provision, repair or replacement of an orthotic/appliance.

Orthotics/Appliances include, but are not limited to, orthopaedic footwear, eyewear, hearing aids, dentures, artificial limbs, artificial eyes, belts, braces and supports.

Orthopaedic footwear refers to footwear prescribed by a health care professional and is specifically manufactured or custom-made as a functional aid necessitated by a work injury. Ordinary “good quality footwear” that is designed for everyday use and can be purchased in a retail store is not considered orthopaedic footwear.

Lenses for the purposes of this policy include contact, prescription, safety and clip-on lenses worn by the worker.

Authorizing Agent means a Claims Entitlement Specialist, Case Manager, or Vocational Rehabilitation Specialist who is authorized to approve orthotic/appliance expenses for injured workers on behalf of the Workers’ Compensation Board (WCB).

BACKGROUND

1. The purpose of reimbursing orthotic/appliance expenses is to ensure workers do not incur additional expenses for the provision, repair and replacement of such devices.

2. Section 103(1)(a) of The Workers’ Compensation Act, 2013 provides that any injured worker who is eligible for WCB benefits is also entitled to receive, without charge, any orthotics/appliances (e.g., prosthetic limb, orthopaedic shoes) required due to the effects of a work injury, as well as replacement or repair of such a device necessitated by normal wear and tear.

3. Section 109(a) of the Act provides that the WCB may assume the expense of “replacing or repairing any prosthetics or apparatus, including broken dentures, eye glasses, artificial eyes or prosthetic limbs when breakage is caused by an accident or injury in the course of the worker’s employment”.

Additional information and guidelines for eligibility and approval process are available in the WCB’s Compensation Manual and polices.
4. Personal responsibility for ordinary maintenance (e.g., cleaning, proper fitting, storage) does not end while the worker is engaged in his/her employment duties.

POLICY

Section 103(1)(c) – Originating from the Work Injury

1. The WCB will provide the original orthotic/appliance, where the following factors are met:
   a. The need was caused by the compensable work injury;
   b. It is to be used as a treatment or functional aid during the worker’s recovery period or as a functional aid on a temporary or ongoing permanent basis; and
   c. It must be prescribed or recommended by the worker’s treating physician or a licensed health care professional as listed in Schedule 1 of POL 05/96, Health Care Services.

2. With respect to the orthotics/appliances provided based on the criteria set out in Point 1, the WCB will also be responsible for any repair or replacement due to ordinary wear and tear, loss or accidental damage, whether work-related or not, as long as the worker requires the device because of the injury, and providing the expense is not the result of the wilful destructive conduct by the worker.

Section 109(a) – Not Originating from the Work Injury

3. Where orthotics/appliances are required for reasons other than the compensable injury, entitlement is based on the determination of whether an injury causing damage or loss occurred in the course of employment versus personal responsibility (e.g., cleaning, proper storage).

4. Where an orthotic/appliance is required for reasons other than the compensable injury but a subsequent work injury necessitates modification of the orthotic/appliance, the WCB is responsible for the modifications, repair or replacement of the orthotic/appliance, and the associated costs.

General

5. All orthotic/appliance expenses must be pre-approved by the appropriate authorizing agent on behalf of the WCB. Workers will be advised in advance of the expenses that will be allowed. Where the expense approved is less than the amount claimed by the worker, reason(s) will be provided in writing.

6. Entitlement will be determined on the basis of whether the worker has encountered additional expense as a result of the provision, repair or replacement of the orthotic/appliance.
7. Entitlement covers the cost of medical examination including refraction.

Coverage – Replacement/Repair

8. The following examples set out WCB principles as to the acceptance of claims for damage or loss to orthotics/appliances:

a. Care
   i. The worker performs routine maintenance on the orthotic/appliance while in the course of employment (and nothing about the employment caused the need for cleaning). The orthotic/appliance is then damaged or lost as a result of the worker’s actions (e.g., worker drops the orthotic/appliance on the floor) rather than an intervening work-related cause. This is ordinary maintenance, a personal responsibility, with no work-related injury. Claim for reimbursement is unacceptable.
   
   ii. An injury occurs during the course of employment (e.g., bumped by a co-worker), either while cleaning the orthotic/appliance as a result of the work environment, or while conducting normal/routine care of the orthotic/appliance. In both situations, the damage is work-caused. The claims are acceptable.

b. Fit/Storage
   i. Damage to orthotics/appliances is caused by improper fit or storage while engaged in a movement or action common to both employment or otherwise. Proper fit and storage is a personal responsibility. Claim is unacceptable.
   
   ii. Orthotics/appliances with proper fitting and storage are damaged in an uncommon or unusual event occurring during employment. Damage is due to a work-related injury. Claim is acceptable.

c. Cumulative Damage
   i. Orthotics/appliances damaged over a period of time from lack of proper protection is a personal responsibility. Claim is unacceptable.

9. Entitlement is based on reasonable repair or replacement of the orthotic/appliance, which was in the worker’s possession at the time of damage. The WCB is not responsible for additional cost based on worker’s preference (e.g., worker requests protective coating for eyeglasses, which the original pair did not have).

10. In accordance with Point 7 above, entitlement for repair or replacement expenses covers the cost of medical examination including refraction.

Eyewear

11. Where the worker sustains a work injury requiring corrective eyewear (or a change in his/her current prescription), entitlement is to include the actual costs of lenses
and up to the maximum allowable for frames as set out in PRO 60/2015, as well as replacement or repair necessitated by normal wear and tear.

12. Where the worker wore eyewear (i.e., eyeglasses, contact lenses) prior to the injury, which is subsequently damaged or lost as a result of a work injury, entitlement is to include the actual costs of lenses and up to the maximum allowable for frames. WCB responsibility is restricted to one pair of eyewear only.

13. Coverage for replacement or repair of eyewear is to be considered on a case-by-case basis, given that wear and tear will vary depending on the injury, prescription changes and/or type of employment.

Footwear

14. The decision to provide orthopaedic footwear or to modify the worker’s existing footwear will be assessed on a case-by-case basis with reasonable input from the worker.

Modification of Existing Footwear

15. Where modification of existing footwear is required due to the effects of a work injury (e.g., to accommodate a brace), the WCB will cover the cost of the initial and subsequent modifications.

Purchase and Repair of Footwear

16. Where the worker’s existing footwear is of insufficient quality to accommodate modifications, the WCB will cover the full cost of one pair of footwear sufficient for modification. Where existing footwear becomes prematurely worn due to the use of an orthotic/appliance, the WCB will also cover the costs for the repair or replacement of the footwear.

17. Where modified footwear requires repair or adjustment, and the worker is unable to work without this footwear (e.g., while the footwear is being modified), the WCB will cover the full cost of an extra pair of footwear to be used in the interim.

18. Where a work injury creates the need for orthopaedic footwear, the WCB will be responsible for the initial cost, repair and replacement of orthopaedic footwear prescribed by the worker’s treating physician or a licensed health care professional as listed in Schedule 1 of POL 05/96, Health Care Services.

19. Where a worker is unable to wear shoes of the same size (e.g., one foot is larger than the other) as a result of a workplace injury (e.g., crushed foot, burns, severed toes, etc.), the WCB will cover the full cost of both pairs of footwear at the initial purchase. When replacement shoes are required, coverage is limited to reimbursement for one pair of shoes.
20. Where the work injury has necessitated a job change and the worker's existing footwear is of insufficient quality to assist in return to meaningful employment, the WCB may consider reimbursement of the purchase of one good quality pair of footwear available at a retail store.

Leisure/Sports Footwear and Prostheses

21. In situations where a worker requires orthopaedic or modified work footwear that is not suitable for casual or leisure wear or requests a specialized sports prosthesis (e.g., for skiing, swimming), consideration will be granted for the full cost, repair or replacement of the leisure footwear and/or sports prosthesis.

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<td>01 January 2009</td>
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**Application**

All workers requiring orthotics/appliances.

**Supersedes**

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4.2.3 Allowance – Temporary Additional Expense (POL 15/2008)

Document Date 04 November 2008
Purpose To establish guidelines for paying additional, incidental expenses related to the work injury.

DEFINITION

Additional expense is that portion of expense which is over and above what a client incurred while working (pre-injury) and is not covered elsewhere by WCB policy. These expenses may include the following: child-care, care of a family member incapacitated by injury or illness, transportation costs, meal preparation, housecleaning or other general day-to-day home maintenance (e.g., lawn care or snow removal). Home maintenance does not include major renovations to a property or home.

BACKGROUND

1. Section 111(b) of The Workers’ Compensation Act, 2013 (the “Act”) enables the Workers’ Compensation Board (WCB) to authorize assistance to the injured worker not specifically covered elsewhere in the Act that will lessen or remove “any barriers resulting from the worker’s injury.” Section 115 of the Act authorizes the WCB to “expend moneys from the [Injury] fund for any expenses incurred in the administration of this Act”.

2. The purpose of this policy is to assist a worker in maintaining his/her pre-injury status (not to improve upon it). As a result of a work injury and ensuing medical treatment or return-to-work (RTW) programming, clients sometimes incur temporary additional expenses that are over and above what they would normally have paid while working.

3. The eligibility period for clients is usually short-term and based on the nature and severity of the injury. However, additional expenses may be reimbursed where the effects of the injury may be temporary (full recovery is expected) or permanent (a PFI may be awarded in the future).

POLICY

1. Workers may be reimbursed for those additional expenses that arise out of any of the following injury-related circumstances:
   a. The severity of the injury makes it impossible to perform these tasks (e.g., bilateral casts or confinement to a wheelchair);
   b. While convalescing following surgery;
   c. While attending secondary or tertiary treatment centres;
d. While travelling for medical or other appointments;

e. While hospitalized;

f. While participating in RTW programs;

g. While the client requires an attendant for transportation between health care facilities.

2. Only expense(s) that exceed what a worker paid pre-injury is eligible and only to maintain the current standard of living. For example, expenses paid by a worker during his/her normal working hours, such as child care, will not be eligible for reimbursement. However, child care needed during the worker’s non-working hours (e.g., evenings while hospitalized) would be considered an additional expense.

3. While there is no maximum, the amount and duration of reimbursement will not exceed what is reasonable in the circumstances and determined by medical evidence.

4. If the additional expense items identified under this policy are reimbursed through a personal care allowance (POL 10/2014) or independence allowance (POL 27/2010), reimbursement under this policy will be discontinued.

Act Sec # 111, 115
Effective Date 01 December 2008
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All injured workers who as a result of a temporary work injury, as well as those waiting for a PFI assessment, incur additional expenses not covered by any other WCB policy.
Supersedes POL 04/2000 Allowance – Temporary Additional Expense (Child Care, etc.)
Complements PRO 15/2008 Allowance – Temporary Additional Expense
POL 27/2010 Allowance – Independence
POL 10/2014 Allowance – Personal Care
POL 23/2010 Permanent Functional Impairment (PFI) – General
4.2.4 Allowance – Clothing (POL 19/2010)

Document Date 16 June 2010

Purpose To establish guidelines for providing clothing allowances for eligible workers under The Workers’ Compensation Act, 2013.

BACKGROUND

Section 79 of The Workers’ Compensation Act, 2013 (the “Act”) states that the Workers’ Compensation Board (WCB) may pay a worker an allowance in any amount that the WCB considers appropriate for the replacement or repair of clothing worn or damaged by reason of the worker wearing an artificial limb or appliance supplied by the WCB with respect of the worker’s injury and to provide for personal care required as a result of his or her injury.

POLICY

1. Workers are eligible for an allowance for damaged clothing provided for by Section 79 of the Act as the result of:
   a. a prosthetic device for upper, lower or both upper and lower limb amputations;
   b. a rigid back, neck, leg or full-length brace or similar rigid supportive device; or
   c. confinement to a wheelchair as the result of a compensable injury.

2. Initial eligibility for clothing allowance begins as of the date of the provision of the prosthesis, brace or wheelchair. Initial eligibility does not require proof of repair or damage to clothing. Payment in the case of rigid braces or supports is contingent on confirmation of need and the continued wearing of the device.

3. Where the worker requires a rigid brace or support on a temporary basis due to a work injury, clothing allowance will be issued monthly. Payment of clothing allowance on a monthly basis will continue until the brace or support is no longer required.

4. Where the worker permanently requires an appliance, clothing allowance will be paid on an annual basis.

5. Payment of clothing allowance will continue as long as the worker continues to meet the eligibility criteria for an allowance for damaged clothing noted in Point 1. Eligibility for clothing allowance will be reviewed annually on the anniversary date of the commencement of loss.
6. Since both the upper and lower body clothing of workers confined to wheelchairs are susceptible to damage, clothing allowance in such instances will be considered equivalent to upper and lower limb amputations.

7. The annual indexing of clothing allowances is based upon increases in the Regina-Saskatoon All Items Consumer Price Index as of November 30 (rounded to the nearest dollar). Increases are indicated in the Clothing Allowances schedule in the Consumer Price Index procedure, for that applicable year.

8. Where a worker dies after the issuance of an annual clothing allowance payment, and the payment made extends for a period beyond the date of death, no recovery efforts will be made by the WCB.

| Act Sec #   | 79
| Effective Date | 03 February 2012
| Amended | References updated 01 January 2014 in accordance with the Worker’s Compensation Act. 2013
| Application | All workers eligible under Section 79 for the clothing allowance on and after the effective date
| Supersedes | POL 02/2001 Allowance – Clothing
| Complements | PRO 10/2012 Allowance – Clothing
|           | PRO 60/2015 Consumer Price Index (CPI) – Annual Increase
4.2.5  Allowance – Independence (POL 27/2010)

Document Date  07 September 2010

Purpose  To establish guidelines for the payment of independence allowance.

BACKGROUND

Section 67 of The Workers’ Compensation Act, 2013 (the “Act”) provides the Workers’ Compensation Board (WCB) with the discretion to award an independence allowance to workers who sustain severe Permanent Functional Impairment (PFI) resulting from a work injury.

POLICY

General

1. This policy replaces all previous policies concerning Section 67 of the Act.

2. Any determination by the WCB concerning the maximum amount of independence allowance is subject to the law in effect on the date of the decision.

Purpose

3. The purpose of the independence allowance is to assist the worker to pay for additional costs of maintaining a home and or travel costs that will allow the client to maintain a reasonable degree of independence.

4. In all cases, the worker must demonstrate an actual need to have, and pay for, this assistance.

5. The worker’s income, including any other WCB benefits, does not affect eligibility for the independence allowance.

Eligibility – Home Costs

6. Eligible home costs refer to routine periodical (e.g., daily, weekly, seasonal) maintenance activities that are required to maintain a principal residence (e.g., hiring someone to cut grass, remove snow or perform housecleaning). Eligible home costs would include condominium or other accommodation fees that are charged specifically for basic maintenance of the property.

7. Major projects or renovations (e.g., house painting, roof repairs) are not considered eligible home costs for the purposes of this policy as these are costs that are normally incurred at intervals of several years.
8. Workers living in nursing homes, extended care facilities or other special care facilities are not eligible, unless their dependent spouse or children continue to maintain the primary residence, in which case the independence allowance may be paid directly to the dependent spouse or children.

Eligibility – Travel Costs

9. Eligible travel costs include hiring of taxis or other transport services (e.g., Para-transit bus services).

Calculation and Criteria

10. The initial independence allowance will be calculated from, and based on the qualifying criteria in effect on the first of the month following the assessment of a qualifying PFI award (POL 23/2010, PFI – General). Subsequent entitlement to independence allowance will be based on the criteria in effect at the time of the additional entitlement.

11. PFI awards for hearing loss will not be considered when establishing entitlement to independence allowance.

12. The qualifying criteria for an independence allowance are as follows:
   a. Effective: September 1, 1985
      Criteria: unemployability, home or travel costs
      Allowance: 10 percent of PFI maximum
   b. Effective: January 1, 1989
      Criteria: 100 percent PFI, home or travel costs
      Allowance: 10 percent of PFI maximum
   c. Effective: January 1, 1994
      Criteria 1: 40 percent PFI, home or travel costs with receipts, or
      Criteria 2: 10 percent – 39 percent PFI, home or travel costs with receipts
      Allowance 1: 10 percent of PFI maximum, or
      Allowance 2: per receipts up to 10 percent of PFI maximum
   d. Effective: February 1, 1999
      Criteria 1: 40 percent PFI, home or travel costs, or
      Criteria 2: 10 percent – 39 percent PFI, home or travel costs
      Allowance 1: 10 percent of PFI maximum, or
      Allowance 2: **Actual PFI percent** x 10 percent of PFI maximum = Adjusted Amount
      40 percent
e. Effective: January 1, 2003

Criteria 1: 40 percent PFI, home or travel costs, or
Criteria 2: 10 percent – 39 percent PFI, home or travel costs
Allowance 1: 5 percent of PFI maximum, or
Allowance 2: \( \text{Actual PFI percent} \times 5 \text{ percent of PFI maximum} = \text{Adjusted Amount} \)

13. Independence allowances will be paid annually on the anniversary of the commencement of loss of earnings. At each annual payment, the criteria currently in effect for independence allowance are applied.

14. Independence allowance continues during the lifetime of the injured worker, so long as the qualifying criteria are met.

15. An injured worker can receive only one annual independence allowance payment, calculated on the combined total of PFI ratings on one or more claims.

16. Where an additional PFI award is granted, increases to the independence allowance will be based on the qualifying criteria in effect on the date when the additional PFI award was provided. Where increases are effective part way through a year, the increase will be pro-rated from the date of the increase to the date of the existing annual payment. After that initial prorated payment, the full increase will be included in the subsequent annual payment.

17. Where multiple PFI awards have been granted on more than one claim, costs for independence allowance will be prorated among each of the claims based on the percentage of PFI attributable to each claim.

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4.3 Travel & Medical Aid Expenses
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4.3.1 Expenses – Travel and Sustenance – General (POL 39/2010)

Document Date 09 December 2010

Purpose To establish guidelines for the reimbursement of travel and sustenance requirements.

DEFINITION

Additional travel requirement means the portion of travel outside the resident community exceeding the worker’s normal pre-injury employment travel requirement.

Complete work cycle means the number of work days and rest days the worker has over a specific period of time (e.g., there are 28 days in a complete work cycle where the worker works 3 weeks in a row, and has 1 week off).

Normal pre-injury employment travel requirement means the average weekly expenses workers are responsible for or incur prior to a work-related injury (e.g., commuting from their resident community and workplace, meals, accommodation and parking).

Resident community means limits of the city, town, or village in which the worker’s permanent place of residence is located.

BACKGROUND

1. The purpose of the travel and sustenance reimbursement is to ensure workers are reimbursed for additional travel requirements when required to travel outside the resident community to attend medical treatment, vocational programs or other appointments or hearings.

2. The Workers’ Compensation Board (WCB) endorses the principle of equally reimbursing injured workers and WCB employees at Public Service Commission (PSC) rates for travel costs.

3. Section 103(1)(d) of The Workers’ Compensation Act, 2013 (the “Act”) obligates the Board to cover travel and sustenance costs associated with receiving medical treatment for their work-related injury. Further, Section 111 of the Act provides the Board with the authority to provide whatever support it considers necessary in assisting the injured worker in the recovery and return to work process. Accordingly, it is the Board’s policy that it will cover the travel and sustenance costs incurred by an injured worker in attending medical or other appointments required for their recovery and return to work.
4. Section 19(1)(a) requires that the Board treat workers in a fair and reasonable manner. This applies to the individual injured worker as well as all workers in a broad sense and the Board endeavours to create policy that is fair, equitable and reasonable to all workers covered by the Act. It is for this reason that only travel and sustenance costs in excess of travel expenses normally incurred in daily employment activities are covered by this policy.

5. Subject to the following policy, travel for the purpose of medical treatment or vocational training will be reimbursed for the portion exceeding the worker’s normal pre-injury employment travel requirement.

6. Average weekly expenses that a worker normally incurs prior to a work-related injury are determined by totalling a worker’s normal pre-injury employment travel requirement over a complete work cycle, and averaging the sum into a weekly amount.

**POLICY**

1. All travel reimbursements must be pre-approved by the WCB. Workers will be advised in advance of the travel requirements that will be reimbursed. Where the approved reimbursement is less than the amount claimed by the worker, the WCB will provide the worker with a written explanation.

2. Reimbursement will be determined on the basis of whether the worker has additional travel requirements when travelling outside the resident community for medical treatment or vocational rehabilitation programming.

3. Travel requirements incurred by workers attending medical review panels and appeal hearings are reimbursed in full without deduction for normal pre-injury employment travel requirements.

4. Wherever possible, workers must attend the closest available treatment facility or training center. Where the worker chooses to bypass the nearest available treatment facility or training center, only travel to the closest available location will be reimbursed.

5. Unless specialized transportation (e.g., taxi) is required due to medical or other circumstances (e.g., the worker is unable to travel in a private vehicle or use public transit due to injury), no reimbursements will be paid where the place of medical treatment is located in the worker’s resident community. Where the worker does not normally pay for parking to attend pre-injury employment, the WCB may reimburse parking receipts.

6. Where the worker’s normal pre-injury employment travel requirement is solely within the resident community, no deduction will be made from reimbursements for travel requirements outside the resident community.
7. Subject to Point 2, where required to travel outside the resident community, but within Saskatchewan, workers will be reimbursed for additional travel requirements:
   a. Kilometres for private vehicles at PSC rates calculated between city center and city center, or the actual cost of public transportation (e.g., STC bus) plus return taxi from the terminal to medical treatment;
   b. Meal per diems at PSC rates where workers are required to be away from home over normal meal times;
   c. Reimbursement for hotel accommodation supported by receipts where required to be away from the resident community for a 24-hour period. Where private lodging is preferred, the PSC rate for staying at a private home will be reimbursed;
   d. Parking receipts, where not considered a normal pre-injury employment travel requirement.

8. Where off work following an injury, the worker changes their place of residence and required travel results in:
   a. Greater travel requirement than their previous entitlement, an amount equivalent to the original sum remains payable; if lesser travel requirement, the amount payable is reduced accordingly;
   b. The exception to (a) above is where, as a result of the compensable injury, the worker relocates for the purpose of new employment and is still undergoing medical treatment; travel and sustenance is payable from the new place of residence to the treatment facility.

9. Where a worker resumes work following a work-related injury, then changes place of residence and a recurrence requires the worker to travel for medical attention once again, whether or not the worker continues to work after the relapse, the worker’s new place of residence is to replace the original resident community in determining whether additional travel requirement will be reimbursed.

10. Decisions for out of province travel will be based on need and or availability of the required medical treatment or vocational training program within the province.

Out of Province Medical Treatment

11. Where a worker is required to travel out of province to expedite treatment, attend specialist appointments, diagnostics (e.g., MRI and CT scans) and or undergo surgery, the following will apply:
   a. The most economical means of transportation (typically airfare) will normally be reimbursed, plus the actual cost of taxi or specialized transportation to and from airports and hotels, along with travel to and from medical facilities;
b. Where the compensable injury precludes travel by public transportation, PSC kilometre rates for private vehicles will apply; and

c. Meals, accommodation and, where applicable, parking, will be reimbursed in accordance with Point 7.

Captive Employees

12. Captive employees in work camps, or workers temporarily residing in employer paid accommodation near a work site, can incur additional travel requirement over the worker’s normal pre-injury employment travel requirement in two circumstances:

a. Round trips from the camp or place of temporary residence to the nearest medical treatment facility will be covered as an additional travel requirement;

b. Where the worker returns to the permanent place of residence to recuperate, travel to the nearest medical center may be covered only where the nearest medical center is not in the resident community.

13. No responsibility will be accepted for the cost of bringing the worker from the camp or work site back to the resident community to recuperate, nor returning the worker to the camp or work site where fit to resume work, as this is a normal employment travel requirement.

Donors

14. Effective treatment of a serious injury may require a donor (e.g., organ transplant). Where necessary, reasonable transportation and sustenance will be authorized on behalf of the donor, subject to the requirements of the emergency.

15. The donor will be compensated on the basis of actual loss of earnings or the equivalent of minimum compensation whichever is greater, for a period not exceeding four weeks. The WCB may grant additional time by which compensation is payable.

Attendants

16. The WCB may pre-approve travel and sustenance for attendants other than qualified medical personnel where it is considered essential by reason of the worker’s injury and confirmed by the treating physician and or WCB staff.

17. An attendant will be reimbursed on the basis of actual salary loss, but only for the period of time that such attendance was necessary and at a rate not to exceed the maximum wage rate (Section 37 of the Act). No salary loss will be paid where the worker is in receipt of a Personal Care Allowance (PCA).
Vocational Rehabilitation

Commuting to Programs

18. Vocational training programs are typically longer in duration than medical treatment and often located outside the worker’s resident community. To ensure the worker is reimbursed for additional travel requirements, the following will be provided:

a. For travel within a 75 km radius from the resident community (considered a reasonable commute), the following will be provided:
   i. PSC kilometre rates up to a maximum of $190 per week for private vehicles;
   ii. Where public transportation is used, actual costs.

b. At the discretion of the WCB, where a worker’s individual circumstances make commuting a hardship, travel requirements (e.g., meals, accommodations, parking) will be reimbursed. This is normally restricted to short-term programs where relocation is not considered.

Relocation

19. Where the commuting distance exceeds a radius of 75 km and it is cost effective, relocation will be considered (POL 02/2014, Vocational Rehabilitation – Moving Allowance). Where the worker relocates, the following will be provided:

a. A travel and sustenance allowance up to the per month maximum referenced in PRO 60/2015, Consumer Price Index – Annual Increase (includes travel and room/board); and

b. One trip to the resident community per month at PSC mileage rates or the actual cost of public transportation.

20. Should the worker choose to commute rather than relocate, only an amount up to the maximum monthly living allowance (referenced in PRO 60/2015) will be paid.

21. Where the commuting distance is less than a radius of 75 km, workers may be relocated outside of their resident community based on their individual circumstances. Determining factors may include expected duration of the program and or whether the worker’s physical restrictions make commuting a hardship.
### Act Sec #
19(1)(a), 37, 103(1)(d), 111

### Effective Date
03 February 2012

### Amended
References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

### Application
All new and existing claims on and after the effective date

### Supersedes
POL 12/2008 Expenses – Travel and Sustenance – General

### Complements
PRO 39/2010 Expenses – Travel and Sustenance – General
PRO 60/2015 Consumer Price Index (CPI) – Annual Increase
PRO 54/2015 Expenses – Travel and Sustenance – PSC Rates
POL 07/2007 Voluntary Relocation Outside Canada
PRO 07/2007 Voluntary Relocation Outside Canada
POL 02/2014 Vocational Rehabilitation – Moving Allowance
POL 02/2012 Expenses – Travel & Sustenance – PSC Rates
4.3.2 Expenses – Travel and Sustenance – PSC Rates (POL 02/2012)

Document Date 10 January 2012
Purpose To allow for the revision of WCB travel and sustenance rates when changes are made to the PSC Rates.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has traditionally followed the provincial government through the Saskatchewan Public Service Commission (PSC) for travel and sustenance rates. These rates apply to both WCB staff and clients.

2. Prior to December 1996, the Board Members approved all updates to WCB travel and sustenance rates. Thereafter, the Chief Executive Officer (CEO) was provided the designated authority, on behalf of the Board Members, to approve these updates.

POLICY

1. WCB travel and sustenance rates will be updated and approved by the CEO, through a published procedure, when the WCB becomes aware that the PSC has updated their rates. WCB travel and sustenance rates will be rounded to the nearest cent.

2. WCB travel and sustenance rates will be applied on and after the effective date of the procedure. WCB rates may not be effective the same date as the PSC rates.

Act Sec # 16, 18, 115
Effective Date 03 February 2012
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application Travel and sustenance allowances for WCB staff and clients
Supersedes POL 16/96 Expenses – Travel and Sustenance – PSC Rates
Complements PRO 54/2015 Expenses – Travel and Sustenance – PSC Rates
POL 39/2010 Expenses – Travel and Sustenance – General
4.3.4 Reimbursement for Medications (POL 10/2011)

Document Date 13 September 2011

Purpose To establish guidelines for the reimbursement of the cost of medications.

DEFINITION

Medical Aid, as defined in Section 2(1)(v) of The Workers’ Compensation Act, 2013 (the “Act”) means “the provision of medical and surgical aid, of hospital and professional nursing services, of chiropractic and other treatment and of prosthetics or apparatus.”

Opioid, also referred to as an analgesic or narcotic, means a prescribed medication that acts on the central nervous system to decrease the sensation of pain (e.g., codeine, morphine, hydrocodone, or oxycodone).

BACKGROUND

1. Sections 19(1)(b), 31(1), 103(1) and 115(c) of the Act direct the Workers’ Compensation Board (WCB) to provide specialized treatment or medical aid that may be required as a result of a work injury.

2. Prescription and non-prescription medications are to be considered under the definition of medical aid and will be reimbursed if necessary and appropriate for the treatment of the accepted work injury.

POLICY

1. The cost of a prescription medication will be reimbursed if:
   a. it is prescribed by the treating physician;
   b. it is appropriate and needed to treat the accepted work injury; and
   c. the use of the medication corresponds to the indications listed in The Saskatchewan Formulary or The Compendium of Pharmaceuticals and Specialties.

2. Where the relationship between the accepted work injury and the prescribed medication is not readily apparent, a WCB Medical Consultant review will be required.

3. The cost of non-prescription medications will be reimbursed under the following two categories:
   a. Over-the-counter (OTC) Medications
Examples of over-the-counter medications are such things as analgesics (e.g., Tylenol, Advil, etc.) and topical ointments (e.g., polysporin for burns or hydrocortisone (half percent) for dermatitis, etc.). These medications may be sufficient and appropriate for the treatment of the accepted work injury and will be covered if their use is recommended by the treating physician.

b. Alternative Health Products

The cost of alternative health products and substances such as vitamins, nutritional supplements, or herbal remedies will be reimbursed if their use is recommended by the treating physician and is approved by the WCB Medical Consultant. For example, supplementary vitamins may be recommended to improve the energy and well-being of clients with some types of cancer. The objective is to improve the client’s quality of life, which may have been compromised by the accepted work injury.

4. The WCB will reimburse the cost of opioid medication only for the treatment of pain when it is prescribed under the guidelines of the College of Physicians and Surgeons of Saskatchewan’s *General Principles of Appropriate Pain Management with Opioids*.

5. The WCB will not reimburse the costs of obtaining, growing, or using medical marijuana (i.e., the smoked form).

6. The WCB will only provide reimbursement for the cost of marijuana drug derivatives where they are listed in *The Compendium of Pharmaceuticals and Specialties*, are prescribed for the listed indications (e.g., intractable nausea), and are approved by the WCB Medical Consultant.

7. Workers are required to submit original receipts unless the pharmacy sends the bills for the medications directly to the WCB.

8. Operations staff will monitor claims for potential problems of drug overuse or abuse. Where these situations occur, the WCB Medical Consultant will perform a review and determine the appropriate action (i.e., a request for tapering of the drug or refusal to authorize payment).

9. The WCB will reimburse the cost of an opioid drug treatment program or strategy where it is determined that an addiction or dependency resulted from the treatment of the accepted work injury.

**Act Sec #** 2(1)(v), 19(1)(b), 31(1), 103(1), 115(c)
**Effective Date** 01 October 2011
**Amended** References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*
**Application** All claims.
**Supersedes** POL 09/2001 Reimbursement for Medications
Complements

PRO 10/2011  Reimbursement for Medications
PRO 53/2006  Medical Aid Billings – Payment
PRO 07/2012  Procurement Procedure
POL 05/96    Health Care Services
4.4 Permanent Functional Impairment (PFI) & Pensions
4.4.1 Retroactive Pension (POL 61/74)

Document Date 17 December 1974

Purpose To establish guidelines for paying retroactive permanent disability entitlement.

BACKGROUND

A number of claims have been approved with awards for Permanent Disability and with retroactive effect. In some cases, awards have included many years of retrospective compensation despite the absence of medical evidence of continuing disability or reduction in earnings. In some instances it is doubtful if permanent disability benefits would have been payable for such periods under the then-current policy of the Board.

POLICY

Retroactive entitlement to permanent disability compensation shall be granted only where there is:

a. A clearly identifiable disability that has been overlooked;

b. Medical evidence of persisting disability; or

c. Evidence of a reduction in earnings that can be reasonably be attributed to the disability claimed.

Act Sec # The Workers’ Compensation Act, 1974 Section 70
Effective Date 01 January 1975
Amendment References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All Claims
Supersedes n/a
Complements n/a
4.4.2 Pension Commutation *(The Workers’ Compensation Act, 1974) (POL 11/2010)*

**Document Date** 03 March 2010

**Purpose** To establish guidelines for the commutation of pensions under *The Workers’ Compensation Act, 1974*.

### DEFINITION

**Client** means an injured worker or dependants.

### BACKGROUND

1. Section 76(1) of *The Workers’ Compensation Act, 2013* (the “Act”) states that “a permanent award established pursuant to any former *Workers’ Compensation Act* must not be reduced except pursuant to that Act and, notwithstanding the repeal of the former *Workers’ Compensation Act*, the former Act remains in force for the purpose of determining any reduction.”

2. Section 82 of *The Workers’ Compensation Act, 1974* provides as follows:
   
   “The board may, in any case where it deems proper and at any time or times, make or direct partial commutation or lump sum payment of compensation, or otherwise alter the form of payment, as in the circumstances the board deems most for the advantage of the worker or dependant.”

3. Under *The Workers’ Compensation Act, 1974* disability pensions can be commuted. That is, rather than continuing to receive a monthly pension, a client may choose to receive a lump sum payment. The lump sum represents an amount equal to the estimated value of the monthly pension over the remaining lifetime of the recipient.

### POLICY

1. The commutation may be in exchange for all or part of the client’s existing pension.

2. Clients must make requests for commutations in writing, providing the specific reasons for making the request and the amount of their existing pension they wish to commute.

3. Each request will be considered on its own merit subject to the following guiding principles:
   
   a. It is in the client’s best long term interest;
   
   b. There is a genuine need;
c. Other sources of financial aid and counselling have been explored;
d. The pension accounts for less than 50 per cent of the client’s total income. Where the pension accounts for 50 per cent or greater of the client’s total income, the client will not be eligible for a pension commutation in whole or in part.
e. Workers who are currently in receipt of, or likely to receive, wage loss benefits are not eligible for pension commutations.

4. Purposes for which a commutation may be granted (subject to Point 3 above) include the following:
   a. Home purchase;
   b. Investment in a potentially successful business;
   c. Reduction or clearance of debts;
   d. Automobile purchase;
   e. Education (aside from that which would be a WCB responsibility).
   The above list is not intended to be all inclusive.

5. An annual letter will be sent to workers in receipt of pension benefits under The Workers’ Compensation Act, 1974. The letter will advise workers of the option of pension commutation, the current commuted value, the criteria to be met before a pension commutation will be approved and the steps to request a pension commutation.

6. Notwithstanding Point 5 above, where workers are receiving wage loss benefits as well as pension benefits, they will not receive the annual letter. Further, dependent spouses will not receive an annual letter advising them of the option of pension commutation.

Act Sec # 76(1); The Workers’ Compensation Act, 1974 82
Effective Date 01 May 2010
Amendment References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All requests for pension commutations under the Old Act.
Supersedes
   POL 14/2007 Pension Commutation (Old Act)
   POL 50/83 Commutation of Periodic Benefits When There is No Loss of Earning Capacity
   POL 24/88 (Amended by 12/95) Section 83 – The Workers’ Compensation Act, 1979 Commuting Compensation for Lump Sum

Complements PRO 11/2010 Pension Commutations

Document Date 26 August 2010

Purpose To establish guidelines for assessing Permanent Functional Impairment (PFI) awards.

DEFINITION

Functional Impairment means any adverse reaction in a worker as a result of a work injury which interferes with the normal performance of the worker’s body or mind.

Disfigurement means a conspicuous alteration or abnormal change in the features of the face, neck, hands, torso, and upper and lower extremities and/or substantial and permanent scarring of these areas. It is related to the cosmetic appearance of the body and not the loss of bodily function.

BACKGROUND

1. Section 66 of The Workers’ Compensation Act, 2013 (the “Act”) authorizes the Workers’ Compensation Board (WCB) to establish a rating schedule to calculate a Permanent Functional Impairment (PFI) award.

2. Section 66 also establishes the minimum and maximum awards payable for PFI, subject to the legislation in effect on the date of the determination of the award. For those decisions made:
   a. Prior to January 1, 2003, Section 66(2)(a) states the minimum amount awarded will be at least $1,100 and the maximum not more than $22,600; and
   b. On or after January 1, 2003, Section 66(2)(b) states the minimum award will be no less than $2,200 and the maximum not more than $45,200.

3. Section 66(4) of the Act dictates that a PFI benefit will not be awarded to a worker who suffers a fatal injury. This legislation does not exclude a worker from receiving an award in situations where an occupational disease, although ultimately fatal, results in a period of permanent impairment prior to death.

4. Section 76(1) declares that “a permanent award established pursuant to any former Workers’ Compensation Act must not be reduced except pursuant to that Act”.

POLICY

1. In the past, impairment evaluations were determined using a rating schedule constructed by the Workers’ Compensation Board (WCB). However, to be consistent
with other jurisdictions and the most current practices in impairment evaluation, the WCB has established *The American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides)* as its new rating schedule.

2. PFI will be assessed when the WCB consultant determines it is medically appropriate.

3. The WCB provides a PFI award to a worker for any measurable permanent functional impairment or disfigurement resulting from a compensable injury arising out of and in the course of employment.

4. A worker will receive a single lump sum PFI award based on a percentage rating applied to the maximum award. Section 66 of the Act defines the minimum and maximum PFI awards.

5. No PFI award is payable until it exceeds the minimum rating percentage applicable. Ratings of 0.5% to 4.87% are eligible for the minimum payment.

6. In accordance with the *AMA Guides*, an injury will be assessed alone or as part of a multiple injury rating that considers the overall whole person impairment (WPI).
   a. In a situation where a worker suffers multiple injuries or disfigurement from one incident, a PFI will be assessed as a multiple injury rating using the *AMA Guides’ Combined Values Chart (CVC)*.
   b. Where a worker suffers multiple injuries or disfigurement from various incidents, the *AMA Guides’ CVC* will be applied, despite there being separate claim numbers and potentially many years between each injury.
   c. The application of the CVC will not reduce a previous impairment rating.

7. Canada Disability Plan payments are not taken into account when determining this award.

8. Workers awarded a PFI for functional impairment may qualify for an Independence Allowance (POL 27/2010). PFI awards for hearing loss or disfigurement will not be considered when establishing entitlement to the Independence Allowance.

9. In the case of a terminal occupational disease, the maximum PFI award will be granted once it is medically confirmed that the disease has resulted in any degree of functional impairment. POL 11/2003, Injuries – Occupational Disease will apply.

10. Where a worker dies prior to entitlement, the PFI award will be paid to the worker’s estate except where Sections 81 and 93 of the Act apply. In these situations benefits are to be paid to a dependent.
11. A PFI assessed prior to the adoption of the *AMA Guides* will have any reassessment rated according to the most advantageous methodology for the injured worker from either the *AMA Guides* or the previously utilized WCB rating schedule.

12. No further PFI award for functional impairment is payable unless, following reassessment, there is an increase in the original level of impairment awarded.

13. Where upon re-assessment, the PFI award is reduced (e.g., the worker’s condition has improved), WCB will review qualification for other entitlements such as Independence Allowance on a prospective basis. Retroactive recovery of the prior PFI will not be made. However, when it is applicable, Independence Allowance will be reduced or discontinued effective the first of the month following the date of re-assessment.

14. Where the PFI award is the result of the acceleration of a prior measurable impairment, cost relief under POL 21/2010, Second Injury and Re-employment Reserve, is to be considered.

15. PFI awards for injuries are to be made in accordance with the established legislation at the time of assessment.

**Act Sec #**
- 19(1), 20, 66, 76(1), 81, 93

**Effective Date**
- 01 September 2010

**Amended**
- References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

**Application**
- All (re) assessments for PFI on or after the effective date.

**Supersedes**
- POL 05/2007 PFI - General
- POL 10/2007 Disfigurement Awards
- POL 13/2010 PFI – Occupational Disease
- POL 04/2008 PFI – Occupational Disease
- POL 25/90 PFI Award for Substance Allergy or Sensitization
- POL 07/2000 PFI – Raynaud’s Phenomenon

**Complements**
- PRO 23/2010 Permanent Functional Impairment (PFI) – General
- POL 27/2010 Allowance – Independence
- PRO 27/2010 Allowance – Independence
- PRO 01/2015 Disfigurement Award Assessment
- POL 15/2008 Allowance – Temporary Additional Expense
- POL 11/2012 Injuries – Hearing Loss
- PRO 11/2012 Injuries – Hearing Loss
- POL 21/2010 Second Injury and Re-Employment Reserve
- POL 11/2003 Injuries – Occupational Disease
- PRO 13/2007 Injuries – Occupational Disease
- POL 01/2009 Injuries – Psychological
- POL 03/2011 Worker’s Death Prior to Issuance of Entitlement
4.4.5 Annuities (POL 13/2013)

Document Date 17 December 2013

Purpose To establish guidelines for providing annuities.

DEFINITION

**Qualifying period** means the worker or dependent spouse will qualify for annuities if they receive eligible compensation for a period exceeding 24 consecutive months (that is, a period of 25 consecutive months). A single 25 month qualifying period may result from eligible compensation paid on more than one work injury claim.

**Eligible compensation** means the amount paid to compensate for lost wages. Eligible compensation does not include compensation paid on any other claims other than those eligible for the qualifying period. Eligible compensation for dependent spouses includes only those amounts paid under Section 81(1), 81(2) and 81(6) of *The Workers’ Compensation Act, 2013*.

**Interest** means a return that accrues annually on the monies (principal and interest accrued from previous years) set aside to provide an annuity.

**Annual Interest Rate** means the internally calculated smoothed rate of return earned by the Workers’ Compensation Board (WCB) on its investment portfolio.

**Minimum annuity amount** means $25,000, adjusted each year after the implementation date of the Act by the percentage increase in the Consumer Price Index (CPI). The WCB will round up the minimum annuity amount to the nearest $100.

BACKGROUND

1. Section 73 of the Act states if the WCB pays compensation to a worker for more than 24 consecutive months, the WCB will set aside an additional amount equal to 10 percent of eligible compensation paid:
   a. During the qualifying period, and
   b. After the qualifying period in the month when it is paid.

   The amount set aside, together with accrued interest, must be used to provide an annuity for the worker at age 65.

2. Prior to 2014, the minimum annuity amount was $20,000. Under Section 73(1) of the Act, this amount increased to $25,000. Beginning in 2014, this amount will be adjusted annually by the percentage increase in the Consumer Price Index (CPI).
3. Sections 81 of the Act provides a dependent spouse who has been in receipt of eligible compensation, for a period exceeding 24 consecutive months, with an annuity at age 65. An amount equal to 10 percent of eligible compensation paid is set aside to provide for the annuity.

4. The understood intent of these sections is to compensate for a reduction of or the total loss of retirement income caused by a work place injury.

POLICY

1. Compensation amounts for which 10 percent will be set aside are amounts that are paid directly to the worker, dependent spouse or third parties. Payments made to employers (salary continuance), though forming part of the qualifying period (see Point 2 below), are not part of the 10 percent contribution.

2. Eligibility for an annuity will be established when compensation is paid for any portion of a month included in the qualifying period. This will include payment to the worker or dependent spouse, payment made to the employer on behalf of the worker or that to a third party (e.g., Employment Insurance, Maintenance Enforcement or Canada Revenue Agency). However, where compensation is suspended under POL 07/2014, Suspension of Benefits, the qualifying period does not have to be continuous. For example, if a suspension of three months occurs after 20 consecutive months of payment, the 21st month will be considered as that month where payment is first made following the suspension.

3. Where a worker qualifies for an annuity, then returns to work and subsequently suffers a recurrence of the original injury, the qualifying period will already have been met. For example, where compensation was previously paid for 30 consecutive months, setting aside annuity amounts will resume the month the worker is again off work as a result the recurrence of the original injury (considered the 31st month).

4. Where the qualifying period was not met prior to a return to work, eligibility for an annuity will be established when the worker is again in receipt of compensation for 25 consecutive months (as in Point 2 above). For example, where the worker initially receives compensation for 20 months, returns to work, and later suffers a recurrence of the original injury, the initial 20 months the worker was in receipt of compensation is not used to establish entitlement to an annuity. Instead, the qualifying period starts over again (considered the first month).

5. When the qualifying period has been met and contributions are being set aside, the worker or the dependent spouse is to be informed of the provisions of Section 73(3) (worker) and Sections 81(3) and 81(4) (dependent spouse).

6. The Act is silent on what is to become of the monies standing to the credit of the worker or dependent spouse should the client pass away prior to reaching 65 years of age. In these cases, the WCB directs that the principal sum together with accrued
interest be paid to the client’s estate upon receipt of the death certificate. Under no
circumstances are these annuity payouts to reduce compensation that may be
payable to dependants should the worker’s death be attributed to the injury for which
he or she was being compensated.

7. The annuity amounts are to be set aside through the last day of the month in which
the worker reaches age 65.

8. The client will be given six months to purchase the annuity from the latter of:
   a. Official WCB notification, or
   b. The end of the month in which the client turns age 65
      with accrual of interest ceasing after the six-month period.

9. Interest that accrues during the current year will do so at an estimated rate equal to
   the interest rate used for the immediately preceding year. After the end of each year,
   the WCB will calculate the actual annual interest rate and adjust the estimated
   accrued interest to the actual amount for any balances still set aside.

10. The normal accrual of interest will start from the first day of the month following the
    qualifying period.

11. Where compensation is retroactively adjusted (upwards or downwards), interest on
    the annuity is to be adjusted retroactively beginning with the first day of the month in
    which interest on the annuity would normally have accrued (ceasing in accordance
    with Point 8), and subject to the following eligibility criteria:
        a. The decision to adjust compensation is made on or after January 1, 2003
           (adjustments of compensation prior to January 1, 2003 are not eligible for annuity
           interest adjustments).
        b. The retroactive adjustment to compensation results in a net annuity change
           (increase or decrease) greater than $100, and
        c. The retroactive compensation adjustment period begins more than six months
           prior to the end of the month in which the adjustment is made.

Example:
A decision is made in March 2005 to retroactively award compensation for January
2005 (a period that is less than six months prior to the end of March 2005) resulting
in a net annuity increase of $200. Because (a) and (b) above are met but not (c), the
annuity amount ($200) is contributed to the annuity but no retroactive interest is
applied.

12. Upon reaching age 65, the annuity client will be required to purchase a life annuity
    where the total for all claims is equal to or greater than the minimum annuity amount.
    In lieu of an annuity, clients or their dependent spouses qualifying under Sections
73(3) or 81(3) and 81(4) respectively, may choose a lump sum payout of the accumulated principal and interest where the total for amounts set aside on all claims is less than the minimum annuity amount, as of the last day of the month in which the client reaches age 65. The annuity must guarantee the return of principal and be payable to a non-registered fund.

13. For clients over the age of 65 who qualify for annuity as a result of an adjustment to compensation, the conditions of this policy will apply in addition to the following:

a. Where a client over the age of 65 first qualifies under Sections 73(3) or 81(3) and 81(4) for an annuity, clients will be required to purchase an annuity if the principal, together with any retroactive interest, is over the minimum annuity amount or, in lieu of an annuity, may elect to receive a lump sum payout when the principal together with any retroactive interest, is under the minimum annuity amount.

b. Where a client has previously been paid annuity funds in accordance with Point 12, there will be no cumulative effect if after age 65, an additional annuity amount is awarded. For example, a client who purchased a $30,000 annuity in 2014 becomes entitled in 2018 to an additional annuity amount of $5,000 (principal together with any retroactive interest). This client may elect to receive a lump sum payout even though the total for the two annuity amounts ($35,000) is greater than the minimum annuity amount. Conversely, if the new annuity entitlement is greater than the minimum annuity amount, the client will be required to purchase an annuity.

c. For Points 13(a) and (b) above, retroactive annuity interest will be applied in accordance with Point 11.

14. Annual adjustments to the minimum annuity amount are noted in PRO 60/2015, Consumer Price Index (CPI) – Annual Increase.

15. Upon evidence that the client has entered into a contract to purchase an annuity, the monies will be paid jointly to the client and the annuity provider/company. The annuity must guarantee the return of principal and be payable to a non-registered fund.

16. In recognition of unusual circumstances where a life annuity would not appropriately meet the objective of replacing the client’s lost pension, the WCB will consider proposals submitted from clients for:

a. An alternate form of annuity that:
   i. Confirms the alternate annuity is for the purposes of providing retirement income.
   ii. Details the terms, conditions and carrier of the alternate annuity.
   iii. Guarantees the alternate annuity will:
      (a) Return the principal portion of the annuity.
(b) Is payable from a non-registered fund.
(c) Is payable for at least 10 years.

The WCB will approve the alternate annuity as long as it meets all of the requirements of a life annuity.

b. Something other than a life annuity. The WCB will make decisions on such requests on a case by case basis.

Reconsideration of a decision will only be made by the Board Members and is not subject to the regular appeal process.

<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>2(1)(h), 73, 81</th>
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<tbody>
<tr>
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<tr>
<td>Amended</td>
<td>References updated in accordance with The Workers’ Compensation Act, 2013</td>
</tr>
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</table>
| Application | Workers injured on or after January 1, 1980
Dependent spouses on or after January 1, 1989 |
| Supersedes | POL 10/2008 Annuities |
| Complements | PRO 13/2013 Annuities
POL 28/2010 Compensation Rate - Minimum and Average Weekly Earnings
POL 07/2014 Suspension of Benefits
PRO 60/2015 Consumer Price Index (CPI) – Annual Increase |
4.4.6 Capitalization of Claims (POL 14/2010)

Document Date 30 March 2010

Purpose To establish the guidelines to capitalize a claim receiving long-term earnings replacement.

DEFINITION

Capitalization means funds calculated and set aside to pay future wage loss costs for a worker with permanent work restrictions who is eligible for long-term earnings replacement until the age of sixty-five. Medical or rehabilitation costs are not capitalized.

BACKGROUND

1. In accordance with Section 116(1) of The Workers’ Compensation Act, 2013 (the “Act”), the Workers' Compensation Board (WCB) will maintain an adequate injury fund so that employers are not unfairly burdened in future years with injuries expected to incur long-term earnings replacement.

2. In accordance with Section 121 of the Act, the employer may be liable for an additional levy where an employer’s total claim cost is greater than the average cost within the same industry.

3. Section 139 of the Act authorizes the WCB to adopt a system of merit rating. Under that authority, the WCB established the Experience Rating Program, which adjusts premium rates to reflect an employer’s claims cost experience.

POLICY

1. A worker with a permanent functional impairment will be eligible for long-term earnings replacement (LTER) when the medical condition has stabilized, the vocational rehabilitation process is completed, and a loss of earning capacity exists.

2. To reduce the long-term effects of a claim on the employer’s cost experience and to ensure that the WCB is financially viable in the future, the WCB may capitalize a LTER claim that is expected to continue until the injured worker has reached age 65.

3. When a claim is capitalized, the employer’s cost experience will be charged with the net present value of the future earnings replacement required for the duration of the claim, to age 65. This amount will reflect total earnings replacement payments that the injured worker is expected to receive.

4. The capitalized amount will be included in the Experience Rating calculation for employers in the Advanced Program. Policy POL 01/2007, Experience Rating Program, will apply.
5. For premium rate setting purposes, the capitalized amounts will be included in the year in which they were applied. The amounts will be used to calculate the premium rates for the industry in which the employer is classified.

6. Once LTER has been established, annual verification of earnings will be completed. POL 12/2010, Verification of Earnings, will apply. If the LTER is adjusted on the basis of a review, the capitalization may also be adjusted.

<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>Effective Date</th>
<th>Amendment</th>
<th>Application</th>
<th>Supersedes</th>
<th>Complements</th>
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| 115, 116(1), 121(1), 134, 139, and 145 | 01 May 2010 | References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013 | Long-term earnings replacement claims | n/a | Capitalization of Claims
| | | | | | Experience Rating Program
| | | | | | Experience Rating Program
| | | | | | Determination of Long-Term Loss of Earnings
| | | | | | Determination of Long-Term Loss of Earnings
| | | | | | Estimating Earning Capacity – Commissioned Sales & Self-Employment
| | | | | | Verification of Earnings
| | | | | | Verification of Earnings
| | | | | | Vocational Rehabilitation – Programs and Services
4.5 Reduction, Suspension or Termination
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4.5.1 Suspension of Benefits (POL 07/2014)

Document Date 29 April 2014

Purpose To establish guidelines for the suspension of benefits.

DEFINITION

Client means an injured worker or a surviving dependent spouse.

Good reason means circumstances or matters beyond the client’s control. An employer would normally find such a reason and the length of absence from work to be acceptable.

Medical aid, also referred to as health care, means “the provision of medical and surgical aid, of hospital and professional nursing services, of chiropractic and other treatment and of prosthetics or apparatus” (Section 2(1)(v) of The Workers’ Compensation Act, 2013 (the “Act”).

Individualized vocational plan (IVP) is a plan signed by the WCB and the worker or dependent spouse to meet a vocational goal. The IVP outlines the short and long-term goals for a suitable return to work.

BACKGROUND

1. The Act requires the WCB to pay benefits for loss of earnings resulting from an injury (Section 68).

2. The WCB requires a worker to (Section 51):
   a. Take all reasonable action to reduce the earnings loss resulting from an injury, and
   b. Co-operate with the WCB in a rehabilitation plan to return the worker to suitable productive employment.

3. The WCB may terminate or reduce benefits when the worker's loss of earnings is not related to the effects of the injury (Section 101(1)(a)).

4. The WCB may terminate or reduce benefits when "without good reason" the client (Section 101(1)(b):
   a. Declines or is unavailable for a job offer that is considered suitable for the client, or
   b. Fails to co-operate in, or is not available for, health care or an IVP that intends to help the client return to employment.
5. Section 101(1) will apply to dependent spouses after the expiration of benefits provided under Sections 81(1) and 81(2).

6. This policy does not apply to the suspension of benefits involving pregnant workers. POL 01/2008, Suspension of Benefits – Pregnancy, will apply.

**POLICY**

1. The WCB will suspend benefits if a client’s absence from health care or an IVP will extend earnings loss.

2. When the client’s absence is for good reason, the WCB may continue wage loss benefits during a notice period. This will provide opportunity for the client to:
   a. Return to the program, or
   b. Access an alternate source of support, such as employer sick leave, and other private or government long or short-term disability plans.

3. Suspension of benefits may be delayed for a maximum of four weeks or until the client qualifies for an alternate source of support, whichever occurs first.

4. During the notice period, a client who received partial wage loss benefits prior to an absence from health care or an IVP will continue to receive benefits in the amount paid prior to the absence.

5. Following an absence for good reason, WCB benefits will resume when the client is medically fit or available to:
   a. Continue health care.
   b. Attend appointments, or
   c. Continue an IVP.

6. Where the client’s absence is without good reason, suspension of benefits will occur. The WCB will not provide a notice period prior to the suspension. The suspension will continue until the client:
   a. Attends the appointments.
   b. Returns to health care, or
   c. Resumes an IVP or participates in rehabilitation planning.

7. The WCB will not suspend benefits in full if it determines that the outcome of the claim would involve ongoing loss of earnings, and that the loss would be there regardless of the absence. In these situations, the WCB will:
   a. Estimate what the earnings loss would be had the client completed the health care and IVP, and
b. Reduce benefits to an estimated wage loss payment during the period of suspension.

8. If the WCB cannot determine if a client will qualify for wage loss entitlement after the conclusion of the health care and IVP, suspension of benefits may occur in full until the client returns to the treatment or programming.

9. The WCB will charge the costs for the notice period, and any additional costs for ending an IVP, to the Second Injury and Re-Employment Fund.

<table>
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<tr>
<th>Act Sec #</th>
<th>Effective Date</th>
<th>Application</th>
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<td>2(1)(v), 19, 20, 35, 51, 58, 68, 81, 99, 100, and 101</td>
<td>01 June 2014</td>
<td>All claims.</td>
<td>POL 03/2009 Suspension of Benefits</td>
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<td>POL 01/2008 Suspension of Benefits – Pregnancy</td>
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<td>POL 05/94 Suspension – While Incarcerated</td>
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<td>POL 06/2009 Benefits – Clients in Transition from WCB to SGI</td>
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<td>POL 15/2014 Determination of Long-Term Loss of Earnings</td>
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</tbody>
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4.5.2 Suspension – While Incarcerated (POL 05/94)

Document Date 21 January 1994

Purpose To establish guidelines for suspension of compensation payments while incarcerated.

BACKGROUND

1. Section 100(3) provides that the Board may suspend earnings loss compensation to an injured worker or a dependent spouse during any period that either is unavailable for employment for a cause unrelated to the injury for which such compensation is being awarded.

2. Incarceration renders a person unavailable for employment. If there is no obvious causal relationship between incarceration and the injury, Board members believe suspension of earnings loss benefits for the period of incarceration is warranted.

POLICY

1. Under the conditions outlined above, suspension of benefits is directed.

2. Incarceration is defined to include confinement to a correctional institute, confinement to a mental institution because of an offence, or being detained because of any immigration matter.

3. In cases where a causal relationship between the injury and incarceration is claimed, e.g. acts precipitated by addiction to drugs prescribed for injury, benefits are not to be disturbed. Claims of this nature will be adjudicated by Board Members.

4. Section 100(4) permits the diversion of suspended or withheld compensation to dependants of the recipient or any other person or persons the Board considers advisable. Such cases will be adjudicated by Board Members.

Act Sec # 100(2), 100(3), 100(4)

Effective Date 04 June 1990 for Points 1 to 3 Inclusive
09 February 1994 for Point 4

Amended References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*.

Application All Injuries On or After the Indicated Effective Dates

Supersedes n/a

Complements POL 07/2014 Suspension of Benefits
4.5.3 Suspension of Benefits – Pregnancy (POL 01/2008)

Document Date 15 January 2008

Purpose To establish guidelines for the suspension of benefits involving pregnant workers.

BACKGROUND

1. Section 100 and 101 of The Workers’ Compensation Act, 2013 (the “Act”) authorize the Workers’ Compensation Board (WCB) to suspend, reduce or terminate benefits based upon a worker’s loss of earnings.

2. POL 07/2014 establishes general guidelines for the suspension of benefits.

3. To ensure that workers’ rights under The Human Rights Code are respected, it is necessary for WCB to provide a special suspension of benefits policy for those situations involving pregnant workers.

POLICY

1. The payment of earnings loss benefits to the worker will not be suspended in circumstances where the worker’s pregnancy presents a valid medical reason for the delay or interruption of:
   a. Medical or vocational rehabilitation programs intended to help return the worker to productive employment; or
   b. Medical or other appointments related to the treatment or rehabilitation of the worker’s injury.

2. Notwithstanding the above, in those circumstances where:
   a. The pregnancy and conditions related to the pregnancy are the sole reason for interruption or delay in returning to work (i.e., worker has recovered from work injury); or,
   b. The pregnancy has terminated (i.e., through childbirth) and non-work-related factors cause a delay in treatment or vocational programming, earnings loss benefits will be suspended in accordance with POL 07/2014. Up to four weeks will be provided for the worker to access alternate income maintenance plans (i.e., Employment Insurance benefits).

3. WCB will normally require a medical opinion or certificate to confirm a pregnant worker’s medical condition.
4. Costs for a period of payment up to four weeks will be charged to the Second Injury and Re-employment Reserve, as will the additional costs incurred for the cessation of a rehabilitation program.

**Act Sec #** 68, 100, 101  
**Effective Date** 01 February 2008  
**Amended** References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*  
**Application** All pregnant workers.  
**Supersedes** POL 05/2002 Suspension of Benefits – Pregnancy  
**Complements** POL 07/2014 Suspension of Benefits
4.5.4 Termination – Age 63 and Over, Age 65, and Retirement (POL 09/2012)

Document Date 19 September 2012

Purpose To establish guidelines for payment of compensation benefits to workers age 63 and over.

DEFINITION

Not more than two years, as referenced in Section 71 of The Workers’ Compensation Act, 2013 (the “Act”), means the worker may be entitled to earnings loss compensation for a period of not more than two years following the commencement of earnings loss date.

BACKGROUND

1. Section 68(2) of the Act states that compensation “is payable for as long as the loss of earnings continues, but the compensation is no longer payable when the worker reaches the age of 65.”

2. Section 71 of the Act provides special consideration to workers injured at 63 years of age or older by extending earnings loss compensation for a period of not more than two years after the commencement of earnings loss date. This provision may extend the date of termination beyond age 65.

3. Section 73(3) and (4) of the Act state:

   If compensation is paid to a worker for a period exceeding 24 consecutive months, the board shall set aside an amount equal to 10% of the compensation paid during the 24-month period and of the future compensation to be paid after the expiry of the 24-month period. The amount set aside, together with accrued interest, must be used to provide an annuity for the worker at age 65.

4. Section 2(3) of The Saskatchewan Human Rights Code (the “Code”) states that age distinctions “permitted or required by any Act or regulation in force in Saskatchewan” are not in contravention of the Code.

POLICY

Workers Under Age 63

1. Workers under age 63 at the commencement of earnings loss are entitled to earnings loss compensation from the commencement of earnings loss date until:

   a. The loss of earnings cease, or
b. The end of the month in which the injured worker reaches age 65, whichever occurs first.

2. Workers in receipt of benefits for a period exceeding 24 consecutive months are eligible for an annuity to be paid at the age of 65.

Workers Age 63 and Over

3. Workers 63 years of age or over at the commencement of earnings loss are entitled to earnings loss compensation from the commencement of earnings loss date until:
   a. The loss of earnings cease, or
   b. A period of two years has expired (i.e., compensation will be payable up to and including the day prior to the second anniversary of the commencement of earnings loss date), whichever occurs first.

4. Workers age 63 or over qualifying for compensation benefits under Section 71 are not entitled to annuity benefits under Section 73. To qualify for the annuity, a worker must be absent from the workforce in excess of 24 consecutive months before reaching age 65.

Effects of Retirement

5. Retirement benefits (e.g., employer sponsored pension plans, Canada Pension Plan Retirement benefits, Old Age Security Pension, etc.) will not be considered as earnings in the calculation of earnings loss compensation under the Act.

Termination of Compensation Benefits

6. When earnings loss compensation benefits are terminated, workers will be advised of the options for alternative support programs.

Other Entitlements

7. The limits outlined in Section 71 exclusively impact the provision of earnings loss compensation. Other entitlements (e.g., medical aid, personal care allowance, independence allowance, etc.) may be extended beyond the two year period.
<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>68(1), 68(2), 71, 73(3) and (4); Section 2(3) of <em>The Saskatchewan Human Rights Code</em></th>
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<td>Effective Date</td>
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<td>Amended</td>
<td>References updated 01 January 2014 in accordance with <em>The Workers' Compensation Act, 2013</em>.</td>
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<tr>
<td>Application</td>
<td>All claims with a commencement of earnings loss date on or after the effective date.</td>
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<tr>
<td>Supersedes</td>
<td>POL 06/2001 Termination – Age 63 &amp; Over, Age 65, and Retirement</td>
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<tr>
<td>Complements</td>
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<td>PRO 17/2010 Termination of Compensation Benefits – Notice</td>
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4.5.6 Bridging Program (POL 11/2013)

Document Date 17 December 2013

Purpose To tell clients about other sources of support.

BACKGROUND

1. The WCB is responsible for the effects of work injuries. When the injury no longer impacts a workers ability to go back to work, the WCB will reduce or stop paying benefits.

2. WCB benefits may be a worker’s only source of money. The WCB will tell workers that get WCB benefits for a long time about other sources of support before stopping benefits.

POLICY

1. If a worker gets benefits for more than 12 months, the WCB will attach a fact sheet to the worker’s termination of benefits notice. The fact sheet will:
   a. Outline other sources of support that the worker may get once WCB benefits end.
   b. Say that the WCB will pay for up to three hours of counselling services.

2. Workers can also see the fact sheet online at www.wcbsask.com.

3. The WCB will review the fact sheet each year to make sure the information is correct.

4. WCB accredited psychologists will provide worker requested counselling services.

Act Sec # 81(6), 101, 111, 115(j)
Effective Date 01 February 2014
Amended References updated in accordance with The Workers’ Compensation Act, 2013
Application Workers that get benefits for more than 12 months
Supersedes POL 11/2000 Bridging Program
PRO 11/2000 Bridging Program
Complements POL 17/2010 Termination of Benefits – Notice
DEFINITION

Fit means, for the purpose of this policy, sufficiently recovered from the work injury to enable a resumption of pre-injury employment at the pre-injury wage.

BACKGROUND

1. Section 101(1)(a) of The Workers’ Compensation Act, 2013 (the “Act”) states that the Workers’ Compensation Board (WCB) may terminate or reduce payment to a worker where the worker’s loss of earnings is not related to the effects of the injury.

2. The intent of this policy is to specifically deal with the “termination” of benefits outlined in Section 101(1)(a) of the Act, whereas the “suspension” and “reduction” of benefits outlined in Section 101(1)(b) of the Act are covered in POL 15/2014, Determination of Long-Term Loss of Earnings and POL 07/2014, Suspension of Benefits.

3. While compensation benefits are to be withdrawn when the effects of the injury are no longer the cause of the worker’s inability to work, consideration will be given to workers who are in receipt of benefits for a prolonged period who are declared fit and their pre-injury employment is no longer available.

POLICY

1. Where the worker no longer has employment to return to when declared fit for pre-injury employment, the WCB will provide a minimum of two weeks notice of termination, commencing on the date of notice, for every 12 consecutive months a worker is in receipt of wage loss benefits, up to a maximum of six months notice.

2. In addition to providing notice of termination, the WCB may inform workers of alternative support programs.

3. Where the worker returns to employment prior to the expiry of the notification period, the WCB will terminate the compensation benefits at the earlier date.
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<tr>
<td>Application</td>
<td>All claims with benefits paid 12 consecutive months or longer, deemed “fit” but with no employment to return to</td>
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<tr>
<td>Supersedes</td>
<td>POL 08/2001 Termination of Compensation Benefits – Notice</td>
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<td>POL 15/2014 Determination of Long-Term Loss of Earnings</td>
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<td>POL 07/2014 Suspension of Benefits</td>
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5.0 BENEFITS TO DEPENDENTS

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5.1 Initial Entitlement and (Re)Employment Assistance – Dependent Spouses (POL 33/2010)

Document Date 09 November 2010

Purpose To establish guidelines for providing benefits and (re)employment assistance to dependent spouses.

DEFINITION

(Re)employment assistance includes, but is not limited to, the provision of job search assistance, relocation assistance, academic or vocational training, temporary modified work programs or workplace modifications.

BACKGROUND

1. Section 19(1)(d) of The Workers’ Compensation Act, 2013 (the “Act”) states that the Workers’ Compensation Board (WCB) will “consult and co-operate with workers and surviving dependent spouses in the development of rehabilitation plans intended to return workers or surviving dependent spouses to positions of independence in suitable productive employment.”

2. Sections 81(1), (2), (5) and(6) of the Act outline entitlement to benefits and (re)employment assistance for a dependent spouse (and dependent children) where the death of the worker is due to the compensable injury.

3. Section 92 of the Act states that the WCB “may direct the person to whom the compensation payments are to be made.”

4. Section 93(1) of the Act states that “on the death of a worker who was or would have been entitled to compensation pursuant to this Act for a period of 24 consecutive months or less at the time of death and if no compensation is payable pursuant to sections 80 to 86, the board shall pay an amount of compensation equal to the compensation that the worker received or would have been entitled to receive, as the case may be, with respect to a period of three months:

   a. To the worker’s surviving dependent spouse; or

   b. If the worker died leaving no dependent spouse, to the worker’s dependent children or any other persons recognized by the board as being dependants.”

5. Section 93(2) of the Act states that compensation is to be paid to the persons mentioned in Section 93(1) “in any share that the board may determine.”

6. Section 93(3) of the Act directs that “if a worker dies of a condition for which no benefits are payable pursuant to Sections 80 to 86 and that worker received
compensation for a period exceeding 24 consecutive months before the day of worker’s death, the board:

   a. Shall pay to the worker’s surviving dependent spouse a monthly allowance, equal to the monthly amount of compensation that was being paid to the worker, for 12 months following the day of the death of the worker; and

   b. May provide the surviving dependent spouse the same counselling and vocational assistance as would be provided to a worker in order to enable the dependent spouse to enter the labour force and become self-sufficient.”

7. Section 111(c) of the Act directs that the WCB may take any measures that it considers necessary or expedient “to encourage a dependent spouse of a deceased worker to become self-sufficient.”

8. Section 115(f) of the Act states that the WCB may expend moneys from the fund for any expenses incurred in the administration of this Act and, without restricting the generality of the foregoing, the WCB may expend moneys for “any costs that the board considers necessary or expedient to assist dependent spouses of deceased workers to become self-sufficient.”

POLICY

General

1. The combination of all benefits paid to dependent spouses or other dependants of the deceased worker, not including retraining and counselling services, or payments made for dependent children or children with a disability, will not exceed the equivalent of full spousal benefits.

Death of the Worker is Due to a Work-Related Injury – Section 81

2. Where the death of the worker is due to a work-related injury, in accordance with Section 81(1) of the Act, an initial period of compensation is payable to the dependent spouse for five years where there are no dependent children.

3. Where there are dependent children, Section 81(2) of the Act directs that compensation may be extended to a dependent spouse until the youngest child reaches age 16, or age 18 if attending school full time.

4. Following the expiration of compensation under Section 81(1) and 81(2) of the Act, until age 65, in accordance with Section 81(6) of the Act, the dependent spouse is entitled to an amount equal to the difference between;

   a. 90 percent of the deceased worker’s average weekly earnings at the time of injury or death, indexed pursuant to Section 69(2) of the Act; and

   b. The dependent spouse’s actual earnings or, if called for by Section 101 of the Act, the spouse’s estimated earnings.
5. In accordance with the provisions of Section 81(5) of the Act, the dependent spouse may qualify for (re)employment assistance.

6. The provisions of POL 02/2015, Compensation – Dependent Spouse After Initial Entitlement apply when estimating the earning capacity of the dependent spouse.

Death of Worker is Not Due to a Work-Related Injury – Section 93

7. Where the death of the worker is not due to a work-related injury and the worker was in receipt of benefits for less than 24 consecutive months, in accordance with Section 93(1) of the Act, benefits will be paid to the dependent spouse, or other dependants where there is no dependent spouse, for a period of three months. Entitlement is based on the rate of benefits the worker was receiving at the time of death. No (re)employment assistance will be provided.

8. Where the worker was in receipt of benefits for a prolonged period of time prior to the day of the worker’s death (i.e., 24 consecutive months or greater), in accordance with Section 93(3) of the Act, compensation will be paid to the dependent spouse for a period of 12 months. Entitlement is based on the rate of benefits the worker was receiving at the time of death. During that 12 month period, the dependent spouse may qualify for (re)employment assistance.

Application of (Re)Employment Assistance

9. In accordance with POL 01/2011, Vocational Rehabilitation – Programs and Services, an Individualized Vocational Plan will be developed where (re)employment assistance will benefit the dependent spouse.

Annuities for Dependent Spouses

10. Annuities will be provided to dependent spouses that are in receipt of compensation benefits for periods exceeding 24 consecutive months (POL 13/2013, Annuities).
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5.2 Compensation – Dependent Spouse after Initial Entitlement (POL 02/2015)

Document Date 22 January 2015

Purpose To establish guidelines for estimating earning capacity of dependent spouses.

BACKGROUND

1. Under Section 2(1)(k) of The Workers’ Compensation Act, 2013 (the “Act”) earnings means:
   a. in the case of a worker who sustained an injury before September 1, 1985, the worker’s gross earnings from employment; or
   b. in the case of a worker who sustained an injury on or after September 1, 1985, the worker’s gross earnings from employment less the probable deductions for:
      i. the probable income tax payable by the worker calculated by using only the worker’s earnings from employment as his or her income, and using only the worker’s basic personal exemption, exemption for dependents and employment-related tax credits, as at the date of the worker’s injury and each anniversary date, as the worker’s deductions;
      ii. the probable Canada Pension Plan premiums payable by the worker; and
      iii. the probable employment insurance premiums payable by the worker.

2. Section 81(1) of the Act provides the surviving dependent spouse of a deceased worker a monthly allowance based on the greater of the deceased worker’s compensation at the time of death or one-half of the average weekly wage. The allowance is paid for an initial period of five years and under certain conditions may be paid for longer periods.

3. Section 81(2) of the Act provides that where the surviving dependent spouse has dependent children of the worker, the compensation payable pursuant to Section 81(1) is to be extended until the youngest child reaches the age of 16 years, or 18 years where any dependent child is attending school full-time.

4. Section 81(6) of the Act directs that following the expiration of entitlement to compensation pursuant to Sections 81(1) and 81(2) and subject to Section 101, a surviving dependent spouse of a deceased worker is entitled to compensation, until the surviving dependent spouse reaches the age of 65 years, equal to the difference between:
   a. the amount of the monthly allowance that would be payable pursuant to Section 81(1) if the surviving dependent spouse were entitled to that allowance; and
   b. the earnings that the surviving dependent spouse is earning from employment.
5. Sections 101(1) and 101(2) of the Act indicate the circumstances when it may be necessary to terminate or reduce benefits to a dependent spouse after their entitlement under Sections 81(1) and 81(2) of the Act comes to an end. If the spouse has little or no earnings from employment, the amount by which benefits are to be reduced may be determined by estimating their earning capacity.

POLICY

Initial Compensation

1. Initial compensation and (re)employment assistance to dependent spouses will be established as per the provisions outlined in POL 33/2010, Initial Entitlement and (Re)Employment Assistance – Dependent Spouses.

2. When establishing initial entitlement, the tax exemption level for the payment of compensation to the dependent spouse will be the same as the tax exemption level recorded for the worker at the time of death. The exemption status for the dependent spouse will not change for the initial entitlement period as referenced in Section 81(1) or Section 81(2) of the Act.

Additional Compensation

3. On the expiration of initial entitlement, a dependent spouse may be eligible to receive additional compensation equal to the difference between the initial compensation amount and the earnings that the dependent spouse is earning from employment. The deductions for earnings from employment will be based on the calculation of earnings defined in Section 2(1)(k). The additional compensation will be calculated using the dependent spouse’s current exemption status.

4. If a surviving dependent spouse is eligible to receive additional compensation, benefits will continue until the end of the month in which the dependent spouse reaches the age of 65 years.

5. Where the dependent spouse does not have any earnings, the dependent spouse’s earning capacity will be estimated as follows:
   a. Health or any other factors that preclude the dependent spouse from entering the workforce or that impairs their ability to earn are to be taken into account in the determination of their earning capacity.
   b. The provisions of POL 26/2010, Determination of Long-Term Loss of Earnings, will apply.
   c. The WCB will consider the dependent spouse’s exemption status to be single unless the spouse can provide substantiation supporting an alternate exemption status.
Act Sec # 2(1)(k), 2(1)(gg), 19(1)(a), 81(1), 81(2), 81(6), 87, 89, 93, 95, and 101

Effective Date 01 March 2015

Application All claims where dependent spouses are receiving benefits under Section 81(6) of the Act beginning at their next annual review.

Supersedes POL 10/2009 Compensation – Dependent Spouse After Initial Entitlement

Complements POL 33/2010 Initial Entitlement and (Re)Employment Assistance – Dependent Spouses
POL 03/2007 Calculation of Net Compensation Payable
POL 15/2014 Determination of Long-Term Loss of Earnings
POL 03/2010 Dependent Spouses, Children with a Disability and Other Dependents of Fatally Injured Workers

Benefits to Dependents

Doc # 5.2 Compensation – Dependent Spouse after Initial Entitlement (POL 02/2015)
5.3 Dependent Spouses, Children with a Disability and Other Dependents of Fatally Injured Workers (POL 03/2010)

Document Date 17 February 2010

Purpose To establish guidelines for the payment of benefits to dependants of fatally injured workers.

DEFINITION

Common law spouse, as referenced under Section 2(1)(gg) of The Workers’ Compensation Act, 2013 (the “Act”), means “a person who is or was cohabiting with the worker as a spouse as at the date of the worker’s death or injury and:

a. The person has or had cohabited with the worker as a spouse continuously for a period of at least one year; or
b. The person and the worker are parents of a child.”

Dependant, for the purpose of this policy, means a member of the family of a worker who is wholly or partly dependent upon the worker’s earnings at the time of the death of the worker or who, but for the death of the worker, would have been so dependent.

A child with a disability, as referenced under Section 85(5), means a person who is physically or mentally restricted in his or her ability to earn a livelihood.

BACKGROUND

1. Section 25 of the Act directs:
   a. The board may act on the report of any of its employees.
   b. Any member or employee of the board or any other person that the board may appoint for the purpose may make any inquiry on behalf of the board that the board considers necessary.
   c. The board may act on a report that is produced as the result of an inquiry.

2. Section 55(b) states that any health care professional who attends to or is consulted with respect to an injury to a worker shall “give all reasonable and necessary information, advice and assistance to the injured worker or the worker’s dependants in making an application for compensation.”

3. Section 82 of the Act states that where the WCB determines “that there is a dependent spouse and one or more additional dependants of the deceased worker and that they do not live together as a family unit, the board may, in its discretion,
divide the payment mentioned in Section 81 among those dependants in any manner that it considers just and equitable.”

4. Section 85 of the Act references the monthly allowance payable by the WCB where there are surviving dependent children of a fatally injured worker. Section 85(5) of the Act states that a child with a disability must continue to receive a monthly allowance “after he or she has reached the age of majority and for as long as he or she remains so restricted.”

5. The WCB also has the discretion under Section 86 of the Act to recognize dependants other than a spouse or child as dependants and award those other dependants compensation where the other dependants depend (partly or wholly) on the financial support of the deceased worker and would have continued to be dependent, but for the death of the worker.

6. Section 87 of the Act states that the WCB “may recognize partial dependency and provide an amount that it considers reasonable and proportionate to the pecuniary loss or loss of valuable services suffered by the dependants who are recognized as partially dependent.”

POLICY

General

1. The combination of all benefits paid to dependent spouses or other dependants of the deceased worker, not including payments made for dependent children or children with a disability, will not exceed the equivalent of full spousal benefits.

Children with a Disability

2. In accordance with Section 85(5) of the Act, a child with a disability will continue to receive a monthly allowance so long as the child remains restricted by their disability. The WCB will review the medical circumstances related to the physical and or mental restriction leading to the child’s condition on a periodic basis.

3. Where the WCB determines that the child, having reached the age of majority, is capable of maintaining full-time employment (i.e., 40 hours per week) earning a wage equal to or greater than the current provincial minimum wage, the child will no longer be considered restricted by their disability. At that point, benefits provided for under Section 85(5) of the Act will cease.

4. Where a child is not restricted by a disability at the date of the worker’s death but later becomes restricted during the period that the child would still be eligible for compensation (i.e., prior to reaching the age of majority), the WCB will provide compensation to the child as per Section 85(5) of the Act.
Spouses (Common Law, Separated, Divorced)

5. Where the provisions outlined in Section 2(1)(gg) of the Act are met, a common law spouse will be entitled to the same compensation benefits as a dependent spouse upon the death of the worker.

6. Where a worker leaves a dependent common law spouse and a spouse who, although is not living with the worker at the time of death, is partially dependent, the WCB may provide compensation to both the dependent common law spouse and the partially dependent spouse. Payment to the partially dependent spouse may be provided in accordance with Section 87 of the Act, in an amount that is reasonable and proportionate to the pecuniary loss or loss of valuable services suffered by the dependants.

7. A spouse and or children separated from the worker at the time of death are not eligible for compensation benefits resulting from the worker’s death, unless the worker was providing the separated spouse and or children with some form of regular financial support, or support under a court order or a similar agreement was being actively pursued. For the purpose of this policy, actively pursued means a verifiable attempt to gain financial support was made within one year prior to the death of the worker.

8. Where financial support under a court order or similar agreement was being actively pursued at the time of the worker’s death, the WCB will provide benefits in accordance with the terms of the agreement, providing the agreement does not call for support in an amount exceeding the provisions of the Act. The WCB will not provide benefits to cover the amount of support payments that may have been in arrears at the time of death.

9. Where the worker is survived by a dependent spouse and one or more additional dependants as described by Section 82 of the Act, any monthly allowance payable to those dependants under the Act will be apportioned by the WCB in a manner that is considered just and equitable.

Other Dependents

10. The WCB may recognize other members of the worker’s family as dependants (e.g., parents, grandparents) and may award compensation to those other dependants upon the death of the worker where those individuals were partially or wholly dependent on the worker.

11. In accordance with Section 86(2) of the Act, the payment of compensation to other dependants may continue so long as, in the opinion of the WCB, it might have reasonably been expected that, had the worker lived, the worker would have continued to contribute to the support of the dependants.
(Re) Employment Assistance

12. The eligibility of a dependent spouse or a child with a disability for (re) employment assistance (e.g., academic or vocational training) will be subject to the provisions of POL 33/2010, Initial Entitlement and (Re)Employment Assistance – Dependent Spouses.

<table>
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<tr>
<th>Act Sec #</th>
<th>Effective Date</th>
<th>Amended</th>
<th>Application</th>
<th>Supersedes</th>
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| 2(1)(j), 2(1)(gg), 25, 55, 81, 82, 85, 86, 87, 88, 90, 93 | 01 April 2010 | References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013. | All new fatality claims on and after the effective date. | n/a | POL 03/2010 Dependent Spouses, Children with a Disability and other Dependents of Fatally Injured Workers  
POL 02/2015 Compensation – Dependent Spouse After Initial Entitlement  
POL 04/2010 Attachment of Compensation  
PRO 04/2010 Attachment of Compensation  
POL 03/2007 Calculation of Net Compensation Payable  
POL 33/2010 Initial Entitlement and (Re) Employment Assistance – Dependent Spouses |
5.4 Support – Family of Seriously Injured Workers (POL 06/2014)

Document Date 29 April 2014

Purpose To give support to the family of seriously-injured workers.

DEFINITION

**Family member** means a spouse, parent, legal guardian, grandparent, child, grandchild, or sibling (Section 2(1)(y) of *The Workers’ Compensation Act, 2013*).

**Serious injury**, for the purpose of this policy, means a life-threatening injury, or an injury that results in a permanent loss of function or significant disfigurement. Serious injuries may include, but are not limited to, the following:

- Quadriplegia.
- Paraplegia.
- Upper limb amputation.
- Lower limb amputation.
- Severe head injury.
- Severe burns.
- Blindness.

BACKGROUND

*The Workers’ Compensation Act, 2013* (the “Act”) allows the Workers’ Compensation Board (WCB) to provide support to the family of seriously injured workers.

POLICY

Travel

1. The WCB may give travel support to family members of seriously injured workers in an effort to reduce the short-term stress and hardship that may be caused as a result of their need to attend the treating facility.

2. The WCB will provide up to seven calendar days of travel support. If a life-threatening condition persists, support can extend past seven days.

3. Travel support includes reimbursement for:
a. Travel expenses to and from the hospital using the most practical means of travel from the family member's home.

b. Lodging.

c. Travel from the short-term lodging to the hospital and return twice per day.

d. Meals.

e. Long distance phone calls.

4. Travel, lodging and meal rates are set in PRO 54/2015, Expenses – Travel and Sustenance – PSC Rates.

Counselling

5. If the family needs help coping with the serious injury and its consequences, the WCB will pay for counselling.

6. The WCB will give travel support to families that need to travel outside their home community for counselling.

Child Care

7. The WCB will pay for child care costs that exceed what the family paid prior to the worker’s injury. This includes costs resulting from:

   a. Traveling to see the worker in hospital.
   
   b. Hospital attendance.

Additional Support

8. If needed, the WCB may also pay for such things as:

   a. Family member earnings loss.
   
   b. Laundry.
   
   c. Parking.

Act Sec # 2(1)(y), 103(1), 115(j)
Effective Date 01 June 2014
Application Family of workers that are seriously injured
Supersedes POL 11/2001  Family Support in Exceptional Circumstances
Complements PRO 06/2014  Support – Family of Seriously Injured Workers
                  PRO 54/2015  Expenses – Travel and Sustenance – PSC Rates
                  POL 39/2010  Expenses – Travel and Sustenance – General
                  POL 15/2008  Allowance – Temporary Additional Expense
                  PRO 15/2008  Allowance – Temporary Additional Expense
5.5 Allowances – Educational (POL 03/97) (Amended by ADM 03/2000)

Document Date 18 July 1997

Purpose To establish guidelines for education allowances for dependent children.

DEFINITION

1. Section 2(1)(ff) defines post secondary institution as follows: "post secondary institution includes a regional college, institute, private vocational school, university and any other educational institution that is not administered pursuant to The Education Act."

2. "Full time attendance" means taking at least 60% of a full-time instructional load for each semester or term as determined by the educational institution at which the student is enrolled, unless otherwise specified.

3. The Board will interpret "any other educational institution that is not administered pursuant to The Education Act" to mean the normally thought of post secondary institution.

4. The Board will interpret "other required fees" in Section 83(1)(b) to mean the fees usually charged by public educational institutions. It does not include such things as purchase, lease or rental of machines, equipment, or vehicles; uniforms; residence on campus; club memberships; intramural or intramural activities; etc.

5. Where relevant, in the context of school term, "term" will be interpreted to mean semester.

6. "A maximum of three years" in Subsection 83(3) means a total of 36 months.

BACKGROUND

1. Section 83 provides educational allowances for dependent children at least 18 years of age and in full-time attendance at a secondary or post-secondary institution.

2. Section 83(2) states that no amount is payable pursuant to subsection (1) after the later of:
   (a) the day on which the dependent child reaches the age of 25 years; and
   (b) the last month in the school term in which the dependent child reaches the age of 25 years.
3. Sections 83(3) states that the amounts described in subsection (1) are payable for a maximum of three years.

4. Sections 83(4) provides the Board with discretion to pay above the statutory monthly amount called for by Section 83(1)(a) to an amount it considers fair and just.

POLICY

1. The Board approves the replacement of policy 06/94 by a new policy of this date. Policy will now define Definition 2 (Full time attendance), previously it contained a reference to The Education Act.

2. Section 2(1)(f) is silent on whether the definition applies only to Saskatchewan located institutions. Application will be extended by the Board to out-of-Provence institutions given the word "includes" and the fact that a dependent child of a fatally injured worker already enrolled in a post secondary education institution outside the province at the time of the fatality would be discriminated against.

3. Amounts awarded for Saskatchewan and other Canadian post secondary institutions will be for actual costs incurred unless specifically approved in advance.

4. Reasonable allowances may be awarded for schooling outside Canada, but may not exceed the maximum cost for similar or related programs at Canadian institutions.

5. Where the desired schooling is not available in Canada, reasonable allowances may be awarded.

6. Correspondence schools and training of any kind that falls outside Definitions 1 & 3 is a special case requiring managerial approval.

7. All requests for allowances must be supported by receipt and certification of attendance.

Act Sec # 2(1)(f), 83
Effective Date 01 January 1997
Amended ADM03/2000 – 10 January 2000
References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All Dependent Children Over 18 Years of Age
Supersedes POL 06/94 Allowances, Educational
Complements PRO 19/96 Dependent Children Attending School
POL 07/2007 Voluntary Relocation Outside Canada
5.6 Worker’s Death Prior to the Issuance of Entitlement (POL 03/2011)

Document Date 24 January 2011

Purpose To provide guidelines for determining and issuing compensation for a worker who dies prior to the issuance of entitlement under The Workers’ Compensation Act, 2013.

DEFINITION

Entitlement, for the purpose of this policy, includes, but is not limited to, allowances, awards, wage loss payments and expense reimbursements.

BACKGROUND

1. Section 81 of The Workers’ Compensation Act, 2013 (the “Act”) outlines entitlement and (re) employment assistance payable to dependent spouses (and dependent children) where the death of the worker was due to a compensable injury.

2. Section 93(1) and (2) directs that on the death of a worker who was or would have been entitled to compensation under this Act at the time of death, the Workers’ Compensation Board (WCB) shall, if no compensation is payable under Sections 80 to 86, pay to the dependent spouse or, if the worker died leaving no dependent spouse, to the worker’s dependent children or any other persons recognized by the WCB as being dependants, in any share that the WCB may determine, an amount equal to the compensation the worker received or would have been entitled to receive, as the case may be, in respect of a period of three months.

3. Section 93(3) of the Act states that if a worker dies of a condition for which no benefits are payable pursuant to Sections 80 to 86 and that worker received compensation for a period exceeding 24 consecutive months before the day of the worker’s death, the WCB shall pay to the worker’s dependent spouse a monthly allowance, equal to the monthly amount of compensation that was being paid to the worker, for 12 months following the day of the death of the worker and, in addition the WCB may provide retraining services to assist the dependent spouse to enter the labour force.

4. The following policy will address how the WCB will provide payment in the event a worker dies prior to the issuance of entitlement.

5. The intent of the following policy is to provide direction for instances where the Act does not dictate that benefits are to be paid to a dependant as called for by Sections 81 and 93 of the Act.
POLICY

1. Where a worker dies and it is evident that the worker would have been eligible for entitlement, payment shall be made to the worker's estate except where Sections 81 and 93 of the Act apply.

2. Entitlement for a PFI award will reflect an estimation of the PFI rating that would have been awarded to the worker had an assessment been completed prior to the worker's death.

Act Sec #  80, 81, 82, 83, 84, 85, 86, 93
Effective Date  03 February 2012 (effective as of implementation date of new claims system).
Amended  References updated 01 January 2014 in accordance with The Workers' Compensation Act, 2013
Application  All claims where death occurs on or after the effective date
Supersedes  POL 06/78  PFI – Fatal Claims
Complements  POL 33/2010  Initial Entitlement and (Re)Employment Assistance – Dependent Spouses
              POL 23/2010  Permanent Functional Impairment (PFI) – General
## 6.0 ADMINISTRATIVE GUIDELINES

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6.1 Arising Out of and In the Course of Employment (POL 12/2013)

Document Date 17 December 2013

Purpose To clarify when an injury arises out of or in the course of employment.

DEFINITION

**Arising out of employment** means the injury must have a link to, originate from, or be the result of a hazard from employment.

**In the course of employment** means the injury must:

a. Happen at a time and place related to employment, and

b. Be the direct result of an activity performed for employment.

**Acute injury** means an injury caused by an identifiable work-related incident that results in immediate or near immediate symptoms.

**Delayed onset injury** means an injury caused by a single or series of work-related incidents or exposures over time that results in a delayed symptom onset.

**Employment hazard** means a work circumstance that presents a direct or indirect risk of injury to the worker.

**Imported hazard** means a risk or condition that is personal to the worker. It is not considered a hazard arising out of employment. For example, a medical condition such as epilepsy or diabetes, food poisoning from a home-made lunch, or catching one’s finger in one’s own car door.

**Employer premises** means the work location in which the worker is entitled to be. This includes employer leased or owned and controlled areas used by workers to go to and from work. For example, entrances, exits, stairs, elevators, lobbies, parking lots and passageways.

**Temporary lodging** means a worker’s residence at a distant work location paid for by the employer. For example, work camps, trailers, motels, or hotels.

**Paid break** means a rest break permitted under a labour agreement or authorized by the employer. For example, coffee breaks.
BACKGROUND

1. Section 2(1)(r) of The Workers’ Compensation Act, 2013 (the “Act”) defines an injury arising out of and in the course of employment as:
   a. The results of a wilful and intentional act, not being the act of the worker;
   b. The results of a chance event occasioned by a physical or natural cause;
   c. A disabling or potentially disabling condition caused by an occupational disease;
   d. Any disablement.

2. The Workers’ Compensation Board (WCB) has exclusive jurisdiction to determine “whether any injury has arisen out of or in the course of employment” (Section 20(2)(b)).

3. Under Section 23 the WCB will base a decision on the real merits and justice of each case. The decision is not bound to follow any legal precedent. The benefit of doubt will be given to the worker when the evidence in support of opposite sides of an issue is approximately equal.

4. Unless the contrary is proven, Section 27 of the Act directs the WCB to presume the following:
   a. If an injury arises out of a worker’s employment, it is presumed that it occurred in the course of employment.
   b. If an injury occurs in the course of a worker’s employment, it is presumed that it arose out of employment.

5. The many circumstances where coverage is or is not indicated cannot be addressed under one policy. Therefore, the examples in this policy have been provided as guidelines.

POLICY

1. The WCB will cover a worker’s injury if it arises out of and in the course of employment.

2. Both acute and delayed onset injuries can arise out of and in the course of employment. When adjudicating a claim, the WCB will obtain all relevant evidence and determine entitlement based on the weight of that evidence. If there is no evidence of an acute injury, the WCB will consider whether the worker has suffered a delayed onset injury.

3. A worker will only have coverage if:
   a. Their actions at the time of injury are being performed for the purpose of employment, or
b. The injury is caused by the conditions of employment.

4. A worker may not receive compensation if the injury is the result of the worker’s serious and wilful misconduct (POL 13/2011, Serious and Wilful Misconduct).

**Arising Out of Employment**

5. An injury arises out of employment when it results from an employment hazard.
   a. An employment hazard may directly arise out of employment. For example, a cut from machinery or inhaling chemicals.
   b. An employment hazard may also indirectly arise out of employment. For example:
      i. Safe access to and from work.
      ii. Reasonable use of employer premises (i.e., a lunchroom or washroom), and
      iii. Work-related travel.
   c. An employment hazard may also arise from repetitive work activities or prolonged exposure to an employment hazard. For example, repetitive strain injuries, occupational noise induced hearing loss, or injuries resulting from poor ergonomics or static positioning.

6. Risks or conditions that are personal to the worker are considered imported hazards as opposed to hazards arising out of employment. The WCB may, however, provide coverage for an injury if the WCB determines that employment hazards increased the risk or aggravated the condition.

**In the Course of Employment**

7. An injury occurs in the course of employment when it happens in a time and place linked to employment.

8. Time and place are not limited to the normal hours of work or the employer premises. However, there must be a relationship between:
   a. The time and place of the injury, and
   b. Employment.

9. A work injury that results from an activity or event incidental to employment will have occurred in the course of employment. For example, a lightning strike or insect bite.

**Coverage, Travelling to and from or for Work**

10. The WCB will not provide coverage for an injury that occurs during travel to and from or for work unless the travel is under the control of the employer. Travel is under the control of the employer when:
a. The worker is travelling to and from employment or for the purpose of employment in a vehicle owned, leased, or otherwise paid for by the employer. For example:
   i. A crew bus, or
   ii. A vehicle supplied by the employer to respond to calls outside normal working hours.

b. The employer pays wages for time spent or mileage for distance travelled in a personal vehicle.

c. A worker responds to an emergency call and must take immediate action. In this instance, coverage is from the time the worker leaves home until their return (POL 28/77, Injuries, Responding to Emergency, and POL 07/2009, Injuries, Workers Acting as Good Samaritans).

d. In the above cases:
   i. Coverage will only apply when the worker is following the most practical route between the worker’s residence and the work site.
   ii. Coverage will extend to basic comfort needs, such as rest stops and meals, which are reasonably close to the direct route of travel.

11. Coverage will not apply to a worker who receives a predetermined travel allowance unrelated to the actual distance travelled. In these cases, the employer does not have control over the route or mode of travel.

Coverage, Temporary Lodging

12. If an employer reimburses a worker for temporary lodging:
   a. Coverage will extend to the reasonable and permitted use of temporary lodging facilities. For example, dining and laundry facilities.
   b. Coverage will not extend to the use of facilities which introduce significant additional risk. For example, pools or fitness facilities.

Coverage, Entering or Exiting Employer Premises

13. The WCB will provide coverage when an injury:
   a. Happens on the employer premises, and
   b. Results from the condition of the property or an event under the control of the employer.

14. A worker will not receive coverage for an injury resulting from an imported hazard. For example, an injury while repairing a personal vehicle on the employer premises.

15. The WCB may extend coverage when there is a combination of:
   a. Hazards imported by the worker or another worker, and
b. Hazards related to the employer premises.

For example, a worker who is struck by another employee’s car or a worker who slips on the employer’s parking lot surface while stepping out of their personal vehicle.

16. A worker will have coverage when using or crossing an employer controlled parking lot for the purpose of:

a. Accessing an employer provided parking spot, or
b. Entering or exiting employment.

17. A worker will not have coverage while crossing public property to enter or exit employment.

18. In multi-user premises, such as malls and business towers, the employer will make payments to the owner of the property to maintain the areas intended for common use. This may include parking lots, common walkways, and elevators.

a. Coverage will extend to common use areas if a worker crosses these areas in the performance of their job or while entering or exiting employment.

b. Coverage will not extend to common use areas if the worker crosses these areas for a purpose unrelated to employment (for example, personal shopping).

Coverage during Rest Breaks

19. The WCB will extend coverage to an injury that occurs during a paid break on the employer premises when it results from hazards of the premises. There is no coverage for an injury resulting from an imported hazard.

20. Coverage will not extend to breaks taken away from the employer premises. For example, breaks taken offsite for personal activities such as:

a. Shopping.
b. Bill paying.
c. Work breaks off of the employer premises, or
d. Going to a car that is not on an employer controlled parking lot.
Act Sec # 2(1)(r), 20, 23, 26, 27, 29, and 30
Effective Date 01 January 2014.
Amended References updated in accordance with The Workers’ Compensation Act, 2013.
Application All injury claims on or after the effective date.
Supersedes
- POL 13/2001 Arising Out of and In the Course of Employment
- POL 12/98 Injuries, Travelling to and from or for Work
- POL 27/95 Injuries, Rest Breaks
- POL 17/91 Injuries, Entering or Exiting Employer Premises
Complements All policies covering injury claims.
POL 13/2011 Serious and Wilful Misconduct
6.2 Employer Late Reporting of Injury Claims (POL 02/2009)

Document Date 10 March 2009

Purpose To establish guidelines for the prosecution of employers for late reporting of work-related injuries.

DEFINITION

Employer, as defined by Section 2(1)(l) The Workers’ Compensation Act, 2013 (the “Act”), means “any person, association or body having in its service any worker engaged in any work in, about or in connection with an industry.” The employer may be a sole proprietor, a partnership, a corporation, or another type of legal entity.

Medical Treatment means attendance for appointments at the primary, secondary or tertiary level of treatment.

BACKGROUND

1. Section 2(1)(r) of the Act specifies that an injury means “all or any of the following arising out of and in the course of employment:
   i. The results of a wilful and intentional act, not being the act of the worker;
   ii. The results of a chance event occasioned by a physical or natural cause;
   iii. A disabling or potentially disabling condition caused by an occupational disease;
   iv. Any disablement.”

2. Section 52(1) of the Act instructs that “within five days after the date on which an employer becomes aware of an injury that prevents a worker from earning full wages or that necessitates medical aid, the employer shall notify the board in writing of:
   a. The nature, cause and circumstances of the injury;
   b. The time of the injury;
   c. The name and address of the injured worker;
   d. The place where the injury happened;
   e. The name and address of any physician who attends the worker for his or her injury; and
   f. Any further particulars of the injury or claim for compensation that the board may require.”

3. Section 54 of the Act directs that “unless excused by the board, an employer who contravenes Section 52 or 53:
a. Is guilty of an offence and liable on summary conviction to a fine of not more than $1,000; and

b. If the board so orders, shall pay to the board any part of the amount of compensation and medical aid that the board awards for that injury, whether or not the employer has been convicted of an offence.”

4. Following consultation with employers, the Board found that the reporting period directed by Section 52(1) of the Act (5 calendar days) creates an unfair burden on the Judicial System because of the high volume of claims that are reported beyond 5 calendar days. Therefore, employers with a chronic pattern of late or non-reporting will prompt punitive measures.

5. Section 163(1) of the Act states that “every agreement between a worker and his or her employer to waive or forego any of the compensation to which the worker or the workers’ dependents are or may become entitled pursuant to this Act is void.”

POLICY

1. In the event of an injury as defined by Section 2(1)(r) of the Act, the employer must report the injury to the WCB in accordance with Section 52(1) of the Act, even where there is disagreement with the validity of an injury. Due to the Board’s directive, employers with a chronic pattern of late reporting of work related injuries will prompt punitive measures. The WCB will consider that an employer has reported an injury on the date the WCB receives details of the injury.

2. The obligation of the employer to report an injury to the WCB commences when an employer or a designated representative of the employer first becomes aware of, or could reasonably have been expected to become aware of, the injury.

3. The worker and employer cannot agree to waive or forgo benefits under Section 163(1) of the Act. Employers have an obligation to report work related injuries to the WCB. An employer cannot, directly or indirectly, attempt to impede a worker, or the worker’s dependant, from reporting an injury to the WCB.

4. Where an employer is identified to have contravened Section 52(1) of the Act and has a chronic pattern of late reporting of work-related injuries, the WCB will provide the employer with a three month grace period before applying Section 54 of the Act, in order to provide the employer with time to correct reporting problems.

5. Where an employer continues to be late in reporting injuries to the WCB following this period, the WCB will issue the employer a “Final Notice Letter.” If subsequent incidences occur, enforcement proceedings under Section 54 of the Act will proceed.
### Administrative Guidelines

**Doc # 6.2**  
**Employer Late Reporting of Injury Claims (POL 02/2009)**

<table>
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<tr>
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<th>2(1)(l), 2(1)(r), 52(1), 53, 54, 163(1), 180(3)</th>
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<td>Amended</td>
<td>References updated 01 January 2014 in accordance with <em>The Workers' Compensation Act, 2013</em></td>
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<td>Application</td>
<td>All employers reporting work injuries</td>
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| Complements | **PRO 02/2009**  
**Employer Late Reporting of Injury Claims** |
6.3 Date of Injury (POL 04/2013)

Document Date 22 May 2013

Purpose To establish guidelines for determining a worker’s date of injury.

DEFINITION

**Acute injury** means an injury caused by an identifiable work-related incident that results in immediate or near immediate symptoms.

**Delayed onset injury** means an injury caused by a single or series of work-related incidents or exposures over time that results in a delayed symptom onset.

BACKGROUND

Section 2(1)(r) of The Workers’ Compensation Act, 2013 (the “Act”) states that “'injury' means all or any of the following arising out of and in the course of employment:

(i) the results of a wilful and intentional act, not being the act of the worker;
(ii) the results of a chance event occasioned by a physical or natural cause;
(iii) a disabling or potentially disabling condition caused by an occupational disease;
(iv) any disablement.”

POLICY

1. The date of injury for acute injury claims is the date of the identifiable work-related incident.

2. The date of injury for delayed onset injury claims is the date the worker initially:
   a. sought medical care for the injury; or
   b. reported the injury to the WCB;
   whichever occurs first.

3. The date of injury for communicable disease injury claims, although considered delayed onset, is the date the worker initially:
   a. sought medical care for the injury;
   b. reported the injury to the WCB; or
   c. informed the employer of the injury;
   whichever occurs first.
### Act Sec #
2(1)(r), 26, 27

### Effective Date
01 July 2013

### Amended
References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

### Application
All claims

### Supersedes
- POL 39/80  Date of Injury
- POL 11/2012  Injuries – Hearing Loss
- POL 02/2010  Injuries – Communicable Disease
- POL 01/2009  Injuries – Psychological
- POL 06/2012  Injuries – Firefighters
- POL 05/2013  Injuries – Heart Attack
- POL 11/2003  Injuries – Occupational Disease
6.4 Funding (POL 01/2014)

Document Date 25 February 2014

Purpose To establish guidelines for the maintenance of a fully funded status.

BACKGROUND

1. Over the years, the funded status of the Workers’ Compensation Board (WCB) has fluctuated according to the operating surpluses or deficits of previous fiscal years. This instability in the WCB’s funded status was due, in part, to the absence of a funding policy. The Workers’ Compensation Act, 2013 (the “Act”) requires the WCB to maintain a funded status although the extent of the reserves to be held by the WCB is left to the discretion of the Board Members.

2. The WCB established its first funding policy in 1997. At that time, a commitment was made to review and adjust the levels in the various reserves to better reflect actual and anticipated usage of these reserves.

3. Changes to the funding policy were implemented in 2002 and 2004 to incorporate current actuarial practices and changes in the accounting principles regarding the reporting of investments and investment income.

4. In 2006, an Asset Liability study was conducted with the specific intent of taking a comprehensive look at the interaction of the WCB’s assets, liabilities, reserves, and funding policy. The study presented some recommendations in regards to target funding levels. In 2007, the WCB received feedback in regards to a discussion paper that was distributed to various stakeholders. As a result, the WCB recommended that the targeted range estimated for the Injury Fund and the levels of the various reserves should be modified to reflect today’s environment while maintaining a fully funded status that is consistent with the statutory requirements of the Act.

5. In 2011, the funding policy required updates to reflect Canada’s conversion to International Financial Reporting Standards (IFRS). These standards are effective for the 2011 financial reporting year.

POLICY

1. To build and support long-term financial stability, the targeted ranges and levels of the funds and reserves maintained by the WCB will be determined by the previous year’s benefit liabilities as actuarially determined.

2. The Injury Fund will ensure sufficient funds are available to meet required benefit levels and will reduce fluctuations in the average premium rate. The targeted funding range for the Injury Fund will be 105 percent to 120 percent of benefit liabilities.
3. Where the Injury Fund shifts out of the targeted range, the WCB will replenish or regulate the fund to maintain the targeted range:
   a. Where the funded status falls below 103 percent, the WCB, at its discretion, will make a decision on how to replenish the Injury Fund. Generally speaking, the replenishment will be accomplished through a charge to the premium rates as part of the annual rate setting process over a period not to exceed five years.
   b. Where the funded status rises above 122 percent, refunds will be given back to the employers, at the WCB’s discretion, over a period not to exceed five years until the fund reaches 120 percent.

4. The Disaster Reserve and the Occupational Disease Reserve are established to meet the requirements of the Act with respect to disasters and to meet the costs of emerging occupational diseases. This reserve is separated into three different reserves:
   a. Disaster – Part 1 will cover the potential volatility in less severe disasters that meet the requirements as specified in point 1(a) of POL 12/2014, Disaster Reserve. This reserve is set at one percent of benefit liabilities.
   b. Disaster – Part 2 will cover rare but severe disasters as specified in point 1(b) of POL 12/2014. This reserve is set at one percent of benefit liabilities.
   c. The Occupational Disease Reserve provides cost relief and protection to employers who may be faced with high costs for diseases caused by past exposure for which they may not be responsible or for industries where the employer is no longer in business. The level of the reserve will be established by the WCB from time to time based on actuarial valuation.

5. The Second Injury and Re-employment Reserve provides employers with cost relief on claims that are attributed to an earlier injury, an injury following re-employment and other circumstances established in POL 21/2010. Based on past utilization of this reserve, the Second Injury and Re-Employment Reserve is set at one percent of benefit liabilities as actuarially determined.

6. To maintain stable funding levels and premium rates under International Financial Reporting Standards (IFRS), unrealized gains and losses on investments will not be considered in the determination of the WCB’s funded status.

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<tr>
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<tr>
<td>Application</td>
<td>Injury Fund and Second Injury and Re-Employment Reserve levels</td>
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<td>Supersedes</td>
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<td>POL 05/2014 Occupational Disease Reserve</td>
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</table>
6.5 Determination of a Worker’s Right to Bring Action (POL 01/2013)

Document Date 15 January 2013
Purpose To establish guidelines for determining if a right of action exists.

DEFINITION

Action means any civil claim against another party which may include grievances and matters that may be examined before other tribunals.

BACKGROUND

1. Section 43 of The Workers’ Compensation Act, 2013 (the “Act”) states “no employer and no worker or worker’s dependant has a right of action against an employer or a worker with respect to an injury to a worker arising out of and in the course of the worker’s employment.”

2. Under Section 169(1) of the Act states “any party to an action may apply to the board for adjudication and determination of the question of:
   a. the plaintiff’s right to compensation pursuant to this Act; or
   b. whether the action is barred by this Act.”

3. Section 169(2) of the Act adds that “the board’s adjudication and determination pursuant to this section is final and conclusive.”

POLICY

1. The Workers’ Compensation Board (WCB) will identify third party actions in accordance with POL 13/2014, Third Party Actions. This will usually involve the Operations staff and Subrogation Administrator determining whether a right of action exists. This determination does not constitute a ruling under Section 169 of the Act.

2. A party to an action may dispute whether the right to the action is removed by the provisions of the Act. To resolve the dispute, the party must make application for a ruling under Section 169 of the Act.

3. All applications under Section 169 shall be received and developed by the Board Services department. All rulings will be made by the Board Members.
<table>
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<th><strong>Act Sec #</strong></th>
<th>43, 167, 168, 169.</th>
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<td><strong>Effective Date</strong></td>
<td>01 February 2013.</td>
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<td><strong>Amended</strong></td>
<td>References amended 01 January 2014 in accordance with <em>The Workers’ Compensation Act, 2013</em></td>
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<tr>
<td><strong>Application</strong></td>
<td>All applicants desiring to bring an action.</td>
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<tr>
<td><strong>Supersedes</strong></td>
<td>POL 26/95 Determination of a Worker’s Right to Bring Action</td>
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6.6 Third Party Actions (POL 13/2014)

Document Date  02 September 2014

Purpose  To provide guidelines for the management of third party actions.

DEFINITION

Client means an injured worker or a surviving dependant.

Third party, for the purpose of this policy, means a person or entity that is not a worker or employer within the meaning of The Workers’ Compensation Act, 2013 (the “Act”).

Subrogation means the substitution of one person or group by another in respect of a debt or insurance claim. This includes the transfer of any associated rights and duties. For the purpose of this policy, the right of subrogation arises when the Workers' Compensation Board (WCB) pays claim costs for a client and then attempts to recover these costs from the third party responsible for the work injury.

Third party action means a civil claim to recover damages suffered by the client as the result of a work injury caused by the actions or neglect of a third party. The client or the WCB would bring legal action against the third party.

BACKGROUND

1. When a client has a right of action against a third party with respect to a work injury, and the client is entitled to WCB benefits, the client (Section 38):
   a. Will receive compensation, and
   b. May bring legal action against the third party.

2. The Act provides the WCB with the right of subrogation (Section 39). To recover claim costs, the WCB may:
   a. Bring legal action in its own name against the third party, or
   b. Join with the client in their legal action against the third party.

3. Before the client receives any money, the WCB will recover money for the claim costs and the WCB’s share of the legal costs. Any sum remaining after the WCB’s recovery is payable to the client (Section 40).

4. When a client plans to take legal action against a third party they must provide written notice to the WCB. Likewise, the WCB will provide written notice if it plans to take action. In either situation, failure to give notice does not affect the claim of action (Section 41).
5. The WCB must provide written approval for any settlement that is less than the amount of the claim costs provided under the Act (Section 42).

**POLICY**

1. A client cannot sue an employer or worker covered under the Act with respect to a work injury. They may, however, take action against a third party not covered under the Act.

Workers' Right to Bring Action

2. Clients, who have a right of action against a third party not covered by the Act, are entitled to:
   a. Receive compensation, and
   b. Take action against the responsible third party.

3. Clients must give notice to the WCB of their intention to take action. The WCB will advise the client or their representative of the WCB’s claim in the third party action.

Subrogation

4. If the client chooses not to take action, the WCB will review the case to determine whether it should take action to recover the costs of the claim.

5. The WCB will only seek recovery on an accepted claim that is work related.

6. The WCB will not seek recovery when the claim is for a worker covered by the Government Employees Compensation Act (GECA).

7. When the WCB takes action against a third party it will seek only to recover the damages for which the WCB has paid or will pay for future claim costs. The WCB will not pursue any part of the action on behalf of the client.

Employer Cost Relief

8. The WCB will provide respective employers cost relief when it is successful in recovering all or part of the claim costs through subrogation or through its own action.

Distribution of Settlement Funds

9. The WCB may:
   a. Keep the entire settlement if the settlement is less than the amount of the client’s claim, or
b. Where circumstances warrant it, the WCB may negotiate a fair and reasonable settlement.

10. If the amount of the settlement is greater than the claim costs and any anticipated future costs, the WCB will:
   a. Keep the funds recovered for current and future costs, and
   b. Pay the remainder to the client.

Approval of Settlements

11. The Board Members give the Chief Executive Officer (CEO) the authority to approve settlements. The CEO may give this authority to the Corporate Solicitor.

Compromised Settlements

12. The WCB must provide written approval for a settlement that is for an amount less than the claim costs.

Act Sec # 2, 38, 39, 40, 41, 42, and 43
Effective Date 01 November 2014.
Application All claims involving third parties.
Supersedes POL 04/2007 Third Party Actions/Subrogation
Complements PRO 13/2014 Third Party Actions
POL 01/2013 Determination of a Worker's Right to Bring Action
6.7 Compensation – Layoff, Strike or Lockout (POL 02/2008)

Document Date 15 January 2008

Purpose To establish guidelines for determining entitlement where the worker’s return-to-work plan is disrupted by layoff, strike or lockout.

DEFINITION

Return-to-Work (RTW) means the act of re-introducing the injured worker to safe and suitable productive employment that eliminates or minimizes wage loss, as soon as medically possible.

Return-to-Work Plan means the plan or process designed to facilitate the injured worker’s return to work through a coordinated effort addressing medical restrictions, individual needs, and workplace conditions.

BACKGROUND

1. Section 26 of The Workers’ Compensation Act, 2013 (the “Act”) states if a worker suffers an injury, the worker is entitled to compensation. Compensation is to be paid by the board out of the fund.

2. POL 08/96 outlines the WCB’s position on return-to-work (RTW) plans. Occasionally a layoff, strike or lockout occurs which affects not only the normal complement of workers, but also those who have returned to work on a RTW plan. Injured workers should not be totally sheltered from the effects of labour disruptions over their fellow workers.

3. The following provides guidelines for determining entitlement to benefits for injured workers who are unable to participate in their RTW or light-duty programming, due to a layoff, strike or lockout.

POLICY

1. Where a worker is employed part-time or participating in a partial RTW program, which is then interrupted by a layoff, strike, or lockout, the worker will continue to receive partial WCB benefits. WCB will neither increase benefits nor place the worker on full benefits so long as the layoff, strike or lockout, rather than the work injury, is the reason the worker cannot continue in his/her employment or RTW plan.

2. Where a layoff, strike, or lockout is long-term without a specific recall date, the worker may be required to make efforts to mitigate his/her losses by seeking appropriate alternate employment, depending on what is reasonable given the
worker’s particular circumstances (e.g., years of seniority, job skill level, nature of employment, severity of injury and how long the work disruption is expected to last).

3. Where the worker is declared fit for full pre-injury employment while the layoff, strike, or lockout continues, benefits will end.

| Act Sec # | 26, 100 |
| Effective Date | 01 February 2008 |
| Amended | References updated 01 January 2014 in accordance with The Workers’ Compensation Act 2013 |
| Application | All workers who are unable to participate in their return-to-work (RTW) programming, due to a layoff, strike or lockout. |
| Supersedes | POL 07/96 Return-to-Work Plan, Layoff |
| Complements | POL 08/96 Return-to-Work Plans |
| | POL 01/2011 Vocational Rehabilitation – Programs and Services |
| | PRO 02/2008 Compensation – Layoff, Strike or Lockout |
| | PRO 01/2011 Vocational Rehabilitation – Programs and Services |
| | PRO 01/2011 Vocational Rehabilitation – Programs and Services |
DEFINITIONS

Client means an injured worker or dependent spouse.

BACKGROUND

The Workers’ Compensation Board (WCB) ensures clients who voluntarily relocate outside Canada continue to receive the best customer service possible by providing consistent case management, efficient and secure payment of benefits, and addressing any administrative issues.

POLICY

1. After acceptance of a claim, WCB will provide the client with information regarding:
   a. The client’s obligation to notify WCB if he/she plans to reside outside Canada; and
   b. The effect the move may have on benefit entitlement (e.g., possible suspension or termination of benefits where a worker is receiving active treatment, which is then interrupted or extended by the relocation).

2. WCB is to conduct an annual review of the client’s file on the anniversary date of the claim.

3. Where the client receives income from any source for which a tax return is filed (whether in Canada and/or the client’s current country of residence), a copy of the return must be provided to WCB. Where the client does not file a tax return, he/she will inform WCB of this in writing, including confirmation of earnings.

Payment of Compensation and Other Expenses

4. Where a client voluntarily relocates outside Canada following a work injury:
   a. Method of payment will be made through either the issuance of a physical cheque or electronic funds transfer (upon the request of the client);
   b. In accordance with current banking processes, clients who request electronic funds transfer as their payment option will be required to maintain a bank account domiciled in Canada into which WCB benefits will be electronically deposited;
c. All payments for earnings loss compensation are to be issued in Canadian funds;

d. All medical expenses associated with the claim (e.g., caregiver services, appliances, prescription drugs) are to be reimbursed in Canadian funds not exceeding Saskatchewan rates. Where WCB arranges the treatment, actual costs will be paid;

e. Travel expenses incurred are to be paid as directed in POL 39/2010 or its successor. Expenses should not be considered in excess of what would be reasonable had the client been required to travel within Saskatchewan to obtain medical care;

f. Where a worker claims total disablement and he/she moves during active treatment, suspension of benefits will be considered if any disruption in medical or rehabilitation services occurs;

g. Where a client relocates outside Canada after resuming work or completing medical treatment/vocational programming and there is a recurrence of the work injury, the new place of residence will be considered the client’s primary residence for payment of expenses.

h. Cost of translations necessary for the management of the claim, regardless of whether WCB makes arrangements, will be the responsibility of the client;

i. The costs for tuition and books for dependent children are to be paid as if they had remained in Saskatchewan and in accordance with POL 03/97 or its successor.
6.9 Verification of Earnings (POL 12/2010)

Document Date 03 March 2010

Purpose To establish guidelines for the verification of earnings.

DEFINITION

Long-Term Earnings Replacement, for the purpose of this policy, means the payment issued when a worker is in receipt of wage loss benefits for a period in excess of 12 consecutive months; a worker is unable to return to pre-injury; or a dependant spouse is in receipt of benefits under Section 81(6) of The Workers’ Compensation Act, 2013.

BACKGROUND

The inception of a wage loss system on January 1, 1980 has required on-going reviews of workers’ actual or estimated earnings where workers are provided compensation for earnings loss resulting from injury. A review of files with wage loss benefits paid identified differences between the information used to determine entitlement and that actually earned or reported by workers. These findings justify the need to establish guidelines for the verification of earnings.

POLICY

1. When a worker or dependent spouse is in receipt of long-term earnings replacement, the Workers’ Compensation Board (WCB) will annually verify the client’s earnings based on information received from the Canada Revenue Agency (CRA). Exemption status and whether Canada Pension Plan benefits are received by the worker will also be verified.

2. Annual verification of earnings will ensure that the information used for the purpose of calculating long-term earnings replacement is reflective of the actual or estimated earnings of the worker or dependent spouse.

3. Where verification of earnings confirms that a client’s long-term earnings replacement was calculated using incorrect information, the WCB will recalculate and retroactively adjust long-term earnings replacement. All overpayments resulting from recalculation will be pursued in accordance with POL 38/2010, Overpayment Recovery – Compensation.

4. Where CRA tax information is unavailable, the WCB may use alternate means of verification that provides proof of earnings.
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6.10 Calculation of Net Compensation Payable (POL 03/2007)

Document Date 28 February 2007

Purpose To explain the calculation of net compensation.

BACKGROUND

1. Section 2(1)(k)(ii) of The Workers’ Compensation Act, 2013 (the “Act”) states that net compensation shall be the worker’s “gross earnings from employment less the probable deductions for:
   (A) the probable income tax payable by the worker calculated by using only the worker’s earnings from employment as his or her income, and using only the worker’s basic personal exemption, exemption for dependants and employment-related tax credits, as at the date of the worker’s injury and each anniversary date, as the worker’s deductions;
   (B) the probable Canada Pension Plan premiums payable by the worker; and
   (C) the probable employment insurance premiums payable by the worker.”

2. Section 68(1)(b) of the Act states that a worker who sustains an injury on or after this clause comes into force shall be compensated for his/her earnings loss “in an amount equal to 90% of that loss of earnings.”

3. Section 2(3) of the Act states the Workers’ Compensation Board (WCB) must annually establish a schedule setting out a table of earnings and probable compensation from employment for the purposes of Section 2(1)(k).

4. New tables must be calculated and published on each occasion where there is a legislated change to income tax deductions either federally or provincially.

POLICY

1. For all legislated changes to the base calculations, WCB will publish revised tables of earnings and incorporate them into the calculation of "net earnings loss" when income tax changes become available.

2. As per Sections 2(1)(k) and 68 of the Act, a worker’s net earnings will be calculated based on gross earnings from employment, less the probable deductions for tax credits and/or tax exemptions. Probable deductions will be based upon the information that the worker has authorized the employer to deduct from his/her employment earnings for income tax purposes and which is available as of the commencement of the loss of earnings.
3. Where, after the initial commencement of loss of earnings, a change occurs to the following:
   a. Dependent status (e.g., through birth or death), or
   b. WCB tax tables (due to federal and/or provincial government announcements regarding retroactive income tax changes)

   the wage base will be adjusted, prospectively, on the anniversary of the claim. A worker’s original wage base will not be adjusted retroactively.

Act Sec # 2(1)(k), 2(3), 37, 68(1)(b)
Effective Date 28 February 2007
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All claims.
Supersedes POL 10/88 Sections 68 (3)(b) & (4) – Calculation of Net Compensation Payable
Complements PRO 59/2015 Calculation of Net Compensation Payable
POL 02/2015 Compensation – Dependent Spouse After Initial Entitlement
6.11 Attachment of Compensation (POL 04/2010)

Document Date 02 March 2010

Purpose To establish guidelines for legal attachments on compensation.

DEFINITION

Wage loss benefits, also referred to as loss of earnings benefits, means the compensation payment for the wage loss incurred beyond the day of injury by a worker as a result of a workplace injury. Wage loss benefits are based on the injured worker’s gross earnings up to the maximum insurable amount and include short-term wage loss, earnings replacement, and or any commutation of these, paid in accordance with The Workers’ Compensation Act, 2013 (the “Act”). Wage loss benefits may also include a medical pension granted under The Workers’ Compensation Act, 1974.

BACKGROUND

1. Section 165 of the Act directs that no compensation payable to a worker may be assigned, charged or attached without approval from the Workers’ Compensation Board (WCB). The exception is where the WCB receives notices of garnishment that are obligatory in nature.

2. Legal attachments on compensation originate almost exclusively from the Canada Revenue Agency (CRA), support orders and agreements filed under The Enforcement of Maintenance Orders Act, 1997, or Employment and Social Development Canada (ESDC).

3. Section 33 of The Enforcement of Maintenance Orders Act, 1997 directs that notwithstanding any other Act, any notice of garnishment or notice of continuing garnishment served pursuant to this Act has priority over:
   a. Any assignment made after the date of service of that notice; or
   b. Any garnishment, execution or attachment made pursuant to any other Act against the same money whether made before or after service of the notice or garnishment or notice of continuing garnishment.

POLICY

1. All legal attachments on compensation from the CRA, the Saskatchewan Ministry of Justice and Attorney General’s Maintenance Enforcement Office (MEO), or ESDC will be honoured by the WCB according to the terms of these agencies.

2. In cases of multiple notices of garnishment that are obligatory in nature, the CRA will have exclusive priority regardless of reason. Second priority will be given to the MEO, and third priority to ESDC.
3. A garnishee must pay the full amount required by the CRA before honouring legal attachments from the MEO or ESDC.

4. Where an obligatory notice of garnishment is received, wage loss benefits, permanent functional impairment or disfigurement awards will be subject to the terms of the notice or order. Annuity benefits will be subject to garnishment if the notice or order is in effect at the time the worker turns age 65 and the annuity is payable, unless any applicable legislation requires payment before age 65.

5. Monetary benefits paid to third parties for services provided in connection with the treatment, rehabilitation and or accommodation of workers (e.g., medical services provided by health care professionals, work or home modifications completed by contractors) are exempt from legal attachments. Allowances and reimbursements provided for travel, sustenance and medications will not be subject to garnishment.

**Act Sec #** 165, 166  
*The Enforcement of Maintenance Orders Act, 1997* sections 33, 40.5, 40.6, 40.7, 40.8, 40.9, 40.91  
*The Enforcement of Maintenance Orders Regulations, 2009* sections 8, 9, Form I, Form M

**Effective Date** 03 February 2012  
**Amended** References updated 01 January 2014 in accordance with the *Workers’ Compensation Act, 2013*  
**Application** All obligatory notices of attachment of compensation benefits on and after the effective date  
**Supersedes** POL 09/2008 Attachment of Compensation  
**Complements** PRO 04/2010 Attachment of Compensation
6.12 Benefit of the Doubt (POL 03/2012)

Document Date 16 January 2012

Purpose To establish the basis on which decisions will be made.

DEFINITION

Decision means, generally, any decision made pursuant to The Workers’ Compensation Act, 2013 (the “Act”), but especially:

a. decisions regarding claim acceptance, a worker’s benefits, medical care payments, return-to-work assistance, and other entitlements under the Act, and

b. decisions regarding an employer’s cost experience or other assessment matters, such as classification, assessable payroll, audits, and collections.

BACKGROUND

1. Section 20 of the Act provides the Workers’ Compensation Board (WCB) “exclusive jurisdiction to examine, hear and determine all matters and questions arising pursuant to this Act,” including:

   a. the acceptance and management of a claim.

   b. whether an industry is within the scope of the Act and the class to which it is assigned, and

   c. whether any worker is within the scope of the Act.

2. Section 23 states:

   a. the board shall make its decisions on the real merits and justice of each case and it is not bound to follow any legal precedent.

   b. in making its decision, the board may have regard to its policy directives.

   c. if, in the opinion of the board, the evidence in support of the opposite sides of an issue is approximately equal, the board shall resolve the issue in favour of the worker.

3. Section 48 requires the WCB to provide a written explanation to a claimant when a decision is not in the claimant’s favour.

POLICY

1. Decisions are based on the balance of probabilities, considering the merits and justice of each case. Although a precedent may be helpful, decisions are not bound to follow any legal precedent.
2. When WCB staff make decisions regarding:
   a. worker files
   b. employer accounts, or
   c. any matter governed by the Act

   they are to reasonably ensure, to the extent that it is possible, that they have gathered and considered sufficient evidence relevant to both sides of an issue. The principle of benefit of the doubt is not to be used as a substitute for lack of evidence.

3. WCB staff will adhere to all relevant WCB policy directives when gathering and considering the evidence of a decision.

4. Where the evidence on both sides of an issue is approximately equal, the issue will be settled in favour of:
   a. the worker
   b. the dependent(s) of a deceased worker, or
   c. where the issue is exclusive to employer account matters, the employer or the applicant for employer status under the Act.

5. Decisions shall be clearly recorded in the appropriate file(s) of the WCB, and communicated in an appropriate manner, usually in writing, to all affected parties.

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6.13 Pre-Existing Conditions – Section 49 (POL 01/2000)

Document Date 03 April 2000

Purpose To establish guidelines for claims where pre-existing conditions exist.

DEFINITION

Following a work injury, the word “aggravation” is used in connection with a pre-existing condition, when it is established that the work injury caused a temporary worsening of the pre-existing condition.

“Acceleration” is also used in connection with a pre-existing condition, following a work injury, when there is usually medical evidence, such as MRI, CT scan, EMG, EEG, etc., to indicate that the work injury has worsened or advanced the pre-existent pathological process causing permanent damage.

BACKGROUND

1. Section 49 of The Workers’ Compensation Act, 2013 (the Act) prevents the denial of work injury claims or a reduction in compensation simply because there is evidence that the worker had a physical or psychological condition prior to the work injury. Section 49 reads:

“The Board shall not reject the claim of a worker or a worker’s dependant for compensation or reduce the amount of compensation payable by reason of a pre-existing condition of the worker if the injury materially aggravates or accelerates the pre-existing condition to produce a loss of earnings or death.”

2. The Act’s definition of “injury” (Section 2(1)(r)) specifies that an injury means certain acts, events or disablements which “[arise] out of and in the course of employment”.

3. According to Sections 26 and 103, every worker who suffers a work injury is eligible for compensation and medical aid.

4. Under Section 20, the board has exclusive jurisdiction to determine all matters arising pursuant to the Act, and specifically such matters as to whether any condition or death was caused by an injury, whether an injury has arisen out of and in the course of employment, and the existence, degree and permanence of any functional impairment resulting from an injury. The board must, therefore, in all cases, and regardless of whether there is a pre-existing condition, determine whether a work injury has occurred, the nature of that injury and its effects, including whether and for how long there is a loss of earnings. Also, the board is responsible for providing appropriate medical aid and rehabilitation following a work injury.
POLICY

1. Pursuant to Section 49, a work injury claim will not be denied nor compensation reduced simply because of evidence that the worker had a physical or psychological condition prior to the work injury. Section 49, however, does not extend coverage beyond the effects of a work injury. Accordingly, the board has no responsibility for disablement or other effects arising solely from a pre-existing condition.

2. In the application of Section 49, Operations staff must determine the answer to a number of questions of medical fact:
   a. the extent of the work injury, which is essentially a matter of diagnosis,
   b. whether or not the worker has recovered from the work injury, and
   c. whether and to what extent a pre-existing condition has been aggravated or accelerated by the work injury.

3. Investigation of all available information regarding the pre-existing condition is essential, and should be completed as quickly as possible after learning there is a pre-existing condition which may affect the course of recovery from the work injury. Particular attention will be paid to:
   a. any history of prior problems in the same or nearby areas as the work injury,
   b. the effect(s) of any pre-existing condition on the worker's function leading up to the work injury (i.e., pre-injury status), and
   c. relevant medical reports regarding such problems and effects.

4. If the work injury results in an aggravation of the pre-existing condition, the board's liability for earnings loss, medical treatment or other benefits or services available under the Act ends when the worker has recovered from the effects of the work injury. See examples under 7, below.

5. If the work injury results in an acceleration of the pre-existing condition, the board will be liable for whatever earnings loss the worker may have, and whatever medical treatment, rehabilitation or other benefits and services the worker may need under the Act as a result of the acceleration. See examples under 8, below.

6. Claims involving a pre-existing condition should be considered for cost relief under the Second Injury and Re-employment Reserve policy.

7. Examples of aggravations of pre-existing conditions:
   a. A worker has had previous shoulder dislocations. He dislocates his shoulder as the result of a work injury. The worker undergoes conservative treatment resulting in full recovery from the work injury dislocation. WCB is responsible only for the temporary worsening of the worker's shoulder condition, and has no liability for treatment of subsequent dislocations unless they are caused by work.
injuries. Partial cost relief may apply, but only if it can be shown that recovery to pre-work injury status took longer than likely would have been the case without the previous dislocations.

b. A worker with asthma encounters an irritant in the workplace that produces asthmatic symptoms necessitating time off work. The worker recovers within a few days of being removed from the workplace irritant, and is fit to return to regular work where the irritant is no longer present. WCB is responsible only for the temporary worsening of the worker’s asthma, and not for the asthma itself. Therefore, liability ends when the worker recovers from the workplace exposure. It is unlikely that cost relief would apply.

8. Examples of accelerations of pre-existing conditions:

a. A worker has had previous shoulder dislocations, as in 7.a, above. She dislocates her shoulder as the result of a work injury. Medical treatment following the work injury includes surgery that was not necessary before the work injury, resulting, in most cases, in a permanent change to the shoulder. Cost relief would be considered, especially if it can be determined that the surgery was necessary at least partly because of the previous dislocations.

b. A worker with degenerative disc disease in the lumbar spine has a work injury that causes a lumbar disc herniation resulting in permanent restrictions and the need for accommodated or alternate employment. In most cases, this type of work injury will have accelerated this type of pre-existing condition, and WCB is liable for any loss of earnings, medical treatment, rehabilitation, etc. that results. Cost relief would be considered where it can be determined that the underlying disc disease prolonged recovery, increased disability or contributed to the need for surgery.

c. A worker with asthma encounters an irritant in the workplace that produces symptoms necessitating time off work. The worker does not recover fully after being removed from the workplace irritant, and subsequent medical findings confirm a permanent worsening of the worker’s asthma as a result of the workplace exposure. The workplace exposure has accelerated the pre-existing asthma, and WCB is liable for any loss of earnings, medical treatment, rehabilitation, etc. that results. Partial cost relief would apply in most cases.

9. Examples of the combined effects of pre-existing conditions and work injuries that involve neither aggravation nor acceleration:

a. A worker with non-work related loss of sight in one eye suffers loss of sight to the other eye in a work injury. There is no aggravation or acceleration of the previous condition, but the work injury has enhanced the effects of the pre-existing condition and vice versa, and WCB is liable for loss of earnings, rehabilitation, etc. resulting from the total loss of vision. Partial cost relief would apply.

b. A worker with degenerative disc disease in the lumbar spine, has a work injury that is diagnosed as a low back strain and treated conservatively resulting in full
recovery from the strain, with no evidence that the disc disease has been worsened by the back strain. The work injury resulted in the introduction of low back pain, but has neither aggravated nor accelerated the pre-existing pathology. WCB liability ends when the worker recovers from the strain. Partial cost relief may apply, but only if it can be shown that recovery from the strain was prolonged by the presence of disc disease.

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6.17 Interjurisdictional Agreement on Workers’ Compensation (IJA) (POL 08/2013)

Document Date 28 November 2013

Purpose To establish an interjurisdictional agreement for workers’ compensation claims.

DEFINITION

Interjurisdictional Agreement on Workers’ Compensation (IJA) means an agreement between the provinces and territories of Canada created to promote and ensure the effective, efficient and timely administration and resolution of interjurisdictional issues and to aid injured workers in claiming and receiving compensation when two or more jurisdictions are involved.

Client means an Injured worker or dependant.

BACKGROUND

1. Section 33(2) of The Workers’ Compensation Act, 2013 (the “Act”) allows the Saskatchewan Workers’ Compensation Board (WCB) to enter an interjurisdictional agreement to provide compensation to clients where work is performed partly within Saskatchewan and partly within another province or territory. These agreements allow clients to receive benefits from either the Saskatchewan WCB or another jurisdiction.

2. In accordance with Section 35 of the Act and subject to the IJA, if a work-related injury occurs outside of Saskatchewan, and the client is entitled to compensation by law of the country or place in which the injury occurs, the client shall elect to file the claim with either the Saskatchewan WCB or the other jurisdiction.

3. Section 35 of the Act also requires the client to give notice of the election to the Saskatchewan WCB within three months of commencement of the loss of earnings or date of death. The Saskatchewan WCB may extend the notice period. However, if the client does not give notice, the client is deemed to have elected not to claim compensation under the Saskatchewan Act.

4. Section 39 of the Act provides the WCB with the right of subrogation. To recover the amount of compensation payable, the WCB may bring legal action in its own name against the third party, or it may join with the client in their legal action against the third party.

5. Worker benefits provided though the IJA may not result in employer protection from law suit.
POLICY

1. The Saskatchewan WCB approves the continuing participation in the IJA.

2. Participation in the IJA will not negate the application of Section 39 of the Act, which subrogates all rights of recovery to the Saskatchewan WCB. Action to recover amounts of compensation paid will be pursued prior to seeking reimbursement from other jurisdictions as required under the IJA.

3. Clients entitled to file a claim in more than one jurisdiction must elect to file their claim in either their home province or territory, or the jurisdiction where the injury or fatality occurred.

4. Where the client elects to file a claim with the Saskatchewan WCB:
   a. The claim will be adjudicated in accordance with Saskatchewan’s Act and approved policy directives.
   b. The client must also waive and forego any rights to compensation with any other jurisdiction for this claim.
   c. The client will not apply for nor accept any benefits from any other jurisdiction for this claim unless released to do so by the Saskatchewan WCB.

5. The Saskatchewan WCB will consider cost relief on IJA claims where all of the following apply:
   a. Injury occurred in Saskatchewan.
   b. Worker elected to file the claim with another jurisdiction, and
   c. Other jurisdiction requested and received reimbursement from Saskatchewan.

ATTACHMENTS

The Interjurisdictional Agreement on Workers’ Compensation

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6.19 Public Interest Disclosure Act Procedure (POL 05/2012)

Document Date 24 May 2012

Purpose To establish the process to manage disclosures by Workers’ Compensation Board (WCB) staff of wrongdoings in accordance with The Public Interest Disclosure Act.

DEFINITION

The Act, for the purposes of this procedure, means The Public Interest Disclosure Act, Chapter P-38.1 of The Statute of Saskatchewan, 2011.

Commissioner, means the Public Interest Disclosure Commissioner appointed by resolution of the Legislative Assembly.

Disclosure, for the purpose of this procedure, means a disclosure of wrongdoing made in good faith by an employee of the WCB.

Designated Officer means, at WCB, the Chair of WCB and, in the event of his or her absence or inability to act in this capacity, the CEO of WCB.

Employee, for the purpose of this procedure, means a person who is an employee of WCB at the time of making of the disclosure.

Government Institution includes the Workers’ Compensation Board.

Reprisal means any of the following measures taken against an employee because that employee has, in good faith, sought advice about making a disclosure, made a disclosure, cooperated in an investigation pursuant to this Act or declined to participate in suspected wrongdoing:

- A dismissal, lay off, suspension, demotion or transfer, discontinuation or elimination of a job, change of a job location, reduction of wages, changes in hours of work or reprimand;
- Any measure other than the ones mentioned above that adversely affect the public servant’s employment or working conditions;
- A threat to take any of the measures mentioned above.

Wrongdoing means:

- A contravention of a Federal or Provincial Act or Regulation.
- An act or omission that creates:
Policy Manual

- A substantial and specific danger to life, health or safety of persons, not including a danger inherent to the employee’s job; or
- A substantial and specific danger to the environment;
- Gross mismanagement of public funds or a public asset, or
- Knowingly directing or counselling a person to commit any of the above.

BACKGROUND

1. The Public Interest Disclosure Act (PIDA), which came into effect September 1, 2011, provides a process for employees of government institutions to make disclosure of wrongdoing with protection against reprisal for making such disclosure if made in accordance with PIDA.

2. As required by Section 6 (1) and (2) of PIDA, the WCB has adopted the following procedure to manage disclosure of its employees in accordance with the legislation.

POLICY

1. An employee who is considering making a disclosure may seek advice from the Designated Officer or the Commissioner.

2. If an employee reasonably believes that he or she has information that could show that a wrongdoing has been committed or is about to be committed, or that could show that the employee has been asked to commit a wrongdoing, the employee may make disclosure to:
   a. The Designated Officer for WCB; or

3. Disclosures must be received by the designated officer or the Commissioner in writing, and should be on the prescribed form. A copy of the prescribed form is attached as Appendix A to this procedure. The form should be placed in a sealed envelope clearly marked “Personal and Confidential to be opened by the Chair only” to ensure confidentiality. The form must include the following information:
   a. A description of the wrongdoing.
   b. The name of the person(s) alleged to have committed the wrongdoing or be about to commit the wrongdoing.
   c. The date of the alleged wrongdoing.
Management of Disclosures

4. Upon receipt by the designated officer, each disclosure must be date-stamped.

5. Each disclosure received by the designated officer, and all records of advice sought from the designated officer by any employees regarding a potential disclosure, must be (1) maintained in a separate, secured file; (2) treated as strictly confidential; (3) protected from unauthorized access.

6. All written information obtained as a result of a disclosure or its review or investigation, must be included in the disclosure file. All pertinent information obtained verbally must be documented, in writing, dated and placed in the disclosure file. When the designated officer creates a paper or electronic record to track disclosures or requests for advice under PIDA, those documents and records shall be handled in such a manner as to ensure confidentiality and the protection of identities as required by PIDA. When the designated officer creates a paper or electronic record to track disclosures or requests for advice under PIDA, those documents and records shall be handled in such a manner as to ensure confidentiality and protection of identities as required by PIDA.

7. The identity of all persons involved in the disclosure process including employees who seek advice about a possible disclosure, employees who make disclosures, witnesses and those alleged to have committed a wrongdoing, must be protected. Any person who obtains information through the performance of his or her duties under PIDA shall not disclose it, except as required by law.

8. If the designated officer determines that an investigation of the alleged wrongdoing is required, it shall be conducted in accordance with the principles of procedural fairness and natural justice. These principles include the requirements that the alleged wrong-doer: (1) has a right to be informed of the nature of the disclosure; (2) must be given an opportunity to make oral or written submissions to the designated officer with respect to the disclosure; (3) should be provided with all information that will be considered by the designated officer and given an opportunity to answer the case against him or her; (4) should be told of the reason for the decision.

9. The designated officer must act in a manner that is not biased, arbitrary or discriminatory, and that is fair and open-minded.

10. In responding to a request for advice from an employee respecting a possible disclosure or with respect to the receipt, review or investigation of a disclosure, the designated officer may: (1) seek legal advice from its legal counsel; (2) seek procedural advice from the Commission; (3) utilize such specialized services within WCB as the designated officer determines necessary, or (4) refer the matter to the appropriate external agency, to conduct an investigation.
11. The designated officer must remove himself or herself from the process surrounding the disclosure and/or its investigation in the event of a conflict of interest.

12. Once a disclosure has been filed with the designated officer, it cannot be withdrawn.

**Procedure for Receiving Disclosures**

13. Within 20 calendar days of receipt by the designated officer of a disclosure, the designated officer shall arrange to discuss the disclosure privately with the disclosing employee.

14. The designated officer must determine and comply with the wishes of the disclosing employee respecting the manner of communication to be used with him or her, by the designated officer, regarding the disclosure matter.

15. The designated officer must advise the disclosing employee that: (1) information related to the disclosure, including his or her identity, will be protected and kept confidential to the fullest extent possible within the law, and in keeping with the principles of procedural fairness and natural justice. (For example, the disclosing employee’s name will not be disclosed unless it is a necessary fact in resolving the disclosure matter. But the disclosing employee should be aware that it may be possible to identify him or her from the facts contained in the disclosure); (2) the disclosing employee also has an obligation to protect information related to the disclosure, including the identity of all persons involved in the disclosure process.

**Assessing Disclosures**

16. The designated officer shall assess the disclosure to determine if the matter, if proven to be true, would be a wrongdoing within the meaning of PIDA, and to determine what action should be taken. That assessment should be completed, where reasonably possible, within 40 days of receipt of the disclosure by the designated officer.

17. In conducting the assessment of the disclosure, the designated officer should consider the following criteria: (1) whether the designated officer is in a conflict of interest and, if so, whether the matter should be referred to the Commissioner; (2) whether the nature of the disclosure pertains to a matter within WCB and, if not, whether the matter should be referred to the designated officer of a different government institution, where it would be more appropriately dealt with; (3) whether the disclosure is a wrongdoing as defined by PIDA; (4) whether the disclosure has been made in good faith and whether the disclosing employee has a reasonable belief that the information disclosed could show a wrongdoing has been or is about to be committed.

18. In the event that the designated officer determines that the disclosure should be referred to the Commissioner or a different government institution, the designated
officer must advise the disclosing employee in the manner agreed to in accordance with paragraph 13 of this procedure.

**Processing Disclosures**

19. If the designated officer determines that no further action is required with respect to the disclosure, the disclosing employee shall be notified and the file closed.

20. If the designated officer determines that the criteria set out in paragraph 16 have been met and action is required, the designated officer shall advise the disclosing employee of the action to be taken, including whether or not an investigation will be required and will provide the alleged wrong-doer with notice of the disclosure and only such relevant information as is consistent with the principles of procedural fairness and natural justice.

21. Any investigation that is to be undertaken with respect to the disclosure shall be managed by the designated officer, although he or she may utilize the appropriate expertise to assist with the process, or may refer the matter to the police during or after the investigation, if the designated officer determines such action to be required.

22. If other employees are invited to participate in the investigation, the designated officer shall advise them of their right to have a person attend with them to provide support (e.g. union representation for in-scope employees) but that support person shall not be entitled to contribute to the investigation or speak on the employee’s behalf.

23. Within 30 calendar days of completion of an investigation, the designated officer will prepare and deliver a written report with respect to his or her findings and any recommendations or corrective action he or she considers appropriate respecting the disclosure and wrongdoing. The disclosing employee shall be advised that a report has been made and provided with such information as the designated officer considers appropriate.

**Complaint of Reprisal**

24. If a WCB employee alleges that a reprisal has been taken or directed against him or her, that employee may make a written complaint to the Public Interest Disclosure Commissioner respecting the matter. Such a complaint may be made in the form attached to this policy as Appendix B.

**Annual Reporting of Disclosures**

25. The designated officer shall ensure that a process is established to track disclosures of alleged wrongdoings received by him or her, for annual reporting of disclosure in accordance with the Act.
26. The PIDA annual report prepared by the designated officer shall include the following information: (1) the number of disclosures received; (2) the number of disclosures acted on and not acted on; (3) the number of investigations commenced as a result of the disclosure; and (4) if an investigation results in a finding of wrongdoing, a description of the wrongdoing and any recommendations or corrective action taken, or the reasons why no corrective action was taken. Each annual report shall be for the reporting period commencing on April 1 in one year and ending on March 31 of the following year.

ATTACHMENTS

Appendix A – Disclosure of Wrongdoing Under The Public Interest Disclosure Act (PIDA)

Appendix B – Complaint of Reprisal

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Appendix A
Disclosure of Wrongdoing
Under The Public Interest Disclosure Act

Under Section 10(1) of the act, where an employee of WCB reasonably believes that he or she has information that could show that an employee of WCB has been asked to commit a wrongdoing, the WCB employee may make a disclosure to:

(a) The designated officer for the WCB, or
(b) The Public Interest Disclosure commissioner

Current Date: __________________________

(please print)

Last Name: ____________________________ First Name: ____________________________

When Employed with WCB: ______________________________________________________

Preferred Contact Information:

Address: ____________________________________________

City or Town: ___________________ Province: ____________________________

Postal Code: ___________________ Telephone Number: ______________________

Email Address: ____________________________________________

Preferred time to contact: Day:_________ Evening:_________ Weekend:_________
Details of Wrongdoing:

(Please provide the details of the nature of the wrongdoing, include name(s), date(s), location(s), etc., attaching any supporting documentation, if possible. Use additional pages, if required.)

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Appendix B

Complaint of Reprisal

Under The Public Interest Disclosure Act

Under section 36(1) of the Act, no personal shall take or direct a reprisal against a WCB employee or former WCB employee because he or she has, in good faith:

(a) Sought advice about making a disclosure from the designated officer of WCB or the commissioner;
(b) Made a disclosure
(c) Co-operated in an investigation pursuant to this Act; or
(d) Decline to participate in wrongdoing.

If the WCB employee of former WCB employee alleges that a reprisal has been taken or directed against him or her, he or she may make a written complaint to the Public Interest Disclosure Commissioner respecting the matter.

Current Date: __________________________

(please print)

Last Name: ____________________________  First Name: ____________________________

When Employed with WCB: ________________________________________________

Preferred Contact Information:

Address: ________________________________________________

City or Town: ____________________________  Province: ____________________________

Postal Code: ____________________________  Telephone Number: ____________________

Email Address: ________________________________________________

Preferred time to contact: Day: _______  Evening: _______  Weekend: _______
Details of Reprisal:

Please provide the details of the nature of the wrongdoing, include name(s), date(s), location(s), etc., attaching any supporting documentation, if possible. Use additional pages, if required.
6.20 Overpayment Recovery – Compensation (POL 38/2010)

Document Date 24 November 2010

Purpose To establish guidelines for the recovery of overpaid benefits.

DEFINITION

Administrative Error means a clerical or calculation error committed by a member of the staff of the Workers’ Compensation Board (WCB). These errors are usually made when determining compensation payments to clients.

Compensation, for the purposes of this policy, means wage loss benefits, travel and sustenance expenses, annuity amounts, former Act pensions, Permanent Functional Impairment (PFI) awards and any other allowances payable under The Workers’ Compensation Act, 2013 (the “Act”) with respect to a work injury or fatality.

Debtor means the payee (i.e., worker or dependent) to whom an overpayment has been issued.

Overpayment means any payment of compensation that is greater than the debtor should have received under the Act. An overpayment becomes a debt owed to WCB as accounts receivable.

Suspending Recovery means active efforts to recover an overpayment have ceased, but the overpayment remains registered against the debtor as a debt due to WCB, such that it can be collected from any compensation which the debtor may become entitled to in the future.

Write-Off means the cancellation of an overpayment from the accounts of WCB that is deemed to be not collectable or that collection will not be pursued.

BACKGROUND

1. Section 112(1) of the Act states that any compensation payments made by the board to a worker beyond the period of the worker’s loss of earning capacity or to a worker or the worker’s dependant in an amount in excess of that to which he or she is entitled are deemed to be an overpayment.

2. Section 112(2) directs that the amount of any overpayment is deemed to be a debt due and owing to the board and may be recovered from the worker or worker’s dependant in any manner authorized by law.

3. Section 113 states that without limiting the board’s remedies for recovery, any money due the board pursuant to this Act, including any penalties imposed by the
board pursuant to this Act, may be set off against any compensation that may be or that may become payable to the person indebted to the board.

4. Section 170 permits the WCB to issue an order for the payment of money owed under the Act and such order may be filed with the local registrar of the Court of Queen’s Bench and is enforceable as a judgment of the Court.

POLICY

1. In all cases, the collection of overpayments that are subject to recovery will be energetically pursued by every cost effective, legal means available, treating all involved with dignity, fairness and professionalism, and except where fraud may be involved, making every reasonable effort to avoid creating undue financial hardship for the debtor.

2. Actions to recover overpayments are governed by the applicable limitations of actions legislation in force when the overpayment occurred or was discovered. Limitation periods in which WCB can commence legal proceedings will be updated periodically in PRO 38/2010, Overpayment Recovery – Compensation as required.

3. An overriding principle for determining if an overpayment should be collected is whether the client could, or should, have reasonably known the payment was in error. Generally, only if the client could or should have known the payment was in error should the overpayment be collected.

4. Notwithstanding Point 3, when an overpayment is identified and the worker notified directly after the overpayment was created (within 30 calendar days), the overpayment may be recovered regardless of how it occurred.

Overpayments Not Subject to Recovery

5. Subject to Points 3 and 4, overpayments resulting from the following circumstances are not normally subject to recovery; however, each situation or claim is to be dealt with on its own merit:

a. A decision is reversed as the result of new information that was not available or which the payee could not have known they were expected to provide at the time of the original decision (e.g., original decision made in good faith but new medical information received establishes a condition not known at the time of the original decision);

b. A decision originally based on best judgment or extension of the benefit of doubt is reversed (per POL 23/2014, Reversing Decisions) because that decision is subsequently seen to have been improper or unreasonable;

c. Recovery action has not been initiated in accordance with the applicable limitations of actions legislation in force at the time the overpayment occurred or
was discovered (PRO 38/2010, Overpayment Recovery – Compensation will apply);  

d. A worker claims personal bankruptcy and the overpayment debt is considered not recoverable; or,  
e. A computer system or administrative error that has or could have affected compensation paid on claims for more than one worker:  
i. Examples of system errors: programming error in a payment formula or data entry error in a benefit table, such as those used for Personal Care Allowances;  
ii. Example of administrative or clerical error: incorrect annual Consumer Price Index rate decision.

Overpayments Subject to Recovery

6. Subject to Points 3 and 4, overpayments resulting from the following circumstances are subject to recovery, and will become accounts receivable. Such circumstances include, but are not limited to:  
a. Where, in the opinion of the WCB, the debtor knowingly provided incorrect or incomplete information to the WCB;  
b. The client or other debtor fails to provide, or WCB staff fail to obtain relevant, accurate or complete information.

7. Where an overpayment is being pursued for recovery, WCB staff will make every attempt to reach agreement with the debtor as to the methods and rates of repayment, but such agreement is not necessary to proceed with collection efforts.

8. Where overpayment recovery efforts are unsuccessful, Section 113 of the Act authorizes the WCB to set off overpayment debts against present and future entitlements. This includes recovery from annuity benefits. However, there will be no recovery from an annuity account until the annuity becomes payable (when the worker reaches age 65 or at the time of death if the worker dies prior to age 65), unless ordered otherwise by the Board.

9. Where the overpayment of wage loss benefits results in annuity benefits accruing on the worker’s behalf, the annuity will be reduced by the amount of annuity benefits paid in respect of the overpayment along with accrued interest on that amount.

10. When an overpayment results from benefits extending beyond the date of death, recovery of the overpayment will not take place unless dependent benefits are payable.

11. When a debtor dies with an outstanding overpayment, efforts to recover the overpayment will continue.
Suspending Recovery

12. Active efforts to collect overpayments may be suspended if collection is unsuccessful after demands and legal recourses have been exhausted. Despite suspension of recovery, the full amount of the overpayment remains a debt due to WCB.

Write-Offs

13. The levels of signing authority for suspending recovery or writing-off of non-collectible overpayments are set out in Point 26 of PRO 38/2010, Overpayment Recovery – Compensation.

Employer Cost Experience

14. The WCB will remove overpayments from the employer’s cost experience record, provided the employer did not intentionally contribute to the overpayment by providing incorrect information. Adjustments to the employer’s experience rating will place them in the same position they would be in if the payment resulting in the overpayment had not been issued.

Interest

15. Interest on overpayments will only apply to amounts due where the overpayment is the result of a worker’s intent to provide misleading information or to withhold information for personal gain. The rate of interest to be charged on an annual basis will be set at the rate applied by WCB to annuity funds. Calculation of interest will begin 30 calendar days from the date of written advice which includes the detailed calculation.

16. Legal costs incurred in the recovery of overpayments will only be recovered where, in the opinion of the WCB, the overpayment is the result of the debtor’s intent to provide incorrect or incomplete information for personal gain.
Doc # 6.20    Overpayment Recovery – Compensation (POL 38/2010)

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<th>2(1)(h), 112, 113, 170; The Limitations Act</th>
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DEFINITIONS

**Safety Association** means an association of employers in any of the classes established under *The Workers’ Compensation Act, 2013* (the “Act”) who form themselves into an association for the purpose of injury prevention, safety and return to work.

**Class** means the industry rate codes and related sub-codes of employers that have formed themselves into a Safety Association for the purposes of injury prevention and safety.

BACKGROUND

1. The Workers’ Compensation Board (WCB) may, through the application of Section 146(1) of the Act, make a grant to a Safety Association formed by employers in any of the classes established under this Act for the purpose of injury prevention and safety, from funds charged against the class represented by the Safety Association and levied as part of the assessment against that class.

2. The Safety Association must be committed to and recognize the value of injury prevention, safety and return-to-work education, programs, and training for both workers and employers in their class.

3. The WCB has the legal responsibility to ensure funds are being utilized appropriately and that the interests of all employers in the class are being represented.

POLICY

**New Applications**

1. The WCB will consider applications from employer groups or associations for funding programs that promote injury prevention, safety and return-to-work education and training for workers and employers in their class.

2. Applications must be submitted by August 31 in the calendar year prior to the grant requirement.

3. For detailed application guidelines, please review the *Guidelines for New Safety Associations* attached as Appendix A.
4. Approval for first-time funding will be at the discretion of the Board members. Renewal applications may be approved by the Vice President of Prevention and Employer Services.

**Preliminary Applications – Letter of Intent**

5. Applicants must submit a letter of intent including;
   a. The name of the group making the request for funding;
   b. A broad statement regarding the mandate, goals and objectives of the proposed safety association;
   c. A preliminary list of estimated financial costs; and
   d. Evidence of sufficient support from the employers in the class for the program.

6. Support from the class will be considered sufficient where:
   a. The proposed program has been endorsed by:
      i. 50 per cent plus one of the employers in the class, or
      ii. 50 per cent of the total payroll subject to assessment; or
   b. The individual merits of an application are satisfactory to the WCB.

7. Where provisional approval for funding has been granted, those applicants who have not yet formed a Safety Association must do so. Upon written request, a grant of up to $5000 may be available to help applicants establish a Safety Association and prepare a detailed proposal for funding (Point 10).

8. Applicants must submit the following documentation:
   a. A copy of the formal resolution of the Safety Association authorizing the application for the grant; and
   b. A certified copy of the Association's Certificate of Non-profit Incorporation and the bylaws the Association will be operating under.

9. A Safety Association Board of Directors must consist of employer and worker representatives elected by the class members funding the Safety Association, and wherever possible, consist of equal representation.

**Detailed Proposals for Funding**

10. Once provisional approval has been granted and documentation received above, applicants must submit a detailed proposal for funding including:
    a. A strategic plan with specific measurable, attainable, realistic and time sensitive goals and objectives for injury reduction;
b. A detailed budget sufficient to cover expenses related to the proposed program(s);
c. An evaluation plan to demonstrate the achievement of goals and objectives; and
d. Any other information the WCB may request.

Release of Funds

11. Release of any funds will be contingent on the applicant:
   a. Entering into a signed Safety Association Funding Agreement with the WCB; and
   b. Where granted first-time funding, attendance at a WCB orientation and training seminar.

Reporting Requirements

12. Each Safety Association granted funding must select a representative to attend quarterly meetings with a designated representative of the WCB.

13. To ensure the Safety Association is achieving its intended purpose, the Association must submit three quarterly progress reports and an annual report against plan based on the approved strategic plan.
   a. The quarterly report must provide:
      i. Quantified progress towards program objectives;
      ii. Budgeted/actual expenditures for the previous year; and
      iii. An explanation of significant variances.
   b. The annual report must provide:
      i. A detailed evaluation of the targeted outcomes, program impact and effectiveness; and
      ii. An audited financial statement for the previous year’s operations.

Disbursements and Levies

14. All grants are funded through special levies charged against the employers in the class represented by the Safety Association.

15. Disbursement of funds will be quarterly, subject to fulfillment of reporting requirements outlined above.

16. Where the terms and conditions of the Safety Association Funding Agreement have not been met, the WCB may terminate funding and take action including legal remedies to obtain reimbursement of any misused funds.
Funding Renewal

17. The WCB is not obligated to grant funding by reason of having done so in the past. Approval for renewal funding will be granted when the following has been received by September 15 of each year:

a. A strategic plan outlining priorities and operational objectives for the next year;

b. A detailed budget request for the upcoming calendar year;

c. A copy of the board motion approving the strategic plan and budget request; and

d. Confirmation of continued status as a Non-Profit Corporation

ATTACHMENTS

Appendix A - Application Guidelines for New Safety Associations

| Act Sec # | 146 |
| Effective Date | 01 October 2010 |
| Amended | References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013 |
| Application | All applications for safety association funding |
| Supersedes | POL 11/2008 Safety Association Funding |
| Complements | PRO 11/2008 Safety Association Funding |
Application Guidelines for New Safety Associations

The Saskatchewan Workers’ Compensation Board will consider requests for funding to employers in any of the classes established under *The Workers’ Compensation Act, 2013* (the “Act”), that have formed themselves into a Safety Association for the purpose of injury prevention, safety and return to work.

To be considered for funding, all new applicants must complete and submit the attached funding proposal application requirements by August 31 in the calendar year prior to the grant requirement to:

Vice President of Prevention and Employer Services  
Saskatchewan Workers Compensation Board  
200-1881 Scarth Street  
Regina SK S4P 4L1

The application process is broken down into six steps. We recommend that you complete each step in the recommended order to help the application process go as smoothly as possible.

**Step One: Understand the Obligations of a WCB Funded Safety Association**

1. Review and understand the Safety Association Funding Policy included in this package. The Safety Association Funding Policy provides guidance on how to achieve and maintain funded status.

2. Review and understand the Safety Association Funding Agreement included in this package. The funding agreement is between WCB and the Safety Association and outlines the obligations of both parties.

3. Review and understand the requirements of the most recent version of the Saskatchewan Non-Profit Corporations Act and Regulations (available on-line at [www.publications.gov.sk.ca](http://www.publications.gov.sk.ca)). WCB funded Safety Associations must be non-profit organizations; therefore it is important to understand the obligations of a non-profit organization in Saskatchewan.

**Step Two: Determine the Members the Safety Association Intends to Serve**

4. Review the current Assessment Rate Classification of Industries booklet to determine which rates code(s) your safety association intends to service. The Safety Association must serve an entire rate code; it cannot serve only certain sub codes within a rate code. Some Safety Associations will serve more than one rate code. If this is the case, the Safety Association should group rates codes that deal with similar safety related issues. For example the Saskatchewan Construction Safety Association members come from the B11, B12 and B13 rates codes. All of these rates codes have similar issues when it comes to safety and injury prevention. *A copy of the Assessment Rate Classification of Industries has been included in this package.*
5. Confirm with WCB the approximate number of employers and workers in each rate code. This is important because you need to understand whether or not you are planning to offer products and services to hundreds or thousands of employers and workers.

Step Three: Establish Industry Support for the Safety Association

6. Review the WCB Safety Association Funding Policy and determine which mechanism you will use to provide proof to WCB that you have the general support of the class to fund the Safety Association. The WCB Safety Association Funding Policy outlines the various ways that this can be accomplished.

7. Execute the necessary actions to prove to WCB you have general support of the class codes that will be funding the Safety Association. If the WCB believes there is not general support for a Safety Association at this point, it can either reject the applicant’s application or it can request further information. Once WCB accepts that there is general support for a Safety Association in the class, the applicant can proceed. The applicant should not proceed beyond this point until written approval from the WCB to proceed has been obtained.

8. The applicants making the funding application can make a written request for a grant to a maximum of $5,000 to help them establish the Safety Association and prepare the application for funding. The grant can be put towards actual expenses incurred while forming the Safety Association. The grant will be paid out based on receipts submitted to the WCB.

Step Four: Establish a Non-profit Safety Association

9. Establish a non-profit organization as stipulated by the Non-profit Corporations Act and Regulations. A certified copy of the Safety Association’s Certificate of Non-profit Incorporation will be required. Directors named in the initial application for non-profit status may not be the Directors who eventually form the Safety Association’s Board of Directors. However, the Directors named are responsible for preparing an initial set of bylaws and gathering together members of the Safety Association that can then duly elect a representative Board of Directors.

10. Call a meeting of members in order to establish a representative Board of Directors as outlined in the funding agreement. Members include the employers in the rate code(s) represented by the Safety Association.

11. The Board of Directors, upon election, must immediately:
   a. Sign the Funding Agreement between the Safety Association and the WCB, and;
   b. Develop and approve by-laws as required by the funding agreement.

Step Five: Preliminary Application – Letter of Intent

12. The Board of Directors must submit a Letter of Intent to WCB by August 31st in order to receive funding at the start of the next calendar year. The Letter of Intent must contain:
a. Name of the Safety Association making the request for funding. This should be the name registered with the Corporations Branch of the Ministry of Justice.

b. A certified copy of the association’s Certificate of Non-profit Incorporation.

c. List of the class whose employers will be members of the Safety Association.

d. A general three year plan outlining how the Safety Association will deliver its programs and related products and services. This plan will likely change and become more specific once more industry specific information is known. The plan should include:

   i. Proposed staffing,

   ii. A timeline for the development of a policy and procedure manual, according to the guidelines in the Safety Association funding agreement,

   iii. How members will be engaged and how services will be marketed to members, and

   iv. Products and services to be offered and how these will be acquired and/or developed.

e. A budget sufficient to cover expenses for one year related to the operation of the Safety Association and the development and delivery of its products and services. Wherever possible, please be as specific as possible. For example: List expected salaries by position or list the office equipment to be purchased or leased. We’ve included a sample budget template and the most current Safety Associations Salary Survey in this package to help you develop your budget and funding request.

(See Safety Association Sample Budget Template – next page)
## Safety Association Sample Budget Template

<table>
<thead>
<tr>
<th>Category</th>
<th>Item Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salaries &amp; Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>(Please specify by position)</td>
<td>$</td>
</tr>
<tr>
<td>Benefits</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Vehicle leases or allowances</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td><strong>Facilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Rental</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Office Maintenance &amp; Cleaning</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Utilities</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Office Equipment Purchases/Lease</td>
<td>(computers, photocopier, fax, projectors, desks)</td>
<td>$</td>
</tr>
<tr>
<td>Office Supplies &amp; Printing</td>
<td>(letterhead, business cards, paper, pens)</td>
<td>$</td>
</tr>
<tr>
<td>Postage &amp; Courier</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Telephone (office, fax, internet, cellular)</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td><strong>Program Development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource Materials</td>
<td>(i.e., Videos or Other Instructional Aids)</td>
<td>$</td>
</tr>
<tr>
<td>Printing</td>
<td>(i.e., Training Manuals or Workbooks)</td>
<td>$</td>
</tr>
<tr>
<td>Other</td>
<td>(Please specify what)</td>
<td>$</td>
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<tr>
<td><strong>Travel Expenses</strong></td>
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<tr>
<td>Mileage / Vehicle Leases</td>
<td>(staff &amp; board members)</td>
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</tr>
<tr>
<td>Hotel</td>
<td>(staff &amp; board members)</td>
<td>$</td>
</tr>
<tr>
<td>Meals</td>
<td>(staff, board members &amp; meetings)</td>
<td>$</td>
</tr>
<tr>
<td>Airfare</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td><strong>Promotion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotional Brochures &amp; Items</td>
<td>(newsletter, pamphlets, giveaway items)</td>
<td>$</td>
</tr>
<tr>
<td>Website</td>
<td>(development and maintenance)</td>
<td>$</td>
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<tr>
<td>Trade Shows</td>
<td>(booth rental)</td>
<td>$</td>
</tr>
<tr>
<td><strong>Board Meetings and AGM Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility Rental</td>
<td></td>
<td>$</td>
</tr>
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<td>Catering</td>
<td></td>
<td>$</td>
</tr>
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<td><strong>Professional Services</strong></td>
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</tr>
<tr>
<td>Insurance</td>
<td>(Property &amp; Board Liability)</td>
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<td>Audit Fees</td>
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<td>$</td>
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<tr>
<td>Accounting &amp; Payroll Fees</td>
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<td>$</td>
</tr>
<tr>
<td>Legal Fees</td>
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<td>$</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
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<td>$</td>
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<tr>
<td><strong>Income from Course Registration Fees</strong></td>
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<td>$</td>
</tr>
<tr>
<td><strong>Sponsorship Income</strong></td>
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<td>$</td>
</tr>
<tr>
<td><strong>Income from Other Sources</strong></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>
DEFINITION

Extrication, for the purpose of this policy, means the removal of an injured worker from a situation that would prevent the worker from receiving medical aid. For example, the removal of a worker trapped in a damaged vehicle or a collapsed building.

BACKGROUND

The Worker’s Compensation Board (WCB) may use its fund for any purposes to carry out the intent of The Workers’ Compensation Act, 2013 (Section 115(j)).

POLICY

1. Extrication may be required when rescuing a worker who is injured in the course of employment.

Extrication from a Licensed Vehicle

2. Saskatchewan Government Insurance (SGI) will be the first payor in all instances involving a licensed vehicle. The WCB will reimburse SGI for extrication services involving an injured worker.

Extrication – Other

3. Where a third party, other than SGI, directly pays for extrication services, the third party may apply to the WCB for reimbursement. The WCB will reimburse the third party for the lesser of the actual costs or $1,000.

Reimbursable Costs

4. The WCB will cover the costs for:
   a. The Jaws of Life.
   b. A crane.
   c. A tow truck, or
   d. Any other means of extrication considered acceptable by the WCB.
Non-Reimbursable Costs

5. The WCB will not cover the costs for:
   a. Firefighting.
   b. Traffic control.
   c. Cleaning of roads.
   d. Medical aid provided by first responders, or
   e. The wages of staff assisting at an incident.

Act Sec # 115(j)
Effective Date 01 December 2014.
Application All claims where the WCB is billed for extrication services.
Supersedes POL 08/2008 Extrication Services
Complements PRO 16/2014 Extrication Services
6.25 Serious and Wilful Misconduct (POL 13/2011)

Document Date 26 October 2011

Purpose To provide clarity on what constitutes as “serious and wilful misconduct.”

DEFINITION

Serious functional impairment occurs as a result of a work injury, where a worker suffers a serious condition that will interfere with the normal performance of their body or mind. Serious functional impairment exists when the injury results in permanent functional impairment in excess of 10 per cent, as referenced in the rating schedule established in conjunction with Section 66 of The Workers’ Compensation Act, 2013 (the “Act”), or time loss in excess of three months.

BACKGROUND

1. Section 2(1)(r) of the Act specifies that an “‘injury’ means all or any of the following arising out of and in the course of employment:
   a. the results of a wilful and intentional act, not being the act of the worker;
   b. the results of a chance event occasioned by a physical or natural cause;
   c. a disabling or potentially disabling condition caused by an occupational disease; or
   d. any disablement.”

2. Section 20(2) of the Act provides the Workers’ Compensation Board (WCB) exclusive jurisdiction to determine whether any condition or death was caused by an injury and whether any injury arose out of or in the course of employment.

3. Section 27 of the Act states:
   a. Unless the contrary is proven, if an injury to a worker arises out of the worker’s employment, it is presumed that it occurred in the course of his or her employment.
   b. Unless the contrary is proven, if an injury to a worker occurred in the course of his or her employment, it is presumed that it arose out of the worker’s employment.

4. Section 30 of the Act directs “if an injury is attributable solely to the serious and wilful misconduct of the worker, no compensation is payable unless that injury results in death or serious functional impairment.”
POLICY

1. From Section 27 of the Act, the WCB interprets the statutory phrase “arises out of employment” to mean that the injury must be related to some hazard which results from the nature, conditions or obligations of employment. “In the course of employment” is interpreted to mean that the injury must happen at a time and place, and in circumstances consistent with and reasonably incidental to employment (POL 12/2013, Arising Out Of and In The Course Of Employment). Where the worker intentionally injures himself/herself, this will not qualify as an “injury” under Section 2(1)(r) of the Act, and the claim will be denied. Section 30 of the Act will only apply where the WCB determines that an injury arose out of and in the course of employment.

2. Serious and wilful misconduct is a deliberate breach of rule or law, well known to the worker, and enforced. It is a voluntary act with reckless disregard for rule or law, which the worker should have recognized as being likely to result in personal injury. Impairment by reason of alcohol or illicit use of drugs will be assumed to constitute serious and wilful misconduct. Where an injury is the sole result of serious and wilful misconduct, compensation will not be payable, unless the injury results in serious functional impairment or death. Conversely, in keeping with the principle of “no fault,” acts of carelessness or negligence will not typically be seen as wilful and compensation may be payable.

3. The WCB will not provide coverage for workers who are injured while participating in a workplace conflict (e.g., fighting) that results solely over a personal matter, as the workers’ actions will be seen as removing oneself from the course of employment. However, if it is determined that the conflict arose over an issue associated with employment, the claim may be accepted.

Act Sec # 2(1)(r), 20, 26, 27, 29, 30, 66
Effective Date 01 December 2011
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013.
Application All work injury claims on and after the effective date.
Supersedes n/a
Complements PRO 13/2011 Serious and Wilful Misconduct
POL 12/2013 Arising Out of and In the Course of Employment
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7.0 MEDICAL CARE

7.1.1 Health Care Services (POL 05/96) ................................................................. 3
7.1.2 Health Care Services Fees (POL 02/97) ............................................................ 7
7.1.3 Medical Fees – Extra Billing (POL 57/80) (Amended by 08/95) ...................... 8
7.1.4 Continuum of Care (POL 08/2014) ................................................................. 9
7.1.5 Medical Boards – Repeal (POL 02/2006) ......................................................... 16
7.1.1 Health Care Services (POL 05/96)

Document Date 25 March 1996
Purpose To define the types and payment methods of health care services to be paid for or reimbursed by the Workers’ Compensation Board (WCB).

BACKGROUND

1. The Board currently designates as policy (and hence subject to public release) the schedule of fees paid to the various health care practitioners for services utilized by clients in Saskatchewan.

2. There is no good reason why the scale of fees needs to be made public. All that is required for public information is the list of services and procedures paid for or reimbursable, with a statement that the fees for these services have been negotiated between WCB and the Professional Associations concerned.

3. It is therefore recommended that the Policies concerned be down-rated to Procedures.

4. The single new Policy created by this submission will show the medical services and procedures that the WCB will pay for or reimburse the client for in a consolidated list.

POLICY

1. The Board approves downgrading of Policy Numbers 03/91, 20/91, 22, 92, 02/93, 03/93, 08/94, 19/94, 22/94, 01/95, 02/95, 03/95, and 04/95 which are currently subject to public release, and convert them to Procedures with the same numbers but which will be for internal circulation only. The underlying Board Orders will therefore remain unchanged. The downgrading will take effect on the date the new Policy Manual is released to replace the old.

2. The Board notes the repeal of policies 24/90, 19/92, 20/92, 31/92, 07/93 and 07/94 by succeeding policies containing the same but updated rate schedules, and directs that where old policies or Board Orders exist for health care services rate schedules that have subsequent updates, the old orders will be automatically repealed by the latest order.

3. The Board approves the attached new policy which details the health care services that will be paid for or reimbursed by the WCB on the basis of current practice, but which does not list the scale of fees (Schedule 1, 2, & 3 attached).
4. The Board directs that any services, procedures, therapies or counselling not listed in Schedule 1 will not be paid for or reimbursed by the WCB without prior approval for the procedure by a staff member of the WCB authorized to do so.

ATTACHMENTS

Health Care Services Schedule 1

Health Care Services Schedule 2

Health Care Services Schedule 3

<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>Effective Date</th>
<th>Amended</th>
</tr>
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</table>
| 103       | 01 April 1996  | References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

<table>
<thead>
<tr>
<th>Application</th>
<th>Supersedes</th>
</tr>
</thead>
</table>
| All Claims  | POL 03/91 Dental Consultant Fees  
|             | POL 20/91 Medical Aid Fees – Wascana Rehabilitation Centre Out-Patient Program Per Diem  
|             | POL 22/92 Replacement or Repair of Eyeglasses  
|             | POL 02/93 Private Sector Physiotherapy Fees  
|             | POL 03/93 Medical Aid – Fees for Chiropractic Services  
|             | POL 08/94 Medical Aid – Hospital Out-Patient and Emergency Services Other Than Physiotherapy  
|             | POL 19/94 Medical Aid – Payment of Chiropodists’ Fees  
|             | POL 22/94 Community Therapy Program  
|             | POL 01/95 Medical Aid – Magnetic Resonance Imaging  
|             | POL 02/95 Medical Aid Fees for Professional Services Not Covered by the M.C.I.B. Payment Schedule  
|             | POL 03/95 Medical Aid – Hospital Out-Patient Physiotherapy Fees  
|             | POL 04/95 Medical Aid – Hospital Per Diem In-Patient Rates  

Complements | PRO 05/96 Health Care Services
# HEALTH CARE SERVICES
## Schedule 1 - Licensed Providers

<table>
<thead>
<tr>
<th>PROFESSIONS</th>
<th>SERVICES</th>
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<tbody>
<tr>
<td>Physician</td>
<td>Medical &amp; Retainer Arrangements</td>
</tr>
<tr>
<td></td>
<td>Acupuncture (visit fee)</td>
</tr>
<tr>
<td></td>
<td>Counselling</td>
</tr>
<tr>
<td></td>
<td>Work Capacity Evaluation</td>
</tr>
<tr>
<td></td>
<td>MRI</td>
</tr>
<tr>
<td>Nurse</td>
<td>Nurse</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td></td>
<td>Conditioning Program</td>
</tr>
<tr>
<td></td>
<td>Work Conditioning Program</td>
</tr>
<tr>
<td></td>
<td>Functional Work Simulation</td>
</tr>
<tr>
<td></td>
<td>Work Capacity Evaluation</td>
</tr>
<tr>
<td></td>
<td>Return to Work Program</td>
</tr>
<tr>
<td></td>
<td>Pain Management Counselling</td>
</tr>
<tr>
<td></td>
<td>Acupuncture (visit fee)</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td></td>
<td>Work Hardening</td>
</tr>
<tr>
<td></td>
<td>Work Capacity Evaluation</td>
</tr>
<tr>
<td></td>
<td>Functional Work Simulation</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>Chiropractic</td>
</tr>
<tr>
<td></td>
<td>Conditioning Program</td>
</tr>
<tr>
<td></td>
<td>Work Capacity Evaluation</td>
</tr>
<tr>
<td></td>
<td>Ergonomic Assessment</td>
</tr>
<tr>
<td>Speech Language Pathologist</td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>Audiologist</td>
<td>Audiometry</td>
</tr>
<tr>
<td>Psychologist</td>
<td>Counselling</td>
</tr>
<tr>
<td></td>
<td>Chronic Pain Program</td>
</tr>
<tr>
<td></td>
<td>Drug, Alcohol Dependency</td>
</tr>
<tr>
<td>Optometrist</td>
<td></td>
</tr>
<tr>
<td>Osteopath</td>
<td>None in province</td>
</tr>
<tr>
<td>Chiropodist (Podiatrist)</td>
<td></td>
</tr>
<tr>
<td>Dentist</td>
<td></td>
</tr>
</tbody>
</table>
HEALTH CARE SERVICES
Schedule 2*

* Where available for utilization, these service providers must be registered with an appropriate recognized national or provincial body.

<table>
<thead>
<tr>
<th>PROFESSIONS</th>
<th>SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conditioning Therapy</td>
<td>Conditioning Program</td>
</tr>
<tr>
<td>Psychotherapist</td>
<td>Counselling</td>
</tr>
<tr>
<td></td>
<td>Chronic Pain Program</td>
</tr>
<tr>
<td>Massage Therapist</td>
<td>Massage</td>
</tr>
<tr>
<td>Naturopath</td>
<td></td>
</tr>
<tr>
<td>Counsellor</td>
<td>Counselling - Various types recognized by WCB</td>
</tr>
</tbody>
</table>

HEALTH CARE SERVICES
Schedule 3*

* When these services are utilized:

1. Components of programs must meet identified criteria.
2. Program must be approved through WCB accreditation process.

Facility:

- Wascana Rehabilitation Centre
- Bourassa and Associates
- Gold Square
- Canadian Back Institute (Regina and Saskatoon)
7.1.2 Health Care Services Fees (POL 02/97)

Document Date 15 April 1997

Purpose To establish the CEO as authority to negotiate and administer health care services fees.

BACKGROUND

Historically, fees for medical aid have been determined by the Board, by means of a Board Decision. The function of negotiation with various health care associations to discuss and set fees and standards is an administrative one, and would more appropriately be carried out by the CEO, rather than the Board.

POLICY

The authority to negotiate and administer fees for medical aid furnished by any health care professional is delegated to the CEO, rather than the present method, which requires a Board Decision.

Act Sec # 59(1), 103, 104(1), 115(c)
Effective Date 01 April 1997
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All Medical Fee Schedules
Supersedes n/a
Complements POL 05/96 Health Care Services
PRO 53/2006 Medical Aid Billings – Payment
7.1.3 Medical Fees – Extra Billing (POL 57/80) (Amended by 08/95)

Document Date 14 July 1980

Purpose To establish guidelines for consideration of excess medical fees.

BACKGROUND

Despite the provision of Section 104, occasionally an individual providing medical aid demands of and receives from the injured worker a fee in excess of that determined by the Board.

POLICY

Where a worker in good faith pays an account in excess of the fee determined by the Board and is unable to obtain a refund from the provider of the service, the Board will assume this additional cost.

Act Sec # 104
Effective Date 14 July 1980
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All Claims
Supersedes n/a
Complements PRO 53/2006 Medical Aid Billings – Payment
7.1.4 Continuum of Care (POL 08/2014)

Document Date 24 June 2014

Purpose To establish the guiding principles of the Continuum of Care Model.

DEFINITION

Continuum of Care Model means a framework for the efficient and coordinated planning and provision of health care and return-to-work plans appropriate to each stage of a worker’s injury and recovery.

Medical aid, also referred to as health care, means “the provision of medical and surgical aid, of hospital and professional nursing services, of chiropractic and other treatment and of prosthetics or apparatus” (Section 2(1)(v) of The Workers’ Compensation Act, 2013 (the “Act”)).

BACKGROUND

1. Under Section 19(1) of the Act, the Workers’ Compensation Board (WCB) has a duty to:
   a. Arrange provision of any health care or treatment that may be needed because of a work injury.
   b. Arrange to provide rehabilitation to injured workers.
   c. Consult and cooperate with injured workers in the development of rehabilitation plans intended to return them to positions of independence in suitable productive employment.

2. Workers have a legislated responsibility to take all reasonable action to lessen earnings loss resulting from an injury and to co-operate with the WCB in a rehabilitation plan to return the worker to a position of independence in suitable productive employment (Section 51).

3. The WCB may request a worker to undergo a medical examination by one or more healthcare providers (Section 58).

4. Section 53 of the Act states “an employer shall co-operate with the board and the worker to achieve the early and safe return of an injured worker to his or her employment.”

5. Saskatchewan human rights legislation requires that all employers make every reasonable effort, short of undue hardship, to accommodate injured workers, and allow them to return to work as soon as medically safe. The Saskatchewan
Employment Act also provides job protection to certain employees who are absent from work due to a work injury.

6. Health care providers examining or treating injured workers are expected to furnish any reports the WCB may require, including recovery and return to work progress reports (Sections 55 and 56).

7. The WCB has established the Health Care Advisory Committee (HCAC) to evaluate and make recommendations to the WCB regarding the provision of health care for injured workers. The HCAC includes:
   a. A chairperson appointed by the WCB.
   b. Up to two members representing employer organizations.
   c. Up to two members representing labour organizations.
   d. And one member from each of the following health care provider areas chosen from their respective health care provider organization:
      i. Physician.
      ii. Chiropractor.
      iii. Physiotherapist
      iv. Occupational therapist.
   e. Other licensed health care providers may be invited at the discretion of the WCB.

8. The Early Intervention Program (EIP) model was implemented by the WCB in 1996. The program intended to ensure an injured worker’s optimal recovery and resumption of normal activities, including work, in the most appropriate, timely and safe manner. The program was renamed Continuum of Care to better reflect the progressive levels of assessment and treatment available to injured workers.

POLICY

General Principles

1. The WCB has adopted an integrated partnership model of recovery and return to work with open communication between all partners – the employer, health care providers, the injured worker, union representative (by the injured worker’s request) and WCB – and an awareness of the role each plays in achieving the most appropriate, timely and safe return to work.

2. The WCB supports the functional rehabilitation model that recognizes the importance of returning the injured worker to functional activities relevant to his or her life, including return to work, during the recovery period. The functional rehabilitation model encourages health care providers and workers to recognize that successful long-term recovery is associated with return to function, even in the presence of increasing subjective symptoms where there are no objective signs of harm.
3. There are three levels of assessment and treatment in the Continuum of Care model – Level I (primary), Level II (secondary), and Level III (tertiary). The levels graduate towards increased program complexity, scope and resources, depending on the needs of the injured worker. The goal is to ensure that injured workers receive the right care at the right time.

**Level I Assessment and Treatment (Primary)**

4. Level I assessment and treatment begins with the initial diagnosis and medical management by the primary health care provider.

5. Injured workers choose their primary health care provider and may also choose to see other providers, with whom the WCB has a relationship agreement, consecutively or concurrently. A referral from a licensed health care provider is required if the other provider is not licensed (for example, an exercise therapist or massage therapist). POL 05/96 and PRO 05/96, Health Care Services, establish the guidelines for the provision of health care services to injured workers.

6. Where requested by the primary health care provider, the WCB will arrange diagnostic tests, specialist appointments or surgeries, as needed. Where a waiting list exists, the WCB may arrange expedited appointments to ensure timely access to treatment. In-province services will be used unless unavailable within a reasonable period of time.

7. Return to work should be integrated into the treatment plan as soon as possible, preferably with the injured worker’s first visit to the primary health care provider. POL 08/96, Return-to-Work Plans, applies.

8. The primary health care provider will assess the worker’s condition and will provide the worker with a list of functional restrictions resulting from the work injury. This list is to be shared with the employer and updated as the worker’s condition changes.

9. A physician, chiropractor, physical therapist, occupational therapist, psychologist or nurse practitioner may arrange and monitor the injured worker’s return to work, with the cooperation of the primary health care provider. Where this occurs, progress reports will be provided to the primary health care provider.

10. Where a work injury results in restrictions that impair a worker’s ability to perform his or her pre-injury duties, whether or not the employer has a return to work (RTW) program, the WCB will assist the worker and employer with a RTW plan that will enable a return to suitable productive employment.

**Level II (Secondary) and Level III (Tertiary) – Advanced Assessment**

11. At any time during treatment, the primary health care provider or WCB may request advanced assessment when:
a. There is no active treatment plan.
b. The worker is not working and has no confirmed RTW date.
c. Significant risk factors for chronic disability have been identified (see Appendix A).
d. The expected recovery date has passed (see Appendix B), or
e. The worker continues to work in employment but has not returned to full duties and/or full hours of work after the work injury as expected.

12. Assessment teams accredited by the WCB bring together a number of health disciplines to perform advanced assessment of a worker’s medical, physical, functional and psychosocial condition.

13. The WCB will select the appropriate assessment team based on the length of time the worker has been away from regular job duties or the presence of psychosocial and pain management issues. Additional specialists may be added to the assessment teams at the discretion of the WCB, or other assessments requested (e.g., psychological or psychiatric), as required.

14. The assessment team will confirm a diagnosis and recommend a plan of treatment to assist the health care provider(s). The required reports and recommendation and fees payable for assessment teams are set out in PRO 51/2012, Medical Fees – Assessment Teams, and the Secondary and Tertiary Assessment Manual.

Level II (Secondary) and Level III (Tertiary) – Advanced Treatment

15. When the primary health care provider approves the assessment team’s treatment recommendations, they may make a direct referral to a WCB approved treatment centre or ask the WCB to make the referral.

16. To prevent an actual or potential conflict of interest the WCB will avoid requesting assessment or treatment from a centre that has a financial relationship with the injured worker’s employer. Where the primary care provider is being offered a choice of treatment centres, any such relationship will be disclosed to the primary health care provider and the injured worker to ensure the opportunity for an informed decision.

17. Once referred to the treatment centre, the primary care provider will continue to see the injured worker and monitor progress throughout the treatment. Other Level I therapies will stop and the recommended treatment will be provided by the Level II or Level III treatment centre.

18. The treatment centre will provide all recommended components of treatment to ensure cohesive health care and re-employment management. When a component
of the treatment is not available in the centre, the WCB will locate an alternate provider for assistance.

19. Workers expected to make a full recovery from the injury and regain the ability to perform the pre-injury job will be referred to Level II treatment. Programs may include: biomechanical treatment, regional conditioning, global conditioning, work simulation, work hardening, psychosocial counselling, ergonomic consultation, education related to the injury and a monitored return to work.

20. Workers expected to make a full recovery from the injury but needing more extensive therapy, as well as those with permanent functional restrictions, will be directed to Level III programming. In addition to the physical conditioning at Level II, Level III treatment involves chronic pain management, lifestyle adjustment and stress management. Suitable duties and tasks will be arranged with the employer while the worker attends the program.

21. The worker will be expected to attend Level II or Level III programs up to five days per week. Where the worksite may be used to make functional progressions, less treatment time may be indicated.

22. Accreditation, practice standards of care and a schedule of fees payable to Level II and Level III clinics are outlined under PRO 54/2011, Medical Fees – Secondary and Tertiary Treatment Centres.

ATTACHMENTS

Risk Factors for Chronic Disability

Expected Recovery & Referral to Advanced Assessment Guidelines

| Act Sec # | 2(1)(v), 19(1), 51, 53, 55, 56, 58(1); The Saskatchewan Employment Act |
| Effective Date | 01 July 2014 |
| Application | All claims |
| Supersedes | POL 04/96 Early Intervention Program |
| Complements | POL 08/96 Return-to-Work Plans |
| | POL 05/96 Health Care Services |
| | PRO 53/2014 Medical Fees – Assessment Teams |
| | PRO 57/2013 Medical Fees – Secondary and Tertiary Treatment Centres |

All Medical Fee Procedures (Section 7 of Procedure Manual).
Appendix A
Risk Factors for Chronic Disability

Injured Worker
- Age – older workers may have difficulty finding jobs because of their age.
- Place of residence – rural workers may have more difficulty finding other employment if they are unable to return to the job they held at the time of the injury.
- Education – jobs with fewer educational requirements usually involve more physical activity.
- Opinion as to the degree of disability is out of proportion to the nature of the injury.
- History of drug or alcohol abuse.
- Financial problems reduce the ability to focus on returning to work as a priority.
- Family problems such as separation, divorce, serious illness or death.
- Language – English as their second language may limit their ability to find work.
- Lack of mobility – if their spouse has a job in the community, or if they have lived there a long time, they may not want to move and this will limit their ability to find work.
- Injured worker cannot be reached when Case Manager calls or tries to meet with him/her.
- Injured worker relies on a third party (spouse or parent) to communicate with the WCB.
- Injured worker has a significant number of prior claims with the WCB.

Employment
- Employment history – length of employment with employer of record, seasonal work, issued a layoff, uncertainly about having a job to return to.
- Nature of employment – no light duties available, employer small in size.
- History of poor performance on the job – employer doesn’t want worker to return to work.
- Excuses for not returning to work – no transportation, unreasonable demand for light duties.
- Little or no contact with employer after injury.
- Rate of compensation provides a sense of security, especially if income from the job the worker held at the time of the injury income was uncertain, sporadic or seasonal.
- Dissatisfaction with the job.
- Lack of job opportunities because of economic conditions within usual field of employment.

Medical
- Period of disability exceeds expected recovery time for the injury.
- Worker has other medical problems at the same time as the injury.
- Lack of physical findings on medical reports to support a delay in returning to work.
- Injured worker frequently changes care providers.
- Past related problems in same body area of the injury.
- Expansion or change in location of symptoms from those of the original injury.
- Injured worker does not participate in treatment, misses appointments, makes excuses for nonattendance, and has only vague recollection of care provider’s advice.
Appendix B
Expected Recovery & Referral to Advanced Assessment Guidelines

<table>
<thead>
<tr>
<th>Type of Injury</th>
<th>Referral to Advanced Assessment May be Made After</th>
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<tbody>
<tr>
<td>Soft Tissue Injury (STI)</td>
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<tr>
<td>Non-STI - Neck and Spine (fractures/surgeries)</td>
<td>12 weeks</td>
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<tr>
<td>Non-STI - Upper Extremity (includes non-arthroscopic surgery)</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Non-STI - Others (includes all non-arthroscopic surgery)</td>
<td>12 weeks</td>
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<tr>
<td>All arthroscopic surgeries</td>
<td>6 weeks</td>
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<tr>
<td>Lower extremity (fractures/surgeries)</td>
<td>16 weeks</td>
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<tr>
<td>All other complex/multiple fractures</td>
<td>16 weeks</td>
</tr>
<tr>
<td>Amputation (lower or complex)</td>
<td>26 weeks</td>
</tr>
<tr>
<td>Spinal fusion</td>
<td>26 weeks</td>
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<tr>
<td>Psychological</td>
<td>4 weeks</td>
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</table>

*More information on the WCB’s Disability Duration Guidelines, including sources, is available on the WCB website.*
7.1.5 Medical Boards – Repeal (POL 02/2006)

Document Date 10 January 2006

Purpose To repeal the policy on Medical Boards.

BACKGROUND

In considering policy and procedure relating to Medical Boards, the Board has concluded that there is no longer any need to establish Medical Boards. Medical Boards have not been convened for a lengthy period of time. The current system of secondary and tertiary reviews has made these types of Medical Boards redundant. Claimants may also appeal their medical status, and if not successful, they may request that a Medical Review Panel (Section 59 of The Workers’ Compensation Act, 2013 and POL 18/2010 refers) consider his or her case.

POLICY

POL 21/94 – Medical Boards and PRO 21/94 – Medical Boards, Procedure for Convening and Conducting are hereby repealed.

Act Sec # 59
Effective Date 01 February 2006
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All claims
Supersedes POL 21/94 Medical Boards
PRO 21/94 Medical Boards, Procedure for Convening and Conducting
Complements POL 18/2010 Medical Review Panels
PRO 18/2010 Medical Review Panels
PRO 55/2015 Medical Fees – Physicians
# 8.0 RE-EMPLOYMENT ASSISTANCE & RETURN-TO-WORK

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<tr>
<th>Section</th>
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<tr>
<td>8.1</td>
<td>Vocational Rehabilitation – Programs and Services (POL 01/2011)</td>
<td>3</td>
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<td>8.2</td>
<td>Equipment and Tools – Vocational Rehabilitation (POL 05/2004)</td>
<td>9</td>
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<td>8.4</td>
<td>Return to Work – Temporary Helper (POL 08/2010)</td>
<td>12</td>
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<td>8.5</td>
<td>Return-to-Work Plans (POL 08/96)</td>
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<td>8.6</td>
<td>Vocational Rehabilitation – Moving Allowance (POL 02/2014)</td>
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<td>8.7</td>
<td>Modifications – Home, Vehicle and Work (POL 04/2015)</td>
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8.1 Vocational Rehabilitation – Programs and Services (POL 01/2011)

Document Date 12 January 2011
Purpose To establish guidelines for vocational rehabilitation programs and services.

DEFINITION

Suitable productive employment means a position or occupation in which the worker is employable, given the worker’s employability assessment and transferable skills analysis, the restrictions imposed by the work injury, and any non-compensable restriction that existed prior to the injury, and that contributes meaningfully to the operation of the business, thereby providing purposeful tasks to the worker.

BACKGROUND

1. Subsection 19(1)(d) of The Workers’ Compensation Act, 2013 (the “Act”) states the Workers’ Compensation Board (WCB) will “consult and cooperate with workers and surviving dependent spouses in the development of rehabilitation plans intended to return workers or surviving dependent spouses to positions of independence in suitable productive employment.”
2. Section 51 of the Act directs that “a worker shall:
   a. take all reasonable action to mitigate the worker’s loss of earnings resulting from an injury; and
   b. if the circumstances require, co-operate with the board in the development of a rehabilitation plan that is intended to return the worker to a position of independence in suitable productive employment.”
3. Sections 111 and 115 of the Act state the WCB will “take any measures that it considers necessary or expedient… to assist in lessening or removing any barriers resulting from the worker’s injury or to encourage a dependent spouse of a deceased worker to become self-sufficient,” and to “expend moneys from the [injury] fund for any expenses incurred in the administration of this Act.”
4. Section 2-41 of The Saskatchewan Employment Act provides guidelines for an employer’s duty to accommodate an injured worker’s return to work.
5. The WCB utilizes a multidisciplinary Case Management Team approach for developing vocational rehabilitation plans intended to return workers to positions of independence in suitable productive employment.
POLICY

1. Where the effects of a work injury result in permanent restrictions that preclude or complicate a return to pre-injury employment, the WCB will provide a worker with the appropriate services and programs to:
   a. Facilitate a return to suitable, productive employment or a status of employability at comparable earning potential with the pre-injury level; and where necessary; and
   b. Address issues of quality of life and independence.

2. A worker is considered employable when the following criteria are met:
   a. The worker has acquired the skills and abilities to competitively pursue suitable productive employment;
   b. The work can be performed without endangering the worker’s safety and the safety of others; and
   c. The work is available in the worker’s immediate locale or in a location to which the worker may reasonably commute or relocate.

3. Varying with the individual circumstances of the worker, the goal of vocational rehabilitation is to:
   a. Return to previous employment;
   b. Return to alternate employment; or
   c. Retrain for a new occupation.

**Individualized Vocational Plan (IVP)**

4. Developed in consultation with the worker, the IVP is a written agreement representing a plan co-signed by the WCB and the worker to meet the vocational goal.

5. The IVP outlines the suitable short and long-term objectives for re-employment, and the selection of programs and services required to meet those objectives. In particular, the IVP specifically outlines the associated costs for implementation, including allowable expenses, any necessary modifications to the workplace to ensure accessibility and independence, ongoing entitlement to compensation benefits and an estimation of earnings capacity.

6. As part of the IVP, and in accordance with Section 51 of the Act, workers are expected to actively seek employment during interruptions in their vocational training program for periods in excess of eight weeks. Where individual circumstances of the worker (e.g., age, location, suitable employment, etc.) and other conditions permit, the WCB may assess a worker as employable for periods less than the eight weeks.
If the worker is considered employable during an interruption in training that is less than eight weeks, written justification will be included to the IVP.

7. The WCB may reduce benefits in accordance with POL 07/2014, Suspension of Benefits, or assess the worker as being capable of earning wages consistent with temporary employment, if the worker does not demonstrate active involvement in their own rehabilitation by seeking employment.

Employability Assessment and Transferable Skills Analysis

8. As a starting point for planning, an employability assessment and transferable skills analysis (QuickNOC Pro) will be completed. This is an assessment of the worker's individual circumstances that impact the selection of an appropriate vocational objective. In general, the following factors are considered:
   a. The compensable and non-compensable work restrictions (obtained from medical and or psychological documentation);
   b. The functional requirements for performance of the return to work position (pre-injury or otherwise);
   c. Prior education and training;
   d. Employment history, job descriptions and duties, and wages;
   e. Assessment of transferable skills, aptitudes, interests, abilities; and
   f. Other factors including but not limited to geographical location, ability/practicality to relocate, labor market opportunities, etc.

Programs and Services

9. Each case will be judged on its merits to determine which services and programs are available to the worker. However, with consideration to the employability assessment and transferable skills analysis, the WCB considers re-employment measures from a Hierarchy of Objectives (Appendix A).

10. The first and foremost objective is to consider a return to the pre-injury employer. Graduated return to work or modified duties may be explored, either temporary or permanent. Any necessary modifications of the physical work environment such as providing specialized equipment or changing the workplace layout may be provided to support a safe and timely return to work (POL 04/2015, Modifications – Home, Vehicle and Work).

11. Where a worker cannot return to the pre-injury job because of the compensable restrictions, some type of alternate work with the pre-injury employer must be explored that is within the worker's functional capabilities. A worker's transferable skills, qualifications or alternate work experience for the new position may be
assessed, and where appropriate, on-the-job or formal training programs (academic or technical) will be provided.

12. If the pre-injury employer is unable to provide a suitable re-employment option (cannot accommodate in any capacity), the preceding programs may be used for returning the worker to the workforce with another employer in the same or different industry. The former would apply when workers are displaced because of the compensable injury; limited assistance such as job search benefits may be all that is necessary if the worker is able to pursue the same type of work (POL 17/2010, Termination of Compensation Benefits – Notice, will apply). If a worker’s restrictions preclude returning to the pre-injury employment in any capacity, the WCB will offer appropriate academic, technical or on-the-job training necessary for obtaining employment in a new occupation. Relocation (temporary or permanent) may be considered to access these programs or to increase employment opportunities (POL 02/2014, Vocational Rehabilitation – Moving Allowance).

13. Self-employment ventures will only be approved where all other conventional re-employment objectives have been exhausted, or it is the only viable option for reaching maximum pre-injury earnings (PRO 11/2014, Vocational Rehabilitation – Self-Employment Plans, will apply). Generally, this will apply to those workers in remote areas where employment and education opportunities are scarce and relocation is not an option (e.g., family obligations), the plan is reasonably cost-effective compared with other return to work alternatives and there is a high probability of success.

14. To enable participation in vocational programs and to address issues of quality of life, the WCB will reimburse appropriate travel and sustenance expenses (POL 39/2010, Expenses – Travel and Sustenance), provide equipment and tools required by selected programs or employment opportunities (POL 05/2004, Equipment and Tools – Vocational Rehabilitation), and consider modifications to the vehicle or residence made necessary by the compensable injury (POL 04/2015, Modifications – Home, Vehicle and Work).

15. At the successful completion of the IVP, wage loss will be based on actual earnings or an estimation of earnings capacity and any benefits payable will be in accordance with POL 15/2014, Determination of Long-Term Loss of Earnings. This may also occur where workers have failed to comply with the IVP and earnings capacity is estimated as if the IVP was completed.

16. Where a worker is considered employable at the successful completion of the IVP, but has not obtained employment, the WCB will offer additional job search benefits in accordance with POL 17/2010, Termination of Compensation Benefits – Notice or POL 02/2014, Vocational Rehabilitation – Moving Allowance, as the case may be.
Special Services

17. In addition to medical aid or access to health care providers, the WCB may provide a personal care allowance to eligible workers to reduce or eliminate barriers to daily living, including various aspects of hygiene, dressing, mobility challenges or supervision (POL 10/2014, Allowance – Personal Care).

ATTACHMENT

Hierarchy of Objectives

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<th>Act Sec #</th>
<th>19(1)(d), 51(a)(b), 69, 111(a)(b)(c), 115(e)(f);</th>
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<td>All workers receiving vocational rehabilitation programs and services as of the effective date.</td>
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<td>PRO 11/2014 Vocational Rehabilitation – Self-Employment Plans</td>
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Appendix A
Hierarchy of Objectives

Objective 1 – Same Work with Same Employer (worker is able to return to pre-injury job, with some restrictions). Wherever possible, the employer should be encouraged to accommodate the worker in graduated return to work or modified duties.

Objective 2 – Different Work Same Employer (restrictions preclude returning to the pre-injury position). The VRS will undertake any additional vocational testing or skills analysis necessary to determine if the worker has the skills, aptitudes and experience that are transferable to alternate work.

Objective 3 – Same Work Different Employer (pre-injury employer unable to accommodate in any capacity; alternatives in the same or related industrial sector are considered). Little intervention may be required, but additional job search benefits or employment readiness program may be provided, as necessary.

Objective 4 – Different Work Different Employer (the worker is unable to return to employment in the same or related industry). Vocational exploration will expand to suitable opportunities in other occupational sectors where the worker’s existing inventory of transferable skills, aptitudes, and interests may be used.

Objective 5 – Training and Education (existing skills are insufficient to restore the worker to suitable employment). The development of new occupational skills will be considered through academic, technical or on-the-job training programs.

Objective 6 – Self Employment (this may only be offered where all other objectives have been exhausted or it is the only viable option for reaching maximum pre-injury earnings). Generally, this will apply to those workers in remote areas where employment and education opportunities are scarce, the plan is cost-effective compared with other reasonable return to work alternatives and there is a high probability of success.
8.2 Equipment and Tools – Vocational Rehabilitation (POL 05/2004)

Document Date 12 October 2004

Purpose To establish guidelines for the purchase of equipment and tools for vocational rehabilitation programs.

DEFINITION

Equipment and Tools for:

- Academic/Technical Training may include but are not limited to computers, printers, software, textbooks, school supplies, and calculators.
- Return-to-Work may include but are not limited to anti-fatigue mats, air-ride hydraulic seats, ergonomic office equipment and uniforms or coveralls.
- Self-employment may include but are not limited to vehicles, buildings, tools, inventory, office equipment or protective safety equipment such as eye, face, hearing and respiratory devices.

BACKGROUND

1. Section 111(a) of The Saskatchewan Workers’ Compensation Act, 2013 (the “Act”), states that the Workers’ Compensation Board (WCB) “may take any measures that it considers necessary or expedient . . . to assist an injured worker in returning to work.”

2. Section 115(e) of the Act states that WCB “may expend moneys from the fund for . . . any grant with respect to any costs of rehabilitation related to any injured worker re-entering the work force or to assist in lessening any hardship caused by the worker’s injury”.

3. In some cases, it may be necessary as part of vocational rehabilitation, for the WCB to provide workers with equipment and/or tools required to complete a sponsored training program or to participate in re-employment opportunities. These are “tools of the trade” not normally provided by the training institute or employer and distinct from the specialized equipment or assistive devices provided under Policy POL 04/2015, Modifications – Home, Vehicle and Work. However, for the purchase of the latter (i.e., ergonomic office equipment) the conditions of purchase contained in this policy will be followed.

4. Parts VII and VIII of the Occupational Health and Safety, Regulations, 1996 (“OH&S Regulations”), require employers to provide adequate and approved personal protective and safety equipment suitable to the risks of the industry.
POLICY

1. All equipment and tools, including conditions of purchase (below) must be identified in the approved Individualized Vocational Plan (IVP) signed by the worker and WCB.

2. Where workplace modifications are provided pursuant to POL 04/2015, Modifications – Home, Vehicle and Work, the employer will be advised of the conditions of purchase below.

3. Equipment and tools will be approved only where the employer or educational/training institute does not normally provide them or they are required for a self-employment plan.

4. With the exception of self-employment plans, WCB will not provide personal protective and safety equipment that employers are required to provide under the OH&S Regulations.

General

5. All purchases must be preauthorized by WCB and are subject to the requirements of the Procurement Procedure (PRO 07/2012).

6. To ensure the equipment or tools meet the requirements of the program or workplace, the Vocational Rehabilitation Specialist (VRS) may consult with technical experts and/or program advisors for specifications.

7. Purchases or grants will be provided on a one-time only basis.

8. Where cost-effective, leasing will be considered as an alternative to purchasing. Program duration and availability, quality and cost of items will contribute to the decision-making process.

Conditions of Purchase

9. Single item purchases under $2500 will be subject to the following conditions:
   a. Workers will be granted ownership of item(s), except where a cost sharing agreement has been made with an employer (e.g., training-on-the-job). In the latter case, ownership will be determined by the WCB, in agreement with the employer, prior to purchase.
   b. The worker will be responsible for the maintenance, repair or replacement of the purchased items. Exceptions may be made where this causes undue hardship to the worker, provided the damage was not caused by a wilful or intentional act.
Security Interest

10. In addition to provisions of Point 9(b), single item purchases $2500 and greater will be subject to the following conditions:
   a. WCB will file a security interest for Personal or Real Property with the appropriate Registry for the original purchase price of the equipment and tools.
   b. The worker will be responsible for all costs pertaining to insurance, licensing, registration, transfer of titles and any other legal costs. The worker must provide confirmation that insurance has been obtained before WCB will release funds or distribute purchased items.

11. WCB will remove its interest in equipment and tools valued at $2500 or greater:
   a. Twelve months following successful completion of the IVP; or,
   b. When the IVP has not been successfully completed but the Estimation of Earnings Capacity is based on the occupation identified in the IVP.

Recovery

12. WCB will recover equipment and tools valued at $2500 or greater when:
   a. The IVP has not been successfully completed; and,
   b. The Estimation of Earnings Capacity is based on a different occupation from the one identified in the IVP and the equipment and/or tools are not necessary in order for the worker to participate in the alternative occupation.

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8.4 Return to Work – Temporary Helper (POL 08/2010)

Document Date 02 March 2010

Purpose To establish provision of temporary helpers in a return-to-work plan for self-employed or those employed under a contract for service.

DEFINITION

Return to Work (RTW) means the act of re-introducing the injured worker to safe and suitable productive employment that eliminates or minimizes wage loss, as soon as medically possible.

BACKGROUND

1. Section 111 of The Saskatchewan Workers’ Compensation Act, 2013 (the “Act”), states that the Workers’ Compensation Board (the “WCB”) “may take any measures that it considers necessary or expedient . . . to assist an injured worker in returning to work.”

2. Under Section 69, where a worker’s injury results in a loss of earnings, the WCB may provide partial wage loss benefits based on the difference between the worker’s pre-injury and post-injury earnings.

3. The WCB supports the functional rehabilitation model, which recognizes the importance of returning the injured worker to functional activities relevant to his or her life, including returning to work, during the recovery period. Early return to work (RTW) serves as a therapeutic component of the recovery process and is vital to the prevention of chronic disability.

POLICY

1. The primary goal of a RTW plan is to return the injured worker to full duties with the pre-injury employer as soon as medically possible. Where medical restrictions prevent an immediate return to full duties, a transitional return-to-work plan may be designed to reinforce the recovery process by promoting a gradual restoration to the worker’s pre-injury duties and tasks. Policy, POL 08/96, Return-to-Work Plans, will apply.

2. Where unable to perform all pre-injury duties, the WCB may assist the injured worker’s RTW through reimbursement of a temporary helper’s wage. The helper will assist the injured worker with more difficult tasks until it is medically possible for the injured worker to resume full duties.
3. Typically, the injured worker requiring the temporary helper will be self-employed or under a contract for service and the employment of a helper will be short-term based on the nature and severity of the injury. Through the assistance of a helper, the injured worker will be able to fulfil the obligations of his/her employment contract and the income generated by the contract should not be reduced.

4. The temporary helper’s wages will be substantially lower than the injured worker’s and WCB reimbursement will not exceed ninety (90) percent of the injured worker’s net earnings.

5. Compensation coverage is provided for any injury sustained by the helper during the course of their employment.

Act Sec # 19, 69, 111, 115
Effective Date 01 April 2010
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application Claims requiring a temporary helper.
Supersedes n/a
Complements

POL 08/2010 Return to Work – Temporary Helper
POL 08/96 Return-to-Work Plans
POL 01/2011 Vocational Rehabilitation – Programs and Services
POL 15/2008 Allowance – Temporary Additional Expense
8.5 Return-to-Work Plans (POL 08/96)

Document Date 01 April 1996

Purpose To establish guidelines for return-to-work plans.

DEFINITION

Return-to-Work, in this context, means suitable work within the medical limitations of an injured worker who has not yet fully recovered from his injuries, is not yet able to return to his original job, but who is capable of some form of employment.

POLICY

1. The Board will encourage and endorse properly established work plans that are set up for rehabilitative purposes to assist injured workers to return to full employment bearing in mind the work limitations caused by injuries.

2. Where a collective agreement exists, the WCB expects the parties to establish appropriate procedures to accommodate Return-to-Work plans.

3. In dealing with the issue of rehabilitative return to suitable employment, the following policy will be used:
   a. All of the facts relating to the nature of the work being offered will be considered, and the WCB must be satisfied that the job description is accurate.
   b. WCB will confirm that the health care provider has all the necessary information to provide an informed opinion on the physical ability of the injured worker to perform the work.
   c. The limitations applied to a worker will be made known to all affected parties.
   d. Any change in limitations applied to a worker under this program must be approved by the health care provider.
   e. Where a worker disagrees with a return to suitable work, the reasonableness of that disagreement will be investigated and a determination made whether to continue, suspend, or terminate benefits by WCB.

Act Sec # 111
Effective Date 01 April 1996
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013.
Application All claimants.
Supersedes POL 01/84 Employer Initiated Short Term Suitable Job Opportunities for Injured Workers
Complements POL 02/2008 Compensation – Layoff, Strike or Lockout
8.6 Vocational Rehabilitation – Moving Allowance (POL 02/2014)

Document Date 29 April 2014

Purpose To establish guidelines for the payment of moving allowances.

DEFINITION

**Resident community** means limits of the city, town, or village in which the worker’s permanent place of residence is located.

**Suitable productive employment** means a position or occupation in which the worker is employable, given the worker’s employability assessment and transferable skills analysis, the restrictions imposed by the work injury, and any non-compensable restriction that existed prior to the injury, and that contributes meaningfully to the operation of the business, thereby providing purposeful tasks to the worker.

BACKGROUND

1. Section 111(a) of *The Workers’ Compensation Act, 2013* (the “Act”) states that the board may take any measures that it considers necessary or expedient “to assist an injured worker in returning to work.”

2. Section 115(j) of the Act states that the board may expend moneys from the fund for any expenses incurred in the administration of this Act and, without restricting the generality of the foregoing, the board may expend moneys for “any other purposes that the board considers necessary to carry out the intent of this Act.”

POLICY

**General**

1. A work-related injury can leave a worker with restrictions. This may make it difficult for a worker to find suitable productive employment in their resident community. To assist these workers, the WCB may pay for a move to a more suitable community.

2. Moving should be approved by the WCB in advance. The WCB may not pay for moving arrangements that were made before approval unless the worker gives good reason for not seeking prior approval.

3. Moving may be considered if the commuting distance from home to work is greater than 75 kilometres (km) and if the move will eliminate, or substantially reduce, the earnings loss benefits being paid to the worker. Where the commuting distance is less than 75 km, approval will be based on individual circumstances.
4. POL 39/2010, Expenses – Travel and Sustenance – General and PRO 54/2015, Expenses – Travel and Sustenance – PSC Rates will be followed to pay expenses, unless otherwise indicated by the WCB.

**Moving for Confirmed Employment**

5. Moving may be approved where the worker secures permanent employment in another community that will eliminate, or substantially reduce, the earnings loss benefits being paid to the worker. The WCB will pay moving costs only where the total cost of the move is not greater than the value of the reduction of earnings loss benefits.

**Moving for Quality of Life**

6. Moving may be approved where the worker’s resident community is unable to meet the worker’s needs given the lasting effects of the work-related injury. The WCB will pay moving costs where there is a reasonable expectation that the worker’s quality of life will be improved. The move does not have to eliminate, or substantially reduce, the earnings loss benefits being paid to the worker.

**Moving to Seek Employment**

7. Moving may be approved for the purpose of actively seeking employment. The WCB will pay moving costs only where the move has a significant potential to reduce the amount of earnings loss benefits being paid to the worker.

8. The move will be within Saskatchewan unless it can be demonstrated that the opportunities in other jurisdictions are significantly greater than in Saskatchewan.

9. When required, for a maximum period of two weeks, the WCB will provide full earnings loss benefits to support a period of settling into a new community prior to beginning or searching for employment.

10. The WCB will pay job search benefits for a minimum of eight to a maximum of 12 weeks.

**Moving for Retraining**

11. Moving may be approved for the purpose of retraining. The WCB will pay moving costs only where the:

   a. Cost of moving is less than the projected cost of any allowances the worker may be entitled to (e.g., kilometre rates, accommodation subsidy, etc.) if the worker were to maintain a primary residence in the resident community; or

   b. Worker permanently moves to the proposed community after the training is completed and there are reasonable opportunities for employment.
12. The WCB will pay job search benefits for a minimum of eight to a maximum of 12 weeks following the completion of retraining.

**Moving Allowance**

13. Where a move for any of the above noted reasons is approved, the worker may be entitled to the following allowances:

   a. Travel, hotel and meal allowances to a maximum of seven days for the worker (and dependants) to arrange living accommodations;

   b. Reasonable expenses for the transportation of the worker’s household belongings (estimates from three different moving companies are required where available);

   c. Travel, hotel and meal allowances enroute to the new location for the worker (and dependants); and

   d. Incidental moving allowance of $300 (receipts are not required).

14. Where a move is approved for confirmed employment, the worker may also be entitled to these additional allowances:

   a. If storage is required in the course of relocation, the WCB will pay the cost of insured short-term storage for household belongings;

   b. A maximum of one month rent for a worker’s house or suite lease if the lease cannot be terminated without cost to the worker.

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**Act Sec #** 111(a), 115(j)  
**Effective Date** 01 June 2014  
**Application** Claimants who relocate on or after the effective date while receiving benefits.  
**Supersedes** POL 10/2001 Relocation Allowances  
**Complements** POL 02/2014 Vocational Rehabilitation – Moving Allowance

- PRO 54/2015 Expenses – Travel and Sustenance – PSC Rates  
- POL 01/2011 Vocational Rehabilitation – Programs and Services  
- PRO 01/2011 Vocational Rehabilitation – Programs and Services  
- POL 15/2014 Determination of Long-Term Loss of Earnings  
- PRO 15/2014 Determination of Long-Term Loss of Earnings  
- POL 39/2010 Expenses – Travel and Sustenance – General
8.7 Modifications – Home, Vehicle and Work (POL 04/2015)

Document Date 27 April 2015

Purpose To establish the process for paying for home, vehicle and work modifications.

DEFINITION

Home Modifications means renovations to the worker’s home given the loss of function due to the injury. Home modifications include, but are not limited to, the following:

- Wheelchair ramps.
- Wheelchair lifts.
- Bathroom renovations.
- Lowering cupboards.

Vehicle Modifications means updates to a worker’s vehicle given the loss of function due to the injury. Vehicle modifications include, but are not limited to, the following:

- Wheelchair lifts.
- Hand controls.
- Power door openers.
- Power seat bases.

Work Modifications means renovations to the worker’s workplace given the loss of function due to the injury. Work modifications include, but are not limited to, the following:

- Widening doorways for wheelchair accessibility.
- Wheelchair ramps.
- Handrails.
- Ergonomic workstations.

Minor Modifications means home and work modifications for short-term injuries that are expected to resolve within 18 months. Minor modifications include, but are not limited to, the following:

- Grab bars.
- Raised toilet seats.
• Ergonomic chairs.
• Wheelchair ramps.
• Specialized keyboards.

**Major modifications** means home, vehicle and work modifications for injuries that are long-term and severe. Major modifications include, but are not limited to, the following:

• Home restructuring.
• Wheelchair lifts.
• Sit/stand stations.
• Specialized computer equipment.
• Vehicle modifications.

**BACKGROUND**

To help workers address quality of life and independence issues, *The Workers’ Compensation Act, 2013* (the Act) authorizes the WCB to pay for home, vehicle and work modifications (Sections 111 and 115).

**POLICY**

**General**

1. Eligibility for modifications (i.e., home, vehicle and work) is based on the following criteria:
   a. Physical need because of the injury.
   b. Cognitive need because of the injury, and
   c. Loss of functional independence because of the injury.

2. All modifications are subject to:
   a. PRO 07/2012, Procurement Procedure, and
   b. POL 05/2004, Equipment and Tools – Vocational Rehabilitation.

**Work Modifications**

3. If the worker’s workplace needs modifications, the WCB may:
   a. Fully fund the modifications, or
   b. Share the modification costs with the employer.

4. The WCB will not pay to restore the workplace back to normal:
a. Once the worker recovers.
b. If the worker switches jobs.

Short-Term Needs

5. If the WCB expects the worker to recover from the injury within 18 months, the WCB will only pay for minor modifications.

Long-Term Needs

6. The WCB will pay for major modifications if the worker’s injury is long-term and severe. Such injuries may include, but are not limited to, the following:
   a. Spinal cord injuries.
   b. Amputations.
   c. Severe visual impairment.
   d. Severe burns that cause a loss of functional mobility.

Act Sec # 111, 115
Effective Date 01 July 2015
Application All workers severely injured before and after the effective date
Supersedes POL 02/2002 Modifications – Residential, Vehicle and Workplace
Complements PRO 04/2015 Modifications – Home, Vehicle and Work
POL 10/2014 Allowance – Personal Care
POL 02/2014 Vocational Rehabilitation – Moving Allowance
PRO 07/2012 Procurement Procedure
POL 01/2011 Vocational Rehabilitation – Programs and Services
POL 15/2008 Allowance – Temporary Additional Expense
POL 05/2004 Equipment and Tools – Vocational Rehabilitation
### 9.0 APPEALS

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9.1 Reversing Decisions (POL 23/2014)

Document Date 10 December 2014

Purpose To establish the process for reversing decisions.

BACKGROUND

*The Workers’ Compensation Act, 2013* (the “Act”) authorizes the WCB to rescind, alter or amend any decision it has previously made (Section 20(5)).

POLICY

1. The WCB may reverse decisions when:
   a. There is new evidence.
   b. The Medical Consultant provides a contrary opinion regarding the relationship of medical issues to the injury and/or employment.
   c. The Appeals department, Assessment Committee or Board Members provide a contrary decision to that of the decision maker.
   d. Operations or Employer Services staff determine that the original decision is unreasonable.

2. If a reversed decision results in the termination of benefits, POL 17/2010, Termination of Compensation Benefits – Notice, will apply.

Act Sec # 18, 20(5), 100(1)
Effective Date 01 January 2015
Application Claim and employer account decisions
Supersedes POL 13/91 Reversing Decisions
Complements PRO 23/2014 Reversing Decisions
POL 20/2013 Appeals – Employer Accounts
POL 21/2013 Appeals – Claims
PRO 21/2013 Appeals – Claims
POL 22/2013 Appeals – Board Appeal Tribunal
POL 17/2010 Termination of Compensation Benefits – Notice
9.2 Appeals – Claims (POL 21/2013)

Document Date 18 December 2013
Purpose To provide guidelines for appeals of claim decisions.

BACKGROUND

1. Section 18 of The Workers’ Compensation Act, 2013 (the “Act”) allows the Board Members to delegate any of their powers or functions to WCB employees. Persons affected by delegate decisions can make appeals. This section also directs that the WCB must create policy to guide the appeals process.

2. Section 20(5) of the Act states that the WCB can reconsider any matter that it has dealt with and any decision that it has made.

3. Section 23 of the Act requires staff to base every decision on the merits and justice of each case. However, WCB recognizes that from time to time, workers and employers desire an independent review of a decision on an injury claim.

4. Section 171 of the Act clarifies that oral hearings are not a right under the Act.

5. The intent of the appeals process is to provide workers and employers with an easily accessible and independent process of review for a decision regarding a worker’s claim for entitlement to benefits.

6. Employer appeals regarding decisions on employer accounts (e.g., assessments) are not covered by this policy (see POL 20/2013, Appeals – Employer Accounts).

POLICY

Appealing WCB Claim Decisions (Workers or Employers)

1. Workers and employers (and their approved representatives) may appeal any claim decision.

2. WCB has established a four-level process for workers or employers appealing a WCB claim decision:
   a. Review of the original decision by the staff responsible for the decision.
   b. Review of the original decision by an Appeals Officer. Appeals Department staff are bound by WCB policy and have authority to confirm, change or reverse any claim decision, except a decision made by the Board Appeal Tribunal, and
   c. Final review by the Board Appeal Tribunal comprised of two or more members of the Board. The Board Appeal Tribunal is bound only by the Act and has full
discretionary authority in all matters as delegated to it under the Act (POL 22/2013).

d. Review by a Medical Review Panel (bona-fide medical questions only) (POL 18/2010, Medical Review Panels).

3. All requests for appeals must be in writing to the Manager of Appeals. The request should specify the decision in dispute, why the appellant disagrees with the decision, and his/her expected resolution to the appeal.

4. Access to the claim file is in accordance with the provisions of section 173 and 174 respectively and will follow the process outlined under PRO 17/2013, Authority for Disclosure.

5. All appeals at the Appeals Department level will be acknowledged in writing, including an outline of the decision in dispute, to all interested parties (workers, employers and their representatives).

6. At each level of appeal, the decision is made by the staff member(s) who review the documents and/or hear the evidence. The decision maker will ensure that he or she has obtained information that, in the staff member’s opinion, is required to provide the best available evidence upon which to make the decision. Decisions made by the Board Appeal Tribunal will only be reviewed by the Board Appeal Tribunal.

7. The decision will be made in accordance with the Act, policies and the rules of natural justice, which require the decision maker to:
   a. Act fairly and in good faith.
   b. Act without bias.
   c. Give each party an opportunity to state their case.
   d. Give each party an opportunity to know the case that they must respond to, and
   e. Ensure that the decision is made by those who hear the evidence.

8. Where the worker or employer provides new information that was not available when the decision being appealed was made, this information must first be considered by the WCB staff member responsible for that decision (e.g., Case Manager, Appeals Officer), before progressing to the next level of appeal (e.g., the Appeals Department, Board Appeal Tribunal).

9. Following each level of appeal, the decision will be communicated in writing to all interested parties. The written decision will comply with POL 15/2013, Privacy of Information, and will outline:
   a. The decision in dispute.
   b. The appeal decision now being made, and
c. The full reasons for the appeal decision, including the applicable authority as set out in the Act or WCB policy.

Standard of Proof

10. At all levels of appeal, all information relevant to the issue(s) under dispute is considered and given weight appropriate to its relevance and level of verification. Decisions are based on the balance of probabilities, considering the merits and justice of the appeal. Where the evidence on both sides of an issue is approximately equal, the issue is settled in favor of the worker; POL 03/2012, Benefit of Doubt, Application, will apply.

Burden of Proof

11. There is no burden of proof on the worker or employer submitting the appeal. However, the worker or employer is expected to provide a reason for disagreeing with the original decision, and to cooperate in providing the information required by the WCB. The onus is on the WCB to ensure that there is sufficient information to make the appeal decision.

**Act Sec #** 14, 15, 18, 20, 21, 22, 23, 29, 73, 80, 100, 169, 171, 173, 174
**Effective Date** 01 January 2014
**Amended** References updated in accordance with *The Workers’ Compensation Act, 2013*
**Application** All appeals
**Supersedes** POL 31/2010 Appeals – Claims
PRO 21/2013 Appeals – Claims
POL 22/2013 Appeals – Board Appeal Tribunal
POL 20/2013 Appeals – Employer Accounts
PRO 20/2013 Appeals – Employer Accounts
POL 15/2013 Privacy of Information
POL 13/2013 Annuities
PRO 05/2005 Appeals – Charter and Constitutional Issues
PRO 17/2013 Authority for Disclosure
POL 03/2012 Benefit of Doubt
PRO 03/2012 Benefit of Doubt
POL 04/2014 Fatalities, Presumption
POL 18/2010 Medical Review Panels
**Complements**
POL 11/2010 Pension Commutation (*The Workers’ Compensation Act, 1974*)
POL 23/2014 Reversing Decisions
PRO 23/2014 Reversing Decisions
9.3 Interest on Benefits Accruing From Successful Appeals (POL 05/2003)

Document Date 21 May 2003

Purpose To establish a policy regarding interest on successful appeals.

BACKGROUND

The Board believes that appeals should be heard within a reasonable period of time, since delays could cause financial hardship for the appellant.

POLICY

1. Where internal administrative delays result in the appellant having to wait longer than 30 calendar days for appeals received at the Appeals Committee or 120 calendar days at the Board, interest will accrue in accordance with the following:
   a. Only appeals received after the effective date and which are ruled on by the Appeals Committee or Board Members are eligible.
   b. Interest is payable only on earnings replacement benefits.
   c. Because factors other than internal administration may cause or contribute to delays in dealing with appeals, the Appeals Committee or the Board Members, as the case may be, will specify in the order if interest is payable.
   d. Interest will bear a rate equal to The Bank of Nova Scotia's prime at the date payment is issued.

2. At the Appeals Committee level, interest will be payable from the 31st calendar day after the date the appeal is received up to and including the date payment of benefits is made.

3. At the Board level, interest will be payable from the 121st calendar day after the date the appeal is received up to and including the date payment of benefits is made.

4. Interest will be calculated by WCB Finance, paid by separate cheque, and accompanied by an explanation of the calculation.

5. Interest costs are to be charged to the Second Injury and Re-Employment Reserve.
### Act Sec #
115

### Effective Date
01 June 2003

### Amended
References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

### Application
Appeals Received on or after 01 June 2003

### Supersedes
POL 02/94 Interest on Benefits Accruing from Successful Appeals

### Complements
POL 21/2013 Appeals – Claims
9.4 Appeals – Charter and Constitutional Issues (POL 05/2005)

Document Date 21 September 2005

Purpose To establish guidelines for responding to appeals based upon the Charter and/or Constitution.

DEFINITION

Constitution of Canada is set out in the provisions of the Constitution Act, 1982 ("Constitution Act"), and under Section 52 is “the supreme law of Canada.” This means that any law in Canada that is inconsistent with the Constitution is void from the time it is enacted.

Canadian Charter of Rights and Freedoms is included in Part I of the Constitution Act. The purpose of the Charter is to guarantee the rights and freedoms enshrined within it, subject only to restrictions that would be considered reasonable for a democratic society to function properly. For WCB purposes, the most relevant provisions of the Charter include Sections 7, which provides the right to life, liberty and security of the person, and 15, which outlines “Equality Rights” (freedom from discrimination on the basis of sex, age, disability, etc.).

Genuine Charter/Constitutional Issues are those that raise legitimate Charter/Constitutional question, as to whether a specific WCB policy discriminates against a client on the basis of disability, race, sex, etc. A further example would be the guaranteed protection of aboriginal rights under Section 35 of the Constitution Act (i.e., hunting, fishing, tax exemptions for reserves). However, if a client states, for example, in his/her written appeal request that his/her Charter/Constitutional rights have been violated simply because his/her claim for benefits was rejected, this would not be a genuine Charter/Constitutional issue.

BACKGROUND

1. Under Section 20(1) of The Workers’ Compensation Act, 2013 (the “Act”), the Workers’ Compensation Board (WCB) has exclusive jurisdiction to determine all matters and questions arising under the Act. Under Section 20(3), the actions and proceedings of the WCB are final and conclusive. Under Section 20(4), the decisions of the WCB under the Act upon all questions of fact and law are not open to question or review.

2. Several decisions by the Supreme Court of Canada (Supreme Court) have ruled that administrative tribunals, including WCB, have the jurisdiction to hear appeals based on the application of the Canadian Charter of Rights and Freedoms (the “Charter”) and/or the Constitution of Canada (the “Constitution”). However, it will not be the
duty of every government official (or employee of an administrative tribunal) to hear appeals that rely on the Charter and/or Constitution, but rather those individuals with whom the legislature has endowed such powers through an enabling statute, such as the Act.

3. In the wake of recent Supreme Court decisions, WCB establishes its authority to hear and determine appeals based on Charter and/or Constitution issues and the body to which appeals of this nature must be directed.

POLICY

1. Under Section 20 of the Act, all genuine Charter/Constitutional issues shall be determined exclusively by the Board Members.

2. As such, procedure PRO 05/2005 will apply and the normal appeals process will be circumvented.

Act Sec # 18, 20
Constitutional Act, 1982
Effective Date 01 October 2005
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All appeals and challenges involving the Charter and/or Constitution.
Supersedes n/a
Complements PRO 05/2005 Appeals – Charter and Constitutional Issues
POL 21/2013 Appeals – Claims
PRO 21/2013 Appeals – Claims
POL 22/2013 Appeals – Board Appeal Tribunal
9.5 Fair Practices Office (POL 14/2013)

Document Date 17 December 2013

Purpose To establish the mandate for the Workers’ Compensation Board (WCB) Fair Practices Office.

BACKGROUND

1. The Fair Practices Office was established in September of 2003 with the appointment of the Fair Practices Officer. This position was created in response to recommendations by the James Dorsey Review in 2000 and the Saskatchewan Workers’ Compensation Act Committee of Review 2001 Report.

2. The establishment of the Fair Practices Office is supported by Section 19(1)(a) of The Workers’ Compensation Act, 2013 (the “Act”), which directs that the WCB shall treat workers and their dependants in a fair and reasonable manner.

3. The Fair Practices Officer is appointed under Section 186 of the Act and can investigate and make recommendations relating to any matter pursuant to this Act, including claims or assessment matters, in which the worker, dependant or employer is or may be aggrieved.

4. Section 172 of the Act directs that subject to Sections 173 and 174, no member and no person authorized to make an inspection or inquiry pursuant to this Act shall divulge or allow to be divulged any information obtained by him or her that came to his or her knowledge in carrying out his or her duties or in exercising his or her powers pursuant to this Act unless:
   (a) Required or permitted pursuant to this Act;
   (b) Authorized to do so by the board; or
   (c) Ordered to do so by a court.

5. Access to information held by the Fair Practices Office in accordance with Sections 25 and 186(4) of the Act is subject to the provisions of Section 172 of the Act.

POLICY

Establishment and Status of the Fair Practices Office

1. The Fair Practices Office is to function as an organizational Ombudsman’s office addressing issues of service delivery raised by workers, dependants, employers and external service providers.
2. The conduct of the Fair Practices Office shall reflect the WCB Value Statements with respect to dignity, fairness, honesty and openness.

Appointment and Qualifications of the Fair Practices Officer

3. The Fair Practices Officer is required to be a person of recognized knowledge, judgment, objectivity and integrity with demonstrated skills in problem solving and dispute resolution.

4. The appointment and termination of the Fair Practices Officer is the responsibility of the Board Members.

5. The Fair Practices Officer is an employee of the WCB and his or her terms and conditions of employment are consistent with the WCB’s Human Resources policies.

Role and Mandate of the Fair Practices Office

6. The Fair Practices Office has a mandate to:
   a. Receive, investigate and resolve complaints about unfair practices in all areas of service delivery raised by workers, dependants, employers and external service providers, and
   b. Identify complaint trends, policy matters and systemic issues and make recommendations for improvements.

7. If upon completion of an investigation as referenced in Point 6(a) above, the Fair Practices Officer determines that an unfair practice has occurred, he or she may seek to resolve the issue at the most appropriate administrative level of the WCB. If an appropriate remedy is not implemented, the Fair Practices Officer will raise the matter to senior management levels of the WCB, including the Chief Executive Officer. Unresolved issues will be reported to the Board Members.

8. The Fair Practices Officer may, on his or her own initiative, investigate, identify and make recommendations on systemic issues. Findings and recommendations will initially be presented to senior management within the WCB, including the Chief Executive Officer and then to the Board Members.

9. The Fair Practices Officer may decline to investigate a complaint based on considerations such as merits or timeliness of a complaint and on a determination of whether the complaint falls within the mandate of the Fair Practices Office. Complaints that a person had knowledge of for more than one year and did not actively pursue will generally not be accepted by the Fair Practices Office.

10. The Fair Practices Officer will publish an independent annual report that may include statistics on the number and types of complaints received, services rendered and complaints resolved. The annual report may also inform about recommendations
that had been made, but not acted upon within a reasonable period of time, including both case specific and systemic recommendations.

11. The Fair Practices Officer will report to the Board Members on a quarterly basis or more frequently as requested by the Board Members or the Fair Practices Office.

Authority

12. In accordance with Point 1 above, the Fair Practices Office has jurisdiction to investigate all areas of service delivery of the WCB including, but not limited to:
   a. Delays in adjudication, communication, referrals and payment.
   b. Conduct of staff.
   c. Verbal and written communications.
   d. Implementation of appeal findings.
   e. Revenue and employer accounts.
   f. Benefit payments, and
   g. Misapplication of policy.

13. In conducting an investigation, the Fair Practices Office will have within normal WCB working hours and with reasonable notice:
   a. Unfettered access to all files, documents and other materials in the possession of the WCB relating to the matter under investigation, and
   b. Unfettered access to all WCB employees.

14. A complaint is not within the jurisdiction of the Fair Practices Office if it pertains to:
   a. Conduct or a decision of the Board Members.
   b. Changes to the Act or its regulations.
   c. An issue outside the jurisdiction of the WCB.
   d. An issue under appeal.
   e. An issue being handled by the Office of the Workers’ Advocate, unless the Workers’ Advocate requests that the Fair Practices Office review the complaint.
   f. An issue referred by WCB staff (e.g., human resource issues), and
   g. An alleged illegal or fraudulent act. Allegations of this nature will be referred to the investigative unit within Internal Audit.

15. Notwithstanding Point 14(f) above, the Fair Practices Office may investigate complaints by WCB staff in their capacity as injured workers.
Code of Ethics


Standards of Practice

17. Although the Fair Practices Office adheres to the International Ombudsman Association Code of Ethics as noted in Point 16 above, the International Ombudsman Association Standards of Practice do not allow its members to conduct formal investigations or maintain their own identifying records. As this is in conflict with the mandate of the Fair Practices Office, the Fair Practices Office has developed its own standards of practice, outlined as follows:

A. Independence

- The Fair Practices Office is independent of WCB operations.
- The Fair Practices Officer reports directly to the Board Members through the WCB Chairperson.
- The Fair Practices Office exercises sole discretion over whether or how to act regarding an individual’s concerns. The Fair Practices Officer may also initiate action on a concern identified through the Fair Practices Officer’s direct observation.
- The Fair Practices Officer holds no other position within the WCB which may compromise independence.

B. Neutrality and Impartiality

- The Fair Practices Officer maintains a moral duty of impartiality and the Fair Practices Office cannot act as an individual’s advocate or representative.
- The Fair Practices Office treats all parties to a complaint with dignity and respect and approaches issues with an open mind. The Fair Practices Office has a responsibility to consider the legitimate concerns and interests of all individuals affected by the matter under consideration.
- The Fair Practices Office conducts investigations and makes recommendations for any remedial or corrective actions based on the findings of the investigation.
- The Fair Practices Office helps develop a range of responsible options to resolve problems and facilitates discussion to identify the best options.

C. Confidentiality

- The Fair Practices Office regards communication with any person seeking assistance as privileged and confidential. Information concerning a complaint or inquiry will not be disclosed unless the person has given permission to do so. The only exception to this privilege of confidentiality is where there appears to be
imminent risk of serious harm, and where there is no other reasonable option. Whether this risk exists is a determination to be made by the Fair Practices Officer.

- The Fair Practices Office does not enter any information on any WCB claim or employer file. The database established by the Fair Practices Office is only accessible by staff of the Fair Practices Office and this information is considered privileged and, therefore, is not accessible under the provisions of The Freedom of Information and Protection of Privacy Act. This privilege belongs to the Fair Practices Officer, rather than to any party to an issue. Others cannot waive this privilege.

- Access to information held by the Fair Practices Office in accordance with Sections 25 and 186(4) of the Act is subject to Section 172 of the Act.

- The Fair Practices Office prepares any data or reports in a manner that protects confidentiality. If an issue is pursued on a systemic basis, it is done so in a manner that safeguards the identity of individuals. All records maintained by the Fair Practices Office for the purposes of receiving, investigating and resolving complaints are kept in a secure location and protected from access or inspection by any other person.

D. Informality and Other Standards

- The Fair Practices Office acts in an informal manner by such means as listening, providing and receiving information, identifying and reframing issues and developing a range of reasonable options to resolve the problem.

- Where the Fair Practices Office has made a recommendation, that recommendation is not binding and the office has no authority to make binding decisions.

- The Fair Practices Office does not replace existing appeal procedures within the WCB and the Fair Practices Office has no authority where a matter is already before an appeal body (i.e. Appeals Department, Assessment Committee and Board Members).

- The Fair Practices Office identifies trends, issues, and concerns about WCB policies and procedures, including potential future issues and concerns and provides recommendations for responsibly addressing them.


- The Fair Practices Officer adheres to the Saskatchewan WCB Code of Conduct and Ethics and other WCB administrative policies.
Administration

18. The Board Members approve the budget of the Fair Practices Office with input from the Fair Practices Officer.

19. The Fair Practices Officer will manage the operating budget and will hire and manage the staff of the Fair Practices Office. To facilitate the management of the Fair Practices Office and its arm’s length relation to operating areas and management of WCB, the Fair Practices Officer is authorized to execute agreements with third parties on behalf of the Fair Practices Office and pay expenses in connection with the ongoing operations of the Fair Practices Office, provided that the expenditures are within the approved budget of the Fair Practices Office and generally follow the principles of WCB administrative policies.

20. The Board Members may request that periodic independent reviews be conducted to evaluate the position of the Fair Practices Officer and or the operations of the Fair Practices Office.

Act Sec # 19, 24, 25, 172, 173, 174, 180, 186
Effective Date 01 January 2014
Amended References updated in accordance with The Workers’ Compensation Act, 2013
Application Workers, employers and external service providers who raise issues regarding service delivery on and after the effective date
Supersedes POL 15/2010 Fair Practices Office
Complements ADM PRO 03/2006 Code of Conduct and Ethics
ADM PRO 06/2013 Employee Indemnity
9.6 Appeals – Board Appeal Tribunal (POL 22/2013)

Document Date 18 December 2013

Purpose To establish the Board Appeal Tribunal as the final step in the appeal process.

DEFINITION

Board Appeal Tribunal means a quorum composed of at least two members of the Board (Board Members and/or Chairperson) who act as the final appeal for injury claim and employer account decisions of the Workers’ Compensation Board (WCB). This role of the Board as an appellant body is distinct from its governance role.

BACKGROUND

1. To ensure fair treatment to workers and employers, the WCB has established an appeal process, the final step of which is an appeal to the Board Appeal Tribunal.

2. Several sections in The Workers’ Compensation Act, 2013 (the “Act”) deal with the right to appeal a decision:
   a. Section 18 of the Act allows the Board Members to delegate any of their powers or functions to WCB employees. Persons affected by delegate decisions can make appeals. This section also directs that the WCB must create policy to guide the appeals process.
   b. Further, Section 20(5) of the Act states, “Notwithstanding subsections (3) and (4), the board may:
      (a) reconsider any matter that it has dealt with; and
      (b) rescind, alter or amend any decision or order it has made.”
   c. Section 100(1) states, “Any weekly or other periodical payment to a worker or a worker’s dependent spouse payable out of the fund may be reviewed:
      (a) on the motion of the board; or
      (b) at the request of the worker, the worker’s dependent spouse or the worker’s employer.”

3. While not specific to appeals, there are certain sections of the Act that are particularly relevant when the Board Appeal Tribunal is reviewing an appeal. They are:
   a. In accordance with Section 14, a “majority of the members constitutes a quorum of the board.”
b. Under Section 15(3), “the board is to sit at any time and conduct its proceedings in any manner that it considers advisable for the conduct of its business and affairs.”

c. Section 21(2) grants the Board the “same powers as are vested the Court of Queen’s Bench for the trial of civil actions:
   
   (a) to summon and enforce the attendance of witnesses;
   
   (b) to compel witness to give evidence; and
   
   (c) to compel witness to produce records or property.”

  

d. Section 22 of the Act authorizes the Board to request depositions of witnesses “to be taken before any person appointed by the board.”

  

e. Under Section 23, a decision of the Board must be based on the merits and justice of each case and is not bound by legal precedent. The benefit of doubt will be given to the worker when the evidence in support of opposite sides of an issue is approximately equal.

4. In accordance with Section 20 of the Act, WCB has established that only the Board Appeal Tribunal will have exclusive jurisdiction to reach a decision in the first instance, or to review an appeal, which includes the following issues:

  
a. Section 29 of the Act regarding presumption claims filed prior to January 1, 2003 (POL 04/2014).

  
b. Section 73 of the Act regarding proposals for alternate forms of annuities (POL 13/2013).

  
c. Section 82 of The Workers’ Compensation Act, 1974 (the “Old Act”) regarding the commutation of pensions (POL 11/2010).

  
d. Section 100(4) of the Act regarding payments to dependant(s) of an incarcerated worker (POL 05/94); Section 169 regarding applications as to whether court action is barred under the Act (POL 01/2013), and

  
e. Matters relating to the Canadian Charter of Rights and Freedoms (POL 05/2005).

5. Section 171 clarifies that the board is not required to hold oral hearings for any matters decided under the Act.

POLICY

1. Any worker or employer, having had their injury claim or employer account appeal considered at the Appeals Department or Assessment Committee level may appeal that decision to the Board Appeal Tribunal.

2. Any person may appeal a decision of the Privacy Officer regarding compliance with privacy policies and procedures to the Board Appeal Tribunal.
3. Board Services staff will acknowledge receipt of the appeal and provide any advice necessary to the worker or employer. For injury claim appeals, both the worker and employer are advised of the appeal and provided an opportunity to submit information in support of their position.

4. Access to the claim file is in accordance with the provisions of Sections 173 and 174 respectively and will follow the process outlined under PRO 17/2013, Authority for Disclosure.

5. The worker or employer may request an oral hearing with the Board Appeal Tribunal. The Board Appeal Tribunal has the discretion as to whether such a meeting will be granted.

6. On occasion, when it is a claim decision appeal, an employer may request to become a party to a worker’s appeal, or vice versa. The Board Appeal Tribunal will consider such applications on a case-by-case basis and where granted, will advise the parties of the process to be followed. The process is subject to modification to ensure fair and reasonable treatment of workers and employers on an individual case basis.

7. The WCB has established policies and procedures that describe how certain issues should be dealt with. However, the Board Appeal Tribunal is not bound by those policies and procedures and will consider any appeal on its true merits and justice in accordance with the provisions of the Act, policies and the rules of natural justice, which require the decision maker to:
   a. Act fairly and in good faith.
   b. Act without bias.
   c. Give each party an opportunity to state their case.
   d. Give each party an opportunity to know the case that they must respond to, and
   e. Ensure that the decision is made by those who hear the evidence.

8. Board Services staff may require the collection of additional information at any time during the process.

9. Following their review, the Board Members will provide a written decision to all interested parties including detailed reasons for the decision.

10. Any decision or direction by the Board Members will be given priority by WCB staff.

**Standard of Proof**

11. At all levels of appeal, all information relevant to the issue(s) under dispute is considered and given weight appropriate to its relevance and level of verification. Decisions are based on the balance of probabilities, considering the merits and
justice of the appeal. Where the evidence on both sides of a claim issue is approximately equal, the issue is settled in favour of the worker. For issues that are exclusive to an employer account file (i.e., has no affect on a worker's or dependent’s entitlement) benefit of doubt will be given to the employer. Policy POL 03/2012, Benefit of Doubt, will apply.

Burden of Proof

12. There is no burden of proof on the worker or employer submitting the appeal. However, the worker or employer is expected to provide a reason for disagreeing with the original decision, and to cooperate in providing the information required by the Board Appeal Tribunal. The onus is on the Board Appeal Tribunal to ensure that there is sufficient information to make the appeal decision.

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<thead>
<tr>
<th>Act Sec #</th>
<th>14, 15, 18, 20, 21, 22, 23, 29, 73, 80, 82, 100, 169, 171, 173, 174</th>
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<tr>
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<td>POL 30/2010 Appeals – Board Appeal Tribunal</td>
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<td>POL 13/2013 Annuities</td>
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<td>POL 03/2012 Benefit of Doubt</td>
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<td>POL 04/2014 Fatalities, Presumption</td>
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<td>POL 11/2010 Pension Commutation (<em>The Workers’ Compensation Act, 1974</em>)</td>
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<td>POL 05/1994 Suspension – While Incarcerated</td>
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</table>
9.7 Appeals – Employer Accounts (POL 20/2013)

Document Date 18 December 2013

Purpose To outline the appeals process for employer account decisions.

BACKGROUND

1. Section 18 of The Workers’ Compensation Act, 2013 (the “Act”) allows the Board Members to delegate any of their powers or functions to WCB employees. Persons affected by delegate decisions can make appeals. This section also directs that the WCB must create policy to guide the appeals process.

2. Section 20(5) of the Act states that the WCB can reconsider any matter that it has dealt with and any decision that it has made.

3. Section 23 of the Act requires staff to base every decision on the merits and justice of each case. However, WCB recognizes that from time to time, employers may desire an independent review of a decision on their account.

4. Section 171 of the Act clarifies that oral hearings are not a right under the Act.

5. The intent of the appeals process is to provide employers with an easily accessible and independent process of review for decisions regarding their employer account.

6. Employer appeals on worker claims issues are dealt with under POL 21/2013, Appeals – Claims.

POLICY

1. Employers (or their approved representatives) may appeal any decision made by WCB, related to their employer account. These decisions may include, but are not limited to employer registration, classification, assessment or experience rating.

2. WCB has a three-level process for employers who wish to appeal a decision on their account:
   a. Review and/or explanation of the decision by the original staff member responsible for the decision.
   b. A review of the original decision by the Employer Services Assessment Committee. The Committee is bound by WCB policy and has authority to confirm, change or reverse any decision originally made by an Employer Services representative, and
c. Final review by the Board Appeal Tribunal comprised of two or more members of the Board. The Board Appeal Tribunal is bound only by the Act and has full discretionary authority in all matters (POL 22/2013).

3. All requests for appeals (by employers and their representatives) must be in writing to the chair of the Assessment Committee. The request should outline the specific issue(s) under dispute, why the appellant thinks the decision is incorrect, and his/her expected resolution to the appeal.

4. Where the employer is appealing or contemplating an appeal regarding their assessment, classification or experience rating decision, access to the employer file or relevant claim cost information will follow the process outlined under PRO 17/2013, Authority for Disclosure.

5. All appeals at the Assessment Committee level will be acknowledged in writing to all interested parties (employers and their representatives).

6. At each level of appeal, the decision is made by the staff member(s) who review the documents and/or hear the evidence.

7. Where the employer provides new information that was not available when the decision being appealed was made, this information must first be considered by the staff member responsible for that decision before progressing to the next level of appeal.

8. Following each level of review, the decision will be communicated in writing to all interested parties, outlining:
   a. The issue(s) under dispute.
   b. The decision made, and
   c. The rationale for the decision, including the applicable authority as set out in the Act or WCB policy.

Standard of Proof

9. At all levels of appeal, all information relevant to the issue(s) under dispute is considered and given weight appropriate to its relevance and level of verification. Decisions are based on the balance of probabilities, considering the merits and justice of the appeal. Where the evidence on both sides of an issue is approximately equal, the issue is settled in favor of the employer. POL 03/2012, Benefit of Doubt, Application, will apply.

Burden of Proof

10. There is no burden of proof on the employer submitting the appeal. However, the employer is expected to provide a reason for disagreeing with the original decision,
and to cooperate in providing the information required by the Assessment Committee. The onus is on the WCB to ensure that there is sufficient information to make the appeal decision.

**Act Sec #** 14, 15, 18, 20, 21, 22, 23, 29, 73, 80, 100, 169, 171, 173, 174

**Effective Date** 01 January 2014

**Amended** References updated in accordance with *The Workers’ Compensation Act, 2013*

**Application** Employers requesting reviews of decisions made by Employer Services staff.

**Supersedes** POL 32/2010  Appeals – Employer Accounts

**Complements** PRO 20/2013  Appeals – Employer Accounts

POL 21/2013  Appeals – Claims

PRO 21/2013  Appeals – Claims

POL 22/2013  Appeals – Board Appeal Tribunal

PRO 05/2005  Appeals – Charter and Constitutional Issues

POL 13/2013  Annuities

PRO 17/2013  Authority for Disclosure

POL 03/2012  Benefit of Doubt

PRO 03/2012  Benefit of Doubt

POL 01/2013  Determination of a Worker’s Right to Bring Action

POL 04/2014  Fatalities, Presumption

POL 18/2010  Medical Review Panels

POL 11/2010  Pension Commutation (*The Workers’ Compensation Act, 1974*)

POL 15/2013  Privacy of Information

POL 23/2014  Reversing Decisions

PRO 23/2014  Reversing Decisions
9.8 Medical Review Panels (POL 18/2010)

Document Date 02 June 2010

Purpose To establish guidelines for Medical Review Panels.

BACKGROUND

1. Section 60 of The Workers’ Compensation Act, 2013 (the “Act”) establishes a Medical Review Panel as the forum by which injured workers may resolve disputes on medical issues. Medical questions from injured workers will be determined by an independent body of medical practitioners once the internal Workers’ Compensation Board (WCB) appeals process has been exhausted.

2. Section 59(1) of the Act states that “this section applies if:

   (a) a worker who claims compensation has:
      (i) represented to the board that:
         A. the worker suffers a greater functional impairment than that decided by the board;
         B. the worker suffers a greater limitation in working capacity than that decided by the board;
         C. the worker should be granted compensation for a longer period than the period allowed by the board; or
         D. the decision of the board was based on a physician’s report that was erroneous or incomplete; and
      (ii) exhausted his or her rights to a reconsideration or review of a decision by the board; or

   (b) a deceased worker’s dependant who claims compensation has:
      (i) represented to the board that:
         A. the deceased worker suffered a greater functional impairment than that decided by the board;
         B. the deceased worker suffered a greater limitation in working capacity than that decided by the board;
         C. the deceased worker should have been granted compensation for a longer period than the period allowed by the board; or
         D. the decision of the board was based on a physician’s report that was erroneous or incomplete; and
      (ii) exhausted his or her rights to a reconsideration or review of a decision by the board.”

3. Section 59(2) of the Act states that “in the circumstances mentioned in subsection
(1), the worker or the deceased worker’s dependant:
(a) may in writing request the board to provide for a medical review panel:
   (i) to examine the worker; or
   (ii) in the case of a deceased worker, to examine the medical information
       relating to the deceased worker; and
(b) if a written request is made pursuant to clause (a), must specify whether the
    examination is to be in Regina or Saskatoon."

4. Section 59(3) of the Act directs that “a written request pursuant to this section must
   be accompanied by a certificate of a physician or chiropractor that:
   a. states that, in his or her opinion, there is a genuine medical question to be
      determined;
   b. sets out the aspects of the board’s determination of the medical question that the
      physician or chiropractor disagrees with; and
   c. provides sufficient particulars of the question to define the matter at issue.”

5. The Medical Review Panel will not address decisions related to claim adjudication.

POLICY

1. Where the worker or dependant of the deceased worker has exhausted their rights
   to reconsideration or review of a decision made by the WCB, Section 59(2) of the
   Act allows the worker or dependant to request a Medical Review Panel.

2. All requests for Medical Review Panels are to be made in writing, and in accordance
   with Section 59(3) of the Act, are to be accompanied by a certificate of a physician
   or chiropractor. The WCB interprets Section 59(3) of the Act to mean the physician
   or chiropractor must identify the medical position taken by the WCB with which they
   are in disagreement. In providing sufficient particulars to define the issue, the
   physician or chiropractor must provide the detailed medical grounds on which the
   disagreement is based. If required, the attending physician or chiropractor may seek
   the verbal advice of the WCB’s Medical Officer as to the requirements for a
   certificate.

3. Upon receiving the request and certificate, the WCB will determine if the legislated
   requirements of Section 59(1), 59(2), and 59(3) of the Act have been met. Based on
   this determination, the injured worker and all interested parties will be provided the
   WCB’s decision in writing as to whether a Medical Review Panel will be convened.

4. Once the certificate of a physician or chiropractor has been accepted, the WCB will
   provide the worker or dependant of the deceased worker a list from which the worker
   or the said dependant may choose either:
a. One chiropractor and one specialist in the class of injury for which compensation is being claimed; or

b. Two specialists in the class of injury for which compensation is being claimed.

5. The practitioners the worker or dependant of the deceased worker selects and the chairperson (a qualified physician engaged in the practice of general medicine that is, with consultation from the Saskatchewan Medical Association, appointed by the WCB), will constitute the Medical Review Panel.

6. The names of the practitioners the worker or dependant of the deceased worker selects for the Medical Review Panel must be forwarded to the WCB in writing.

7. The chairperson will make the necessary arrangements for the Medical Review Panel to examine the worker or the medical information about the worker, in either Regina or Saskatoon. The appropriate travel allowances will be provided for the worker to attend the Medical Review Panel.

8. Following the examination, the chairperson will provide the WCB with a certificate of decision which states:

a. The condition of the worker,

b. The fitness of the worker for employment;

c. Where the worker is found unfit to work, the cause of that inability to work;

d. The nature and degree of any limitation in the worker's capacity to work caused by the injury in respect of which the worker claims compensation;

e. The extent of any permanent functional impairment of the worker caused by the injury in respect of which the worker claims compensation; and

f. Any further medical matters that any member of the Medical Review Panel considers to be pertinent to the claim.

9. Where the Medical Review Panel's certificate of decision fails to address all of the above stated issues, the WCB will return the certificate to the Medical Review Panel for clarification.

10. A complete certificate of decision is binding on both the injured worker and the WCB.

11. The WCB will not be bound by opinions or recommendations made in the certificate of decision that are outside the scope of the legislated issues or the disputed medical question.
Act Sec # 59, 60, 61, 62, 63, 64, 65
Effective Date 02 June 2010
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All claimants
Supersedes POL 20/2001 Medical Review Panels
Complements PRO 18/2010 Medical Review Panels
POL 39/2010 Expenses – Travel & Sustenance – General
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10.0 GOVERNANCE, SAFETY, PRIVACY AND ACCESS TO INFORMATION

10.1 Privacy of Information (POL 15/2013) ................................................................. 3
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10.7 Governance Policy (POL 09/2014) ........................................................................ 13
10.1 Privacy of Information (POL 15/2013)

Document Date 18 December 2013

Purpose To provide guidelines for protecting the privacy of information.

DEFINITION

Relevant means having some reasonable connection with, and some value or tendency to prove or disprove a matter of fact significant to the decision. It is the evidence’s tendency to prove or disprove a matter of fact that is related to an issue in dispute in the case.

BACKGROUND

1. Collecting information about workers and employers is fundamental to the administration of The Workers’ Compensation Act, 2013 (the “Act”). The Workers’ Compensation Board (WCB) takes seriously the need to protect the confidentiality and security of this information. The WCB is guided by the Act in the collection, use, storage and disclosure of information.

2. In addition to the provisions of the Act, the WCB, where applicable, complies with The Freedom of Information and Protection of Privacy Act (FOIPP), The Health Information Protection Act (HIPA) and the provincial government Privacy Framework.

3. The WCB is aware that information provided to workers and employers may also be needed by them to discharge their responsibilities related to work injuries, under other statutes which may include those governing occupational health and safety, human rights and labour standards.

4. Section 2(1)(e)(ii) of FOIPP and Section 4(c) of the FOIPP Regulations prescribe the Chairperson of the WCB as the “head”, for the purposes of FOIPP. Section 60 of FOIPP provides that the head may designate to one or more officers of the WCB any power granted to the head or vested in the head under FOIPP.

5. The head has delegated responsibility for responding to access and privacy matters that arise under FOIPP to the Corporate Solicitor who will act as the WCB’s “Privacy Officer”.

6. In compliance with the provincial government’s Privacy Framework, the WCB is required to designate an officer responsible for compliance with the legal framework governing the protection of personal client information. The WCB has also appointed the Corporate Solicitor as the “Privacy Officer” as prescribed by the provincial government Privacy Framework.
7. Decisions will be made in accordance with the Act, policies and the rules of natural justice, which require the decision maker to:
   a. Act fairly and in good faith.
   b. Act without bias.
   c. Give each party an opportunity to state their case.
   d. Give each party an opportunity to know the case that they must respond to, and
   e. Ensure that the decision is made by those who hear the evidence.

POLICY

Inquiries – Collection of Information

1. Inquiry for the purpose of this policy, is defined as any and all legal means of normal file development, including but not limited to the following: routine inquiries, information gathering, questioning, observing, recording, fact-finding, taking depositions, verification, corroboration, authentication, or hearings, whether undertaken by Operations staff (including claims representatives conducting field investigations), Employer Services or any other person(s) the WCB may authorize to do so from time to time. This definition, however, does not include investigations for fraud by Internal Audit.

2. Various sections of the Act, notably Sections 21, 22 and 25, authorize the WCB to gather evidence needed to determine all matters or questions arising under the Act, pursuant to Section 20.

3. Section 4(4)(h) of HIPA exempts the WCB from its Part II consent requirements, PART IV collection and use requirements, and Part V access requirements.

4. The WCB collects information from many sources, including, but not limited to: workers, employers and health care professionals. The purpose of such collection is to decide entitlement or assessment or any other matter arising under the Act.

5. Information means information collected, recorded, transmitted or stored in the normal course of business, including paper or electronic documents (email, photograph, microfilm, image and video) that may be released to a worker, a worker’s representative, an employer or other third party. The following types of information may be collected but would not form part of the claim record:
   a. Legal opinions.
   b. Comments or advice concerning specific courses of action recommended by the Corporate Solicitor, Legal Services and/or the Privacy Officer.
   c. Opinions and recommendations of the Fair Practice Office.
d. The working papers or notes taken by the Board Appeal Tribunal members during the course of a hearing or deliberation.

e. Internal Audit investigation reports.

f. The working papers or notes of a fraud investigator of Internal Audit, or

g. Documents related to WCB Security Policy.

6. This policy governs collecting, storing, accessing and disclosing information on claims and employer accounts. Other information recorded by the WCB in its operations, which may be thought of as “administrative records”, is not covered here. It may be subject to FOIPP, and any questions should be directed to the Privacy Officer.

Access to and Disclosure of Information

7. In addition to the provisions of the Act, when disclosing information, the WCB, where applicable, complies with FOIPP, HIPA and the provincial government Privacy Framework.

8. Section 4(4)(h) of HIPA exempts the WCB from its PART IV and PART V collection use, disclosure and access requirements.

9. Section 23(3)(k) of FOIPP recognizes the operation of Sections 172, 173 and 174 of the Act.

10. Section 29 of FOIPP permits the WCB to enter into mutual information sharing agreements that are advantageous to the WCB, workers, employers and outside agencies without offending the privacy of individual workers or employers under Section 172 of the Act.

11. Section 172 of the Act states that it is an offence for any member of the WCB to divulge information unless they are:

   a. Required or permitted to do so pursuant to this Act.

   b. Authorized to do so by the board, or

   c. Ordered to do so by a court.

   WCB staff will be bound by a signed confidentiality agreement that prohibits them from disclosing any information gathered in the course of their duties, unless expressly authorized to do so.

12. Under Section 173 of the Act, the WCB must provide copies of claim documents to workers, dependants, or their representatives.

13. Under Section 174 of the Act, the WCB may provide copies of relevant claim documents to employers, or their representatives.
14. Where under a legal obligation to disclose information (e.g., courts, law enforcement agencies, maintenance enforcement officials, employment insurance officials), the WCB will comply with their written requests for such disclosure. Any questions regarding the disclosure of information should be directed to the Privacy Officer.

15. Where under no legal obligation, requests for disclosure to assist the worker in establishing entitlement to other benefits (e.g., Social Services, Canada Pension Plan, private insurers), a signed release from the worker is required. Such a release will only authorize the WCB to respond to specific questions posed by the third party.

16. Inquiries from Members of the Legislative Assembly or Members of Parliament are presumed to establish that they are acting as representatives of a worker, dependant or employer, and they may be given an oral response. If copies of claim documents are required, Sections 173 and 174 procedures will apply.

17. An employer questioning assessment, classification or experience rating decisions affecting their own account, may be provided with relevant claim information or employer account information.

18. Where information that may adversely affect entitlement has been provided by a person, and there is a risk of injury to that person, the identity of the source will not be disclosed unless their permission is obtained.

19. In accordance with POL 08/2013, Interjurisdictional Agreement on Workers’ Compensation (IJA), the WCB will respond to information requests from other workers’ compensation jurisdictions to ensure the proper adjudication of IJA claims. The purpose is to facilitate provision of benefits and services to workers and employers.

20. The WCB may enter into written agreements with government agencies or organizations for the exchange of information. This may include Employment and Social Development Canada (ESDC), Canada Revenue Agency (CRA), Saskatchewan Ministry of Social Services, Saskatchewan Ministry of Health, Saskatchewan Ministry of Labour Relations and Workplace Safety (LRWS), Saskatchewan Ministry of Education, Saskatchewan Ministry of Advanced Education, Office of the Workers’ Advocate, Ombudsman Saskatchewan, Saskatchewan Government Insurance (SGI), or Safety Associations formed pursuant to POL 20/2010, Safety Association Funding.

21. Where no ongoing agreement exists, information about injuries or employers may only be provided as bulk data, sufficiently aggregate so that an individual client cannot be identified. For such one-time requests, the person or agency must agree, in writing, to appropriate conditions.
22. The WCB will respond to general media inquiries from a policy perspective. The WCB will respond to media inquiries specific to a claim or employer account only with written approval from that worker or employer.

23. Care must be taken to ensure that claim or employer account information is provided on the telephone or in person only to the authorized individuals.

24. The WCB is committed to improved health and safety in the workplace, and will support initiatives taken by individual employers, and industry-based Safety Associations. The effectiveness of Safety Associations is dependent on comprehensive information concerning claims activity in their industry. The disclosure of such information is supported by Section 172 of the Act and Section 29 of FOIPP. A confidentiality agreement is required with the Board Members and staff of the Safety Association concerned. Information provided as bulk data will include industry and individual employer claim activity, without identifying individual injured workers.

25. Information similar to that provided to employers will be provided to the Occupational Health and Safety Division of LRWS. This is supported by Section 140 of the Act and Section 29 of FOIPP. A confidentiality agreement with the Ministry is required.

Records Management

26. The WCB is subject to the provisions of Sections 7, 9, 10 and 11 of The Archives Act (AA) regarding storage, retention, archiving and destruction of information, and must work with the Saskatchewan Archives Board to establish processes and procedures for meeting these requirements.

27. According to AA, the WCB is responsible and accountable for the personal information under its control until transfer to the Archives Board or ordered to be destroyed in accordance with AA.

28. Sections 16 and 17 of HIPA require the WCB to establish policies and procedures related to the protection, retention and destruction of personal health information.

29. Section 18 of HIPA requires the WCB to enter into agreements with information management service providers (as defined in HIPA) to whom it provides personal health information for storage and prescribes the terms that must be included in such agreements.

30. The WCB recognizes that to maintain security and confidentiality, a standardized process must be implemented for the storage, archiving and destruction of all WCB records. Given the volume of information, documents and records maintained by the WCB in various formats, there is an increasing urgency to implement a consistent records management system to secure, store, archive, and destroy information.
31. All WCB records, administrative and operational, created by WCB employees in the course of their duties will be retained for as long as they are required to meet the operational, legal and administrative requirements of the WCB and the retention and disposal provisions of HIPA and AA.

32. The Privacy Officer will be the primary contact with the Saskatchewan Archives Board, ensuring the classification and appropriate disposition of all WCB records.

Access and Privacy Complaints

33. Any person may challenge WCB compliance with its privacy policies and procedures or about its information practices; including accuracy of information collected, recorded, stored or disclosed, or the applicability in particular cases of FOIPP or HIPA. Any such complaints will be addressed by the Privacy Officer.

34. A complainant may appeal a decision of the Privacy Officer to the Board Appeal Tribunal.

35. The Office of the Information and Privacy Commissioner (OIPC) may receive complaints under FOIPP or HIPA. Any information received from the OIPC office about such complaints should immediately be sent to the Privacy Officer.
10.2 Policy Directives (POL 23/2013)

Document Date 18 December 2013

Purpose To ensure the public release of policy directives.

DEFINITION

Board means collectively the Board Members appointed under Section 9 of The Workers’ Compensation Act, 2013 (the “Act”).

Policy directives are policy and procedure documents that form the basis of actions performed or decisions made under the Act.

Procedures support policies and provide specific instructions for day-to-day tasks or functions, required to implement policy.

BACKGROUND

1. The Act recognizes the authority of the Board to develop policy directives (Sections 2(1)(ee), 18 and 23).

2. The Board is required to make policy directives available to the public in a manner that the Board considers necessary (Section 19(2)).

3. The Workers’ Compensation Board (WCB) is required to make its decisions on the real merits and justice of each case but may consider its policy directives (Section 23).

POLICY

1. The Board delegates its powers and functions to its staff through policy directives. Actions performed and decisions made by its staff are bound by these policy directives.

2. All current policy directives, other than purely administrative documents, are published electronically in a Policy and Procedure Manual (Manual). Policy directives that have an effect on injury benefits or employer assessment must be included in the Manual.


4. The Manual is provided in portable document format (PDF) to ensure access regardless of the computer system or internet browser used. Stakeholders are advised to download free Adobe Reader software.
5. Stakeholders can view a paper copy of the Manual during business hours in the reception areas of the Regina and Saskatoon offices.

6. Upon request, the WCB will provide paper or electronic copies of individual policies and procedures.

7. The Manual is updated within 30 days of the effective date of each new or revised policy and procedure.

8. A free email subscription service to inform stakeholders of changes to the Manual is available at www.wcbsask.com.

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Complements

All Policies and Procedures
10.6 Safety and Security – Workplace (POL 09/2010)

Document Date 04 March 2010

Purpose To establish the authority to provide a safe and secure workplace.

BACKGROUND

1. The Board Members (“Board”) of the Workers’ Compensation Board (WCB) acknowledge their responsibility under The Workers’ Compensation Act, 2013 (the “Act”) to treat workers and employers in a fair and reasonable manner.

2. The Board also has an obligation to ensure that WCB employees are able to carry out their duties in a safe and secure environment without fear of harm, whether physical or psychological.

3. Aside from the Board’s responsibilities under the Act, Section 3-8 of The Saskatchewan Employment Act (the “SEA”) requires that employees be provided with a safe work environment.

4. Section 3-21 of the SEA requires that employers must develop, in consultation with a labour-management Occupational Health Committee (OHC), appropriate policy or procedure if workplace violence has occurred or may reasonably be expected to occur.

POLICY

1. The Saskatchewan Workers’ Compensation Board is committed to zero tolerance for all threatening and abusive behaviour.

2. The Board hereby delegates the authority for the safety and security of WCB employees to the Chief Executive Officer (CEO) of the WCB, who shall ensure that proper security measures are in place to protect WCB staff.

3. Executive management, directors/managers, supervisors, team leaders and employees shall share in the responsibility for workplace safety and security during the administration of the Act (ADM 01/2008, Safety and Security – Workplace).
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10.7 Governance Policy (POL 09/2014)

Document Date 24 June 2014

Purpose To approve the Workers’ Compensation Board’s Governance Policy.

BACKGROUND

1. The Workers’ Compensation Board (WCB) Board Members are responsible for the stewardship of the WCB, and to oversee the WCB’s adherence to provisions of The Workers’ Compensation Act, 2013.

2. The Board believes that a strong governance framework is necessary to ensure that it fulfils its responsibilities to workers and employers in the most effective manner. As a result, the Board is committed to ensuring that its governance structures and activities reflect sound governance principles.

POLICY

1. The Board Members hereby approve the Governance Policy which describes WCB’s public policy objectives and the governance framework which has been adopted to achieve them.

2. The Board Members will review the Governance Policy annually. The Governance Policy will be revised when appropriate to ensure alignment with the needs of the WCB and governance best practices.

ATTACHMENTS

Governance Policy

Act Sec #

The Workers’ Compensation Act, 2013
The Workers’ Compensation General Regulations, 1985
The Workers’ Compensation Act Exclusion Regulations, 2014

Effective Date 24 June 2014

Application Board Members, Chief Executive Officer, Management.

Supersedes ADM 13/2000 Corporate Governance
ADM 04/2001 Mandate of the Audit Committee of the Board

Complements ADM POL 03/2014 Protocols – Board and Committee Meetings and Communications
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11.0 COMPLIANCE

11.1 Fines and Penalties – General (POL 26/2013) ................................................. 3
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11.1 Fines and Penalties – General (POL 26/2013)

Document Date 19 December 2013

Purpose To establish guidelines for pursuing summary convictions or applying penalties.

DEFINITION

Representation means a written submission from a person who has contravened a provision of The Workers’ Compensation Act, 2013 (the “Act”), presenting rationale as to why a penalty should not be imposed or disputing the amount of the penalty.

BACKGROUND

1. The Workers’ Compensation Act, 2013 (the “Act”) outlines the obligations and reporting responsibilities for employers and workers in industries covered under the Act. To ensure the compensation system works efficiently, it’s important that these obligations are met.

2. The Act provides the Workers’ Compensation Board (WCB) with authority to pursue summary convictions and/or impose discretionary penalties and administrative penalties for non-compliance with specific provisions of the Act.

POLICY

General

1. There are three types of fines and penalties that WCB can pursue and/or impose on a person who has contravened the Act:
   a. Summary conviction to a fine of not more than $1,000.
   b. Discretionary penalty in a monetary amount ordered by the WCB.
   c. An administrative penalty, not exceeding $10,000.

2. Some or all of the above fines and penalties can be applied, if the following offences are committed:
   a. Failing to notify the WCB of an injury (Sections 52 and 54).
   b. Failing to co-operate to achieve a worker’s return to employment (Sections 53 and 54).
   c. Deducting from a worker, or requiring a worker to contribute towards the expense of medical aid (Section 105).
d. Failing to provide accurate statements of assessable earnings (Sections 122 and 123).
e. Obstructing or hindering a WCB inspection of an employer’s books or accounts or an employer’s premises (Section 127(7)).
f. Failing to provide an estimate of payroll for the remainder of the year and failing to pay an assessment for a business that commenced after an assessment has been made (Section 158).
g. Failing to pay, or provide security for payment of, assessment when business is temporary (Section 158(4)).
h. Attempting to, or threatening to, prevent a worker from applying for or receiving compensation (Section 163).
i. Deducting from a worker, or requiring a worker to contribute towards, an employer’s WCB liabilities (Section 164).
j. Knowingly providing false or misleading information (Section 180(1)(a)).
k. Failing to report a person’s return to work (Section 180(1)(b)).
l. Failing to inform the WCB of a material change in a person’s circumstances that may affect entitlement to compensation or other WCB benefits (Section 180(1)(c)).

3. In addition to these specified offences, Section 180(1)(d) allows the Board to define in the future other offences for contraventions of the Act and regulations. A Board policy decision would be required.

4. In determining whether to pursue a summary conviction or impose a penalty, the WCB may consider:
   a. If the employer intentionally contravened the Act.
   b. The severity of the infraction.
   c. The extent to which an infraction adversely affects a third party, such as a worker.
   d. The pattern or history of offences.
   e. The need to establish deterrence, and
   f. The need to prevent continued non-compliance.

Summary Convictions

5. Summary convictions can be pursued regardless if a discretionary or administrative penalty is imposed. The WCB will decide if the offence should be referred to the Crown Prosecutor or if a penalty will be imposed or both.
**Discretionary Penalties**

6. Discretionary penalties may be imposed in an amount ordered by the Board, whether or not the employer has been convicted of an offence. These amounts will be based on compensation, medical aid, assessment or deductions as specified by each section of the Act.

**Administrative Penalties**

7. Generally, an administrative penalty will be applied in cases where repeat offenders exist. An administrative penalty, up to $10,000 can be applied in addition to a summary conviction and a discretionary penalty.

8. The WCB must impose administrative penalties within three years of when the breach of the Act is discovered. Written notice will be sent to the employer.

**Penalty Payment**

9. Penalties must be paid in full within 30 days from the date of the initial decision or any decision following written representation.

**Penalty Appeal Process**

10. Within 30 days from receipt of the discretionary or administrative penalty notice, the employer can submit a written representation to the Board Appeal Tribunal presenting rationale as to why a penalty should not be imposed or to dispute the amount of the penalty. A written copy of the decision will be sent to the employer.

11. Penalties can be appealed on a question of law only to a judge of the Court of Queen’s Bench within 30 days of the WCB’s decision to impose a penalty.

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1.3 Coverage Within Saskatchewan – Out-of-Province Employers (PRO 07/2002)

Document Date 31 July 2002
Purpose Outlines the responsibilities of all parties with respect to registration and payment of premiums.

BACKGROUND

1. The Board has approved policy guidelines outlining the criteria under which out-of-province employers contracted for services by a principal in a Saskatchewan industry are required to register with the Saskatchewan Workers' Compensation Board (the "Board").

2. The following procedure outlines the responsibilities of all parties with respect to registration and payment of premiums.

PROCEDURE

1. Clear concise documentation will be filed outlining the information obtained and decision process used to arrive at a determination as to whether an out-of-province employer is required to register with the Board.

2. As per Point 1 of the policy, a "place of business" includes but is not limited to:
   a. a permanent facility or structure
   b. a rented facility or structure
   c. oil wells
   d. offices on construction sites,
   e. private residence, when used for business.

3. Where it has been determined that an out-of-province employer is required to register, a Letter of Good Standing must be obtained by the principal from the Board indicating that the out-of-province employer is registered and the account is in good standing. A Clearance Letter must be obtained by the principal when the job is completed and prior to releasing final payment for services, to ensure the account is paid in full.

4. Where a registered out-of-province employer defaults on premiums payable with respect to the work being carried out in a Saskatchewan industry, the principal will be personally liable to pay the premium on the labour portion of that contract. The penalties and remedies available under The Workers' Compensation Act, 2013 (the
"Act") and the *Workers' Compensation General Regulations, 1985* (the "General Regulations") will apply.

5. Where registration is not mandatory, applicants will be advised that they will not be regarded as workers under the Saskatchewan Act and therefore, must ensure that coverage is extended by the resident jurisdiction while work is being conducted in Saskatchewan, unless:
   a. the Saskatchewan principal becomes responsible for the premiums payable to the Board, or
   b. the out-of-province employer elects voluntary coverage with the Saskatchewan Board.

6. If neither 5(a) or (b) is the case, the out-of-province employer must provide a letter to the principal from the resident jurisdiction confirming the employer is in good standing and that coverage has been extended while work is being conducted in Saskatchewan. As notification to the Board, a copy of the letter must be submitted with the principal’s payroll report to avoid further assessment in Saskatchewan. It is important to note that even where a non-resident worker receives coverage under the resident jurisdiction, Saskatchewan principals are not protected from legal action commenced by an out-of-province worker in the event of a work-related injury.

7. Independent workers (with no employees) performing services for a principal in a Saskatchewan industry who demonstrate multiple Saskatchewan contracts over the previous three years are the exception, in which case application for an employer account may be granted (see Policy POL 15/2000).

8. Any other exceptions must be forwarded to the Director of Employer Services for consideration.

**Act Sec #**

2(1)(l), 2(1)(q), 3(1), 20, 26, 122, 131, 132, 153, 158(1);

*The Workers’ Compensation Act, 2013*

*The Workers’ Compensation Act Exclusion Regulations, 2014*;

*The Workers’ Compensation Act Exclusion Regulations, 2014*;

**Effective Date**

August 1, 2002

**Amended**

References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

References updated 01 May 2015 in accordance with *The Workers’ Compensation Act Exclusion Regulations, 2014*

**Application**

All employers based outside of Saskatchewan who carry on or undertake to carry on activities in Saskatchewan

**Supersedes**

PRO 03/2000 Incidental Incursions

**Complements**

POL 07/2002 Coverage Within Saskatchewan – Out of Province Employers

POL 22/2014 Employer Accounts - Clearances and Letters of Good Standing

POL 15/2000 Coverage, Independent Worker

---

*Coverage*  

Doc # 1.3 Coverage Within Saskatchewan – Out-of-Province Employers (PRO 07/2002)
1.4 Coverage – Contracts Involving Equipment (PRO 02/2011)

Document Date 27 January 2011
Purpose To establish coverage when an equipment owner enters into a contract requiring equipment.

BACKGROUND

POL 02/2011, Coverage – Contract Involving Equipment, establishes coverage for contractors in accordance with Section 8 of The Workers’ Compensation Act, 2013 (the “Act”).

PROCEDURE

1. Employer Services staff will determine if the contract involves major equipment as defined in POL 02/2011.

2. Where the owner and/or operator of the equipment is considered a worker of the principal, the principal must report the amount of the contract (net of sales taxes) on the employer payroll statement. The principal may deduct or recover from the equipment owner the sum equivalent to the premiums paid based on the firm’s net premium rate for the work being completed.

Example

Company A enters into a contract for $3000 with an equipment owner to complete an excavation project that requires the use of major equipment. Using the Assessment Schedule for Contract Labour (PRO 07/2004), Company A determines that 25% of the total contract value (net of sales tax) is assessable. Therefore, Company A reports $750 as the labour portion of the excavation contract to Employers Services staff.

\[
\text{Total contract value (net of sales tax)} = \$3,000.00
\]

\[
\text{Multiplied by the labour percentage (25%) } \times 0.25
\]

\[
\text{Labour portion of contract} = \$750.00
\]

To determine WCB premiums required for the labour portion of the contract and the allowable portion to deduct from the contractor of the excavation equipment, Company A uses their net premium rate, which is $2.76 per $100 of assessable payroll:

\[
\text{Labour portion of contract} = \$750.00
\]

\[
\text{per } \$100 \text{ of assessable payroll } \div 100.00
\]

\[
7.50
\]

\[
\text{Multiplied by Principal’s net premium rate} = \$2.76
\]

Amount principal must remit and is allowed to deduct:

\[
\$20.70
\]
Coverage

Section 1 – Page 6

Doc # 1.4 Coverage – Contracts Involving Equipment (PRO 02/2011)
1.7 Coverage – Offenders in Work-Based Programs (PRO 20/2014)

Document Date 10 December 2014
Purpose To provide coverage to offenders participating in work-based programs.

BACKGROUND

1. POL 20/2014, Coverage – Offenders in Work-Based Programs, and the Memorandum of Understanding (MOU) between the Workers’ Compensation Board (WCB) and the Ministry of Justice and Attorney General (Justice) specify the circumstances under which offenders will be covered by the WCB when participating in work-based programs sponsored, in whole or in part, by Justice.

2. This procedure provides the guidelines and responsibilities for when an injury claim for an offender participating in a work-based program is received by the WCB.

PROCEDURE

1. Justice will be designated as the employer for offenders participating in work-based programs offered by authorized agencies of Justice.

2. Justice shall:
   a. Approve work-based programs.
   b. Ensure the maintenance of records of offenders.
   c. Obtain information required by the WCB to confirm the eligibility of an offender for whom a claim is submitted to the WCB.
   d. Set up and maintain procedures satisfactory to the WCB for the submission of claims in respect of offenders.
   e. See that workplace injuries involving offenders are reported to the WCB, and
   f. Bear the sole responsibility for communicating the terms, conditions and responsibilities under the MOU to all entities that will provide work-based programs to offenders.

3. Justice must hold a signed Work-Based Programs Consent and Agreement for all participating offenders.

4. If any injury is sustained during participation in a work-based program in a correctional facility, there are no benefits payable while the offender is incarcerated.
Benefits may become payable upon the offender’s release from the correctional facility based on medical confirmation of the work-related injury.

5. Claims costs will be applied to the cost experience of Justice and the cost of extending coverage to eligible offenders will be reflected in the premiums charged to the Government of Saskatchewan.

6. If an offender works for an employer who pays them an actual salary, then the offender is considered a worker of that employer and claim costs will be charged to the employer’s claims experience.

7. If applicable, WCB staff will facilitate and assist the injured worker’s return to work.

8. Confirmation of coverage for claims involving offenders participating in work-based programs sponsored by Justice will be made by Employer Services.

ATTACHMENTS

Schedule “A” – Work-Based Programs Consent and Agreement

| Act Sec # | 2(1)(ii), 3, 20, and 80; Criminal Code of Canada 717(1); Youth Criminal Justice Act 10; The Correctional Services Act 2 |
| Effective Date | 01 March 2015 |
| Application | All offenders in work-related programs sponsored by Justice. |
| Supersedes | n/a |
| Complements | POL 20/2014 Coverage – Offenders in Work-Based Programs |
| | POL 05/94 Suspension – While Incarcerated |
**Schedule “A”**

**Work-Based Programs Consent and Agreement**

Work-based programs are programs that have been approved by the Ministry of Justice and Attorney General.

Offenders participating in the programs are covered under the provincial workers’ compensation system during the time spent in the work-based programs.

Workers’ compensation is a collective liability no-fault protection plan for workers. Offenders are entitled to the benefits that are available to workers who are normally covered by *The Workers’ Compensation Act, 2013*, or any legislation succeeding this Act.

Employers and their workers who participate in work-based programs cannot be sued for injuries which occur to Offenders arising out of and in the course of employment.

The Workers’ Compensation Board (“Board”) and the Ministry of Justice and Attorney General (“Ministry”) entered into a Memorandum of Understanding (“Memorandum”) to extend the foregoing workers’ compensation benefits to eligible Offenders while in a work-based program. The Ministry applied to the Board to extend coverage under the Act to eligible Offenders. The Board ordered that such Offenders be covered, upon the proper completion of the following consent.

The Act and the Memorandum detail the rights and obligations of Offenders in work-based programs.

**Consent**

The Offender (and the parent/guardian, if a minor) consent:

1. to the eligible Offender participating in the work-based program,

_____________________, (name of program) and

2. to the Ministry having applied on behalf of the eligible Offender to the Board for an order that the Offender be brought within the scope of *The Workers’ Compensation Act, 2013*, or any legislation succeeding this Act, as a worker.

Dated at _____________________________, Saskatchewan this _____ day of ____________, 20____.

_____________________________  ________________________________  
Offender  Parent/Guardian (of a minor Offender)

_____________________________  
Witness (for an Offender)
1.8 Coverage – Out of Province/Country (PRO 08/1999)

Document Date 21 April 1999

Purpose To provide coverage for workers in the course of employment outside of the province/country.

BACKGROUND

1. POL 08/1999 provides compulsory coverage under The Workers’ Compensation Act, 2013 for certain workers who are required to work outside the province or country for continuous periods of less than two years.

2. POL 08/1999 also allows employers to apply for optional coverage for certain workers who are required to work outside Saskatchewan for continuous periods of longer than two years but less than five years.

PROCEDURE

1. When considering a request for coverage for workers outside the Province of Saskatchewan for periods of over two years, the following information will be required in writing from the employer prior to a decision being made regarding extension of coverage:
   a. Name and position of worker.
   b. Detailed explanation of job duties, which would remove the worker from the Province of Saskatchewan.
   c. Dates of departure and return.
   d. Detailed information, if required, ensuring worker and employer meet the definitions outlined in this policy.

2. Each application will be reviewed on its own merits by Employer Services.

3. Where out of province/country coverage is requested, a letter confirming or denying the coverage is to be provided. Where denied, the reasons for denial will be provided. Where coverage is approved, the employer will be informed of the duration of and what is required to maintain the coverage and is to be advised that the immunity from suit under Section 43 is not provided and that the coverage is on an insurance basis only.

4. Where a worker is injured out of province/country, Operations staff will determine the date the worker left and together with Employer Services will determine the coverage which applies, before the claim is accepted.
5. Each situation where coverage is provided will be reviewed on a regular basis, as needed, by Employer Services. Clarification from the employer relating to continued placement of workers will be obtained.

<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>2(1)(i), 2(1)(ii), 3, 33, 34, 35, and 43</th>
</tr>
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<tbody>
<tr>
<td>Effective Date</td>
<td>21 April 1999</td>
</tr>
<tr>
<td>Amended</td>
<td>References updated 01 January 2014 in accordance with <em>The Workers’ Compensation Act, 2013</em></td>
</tr>
<tr>
<td>Application</td>
<td>To employers in Saskatchewan who assign Saskatchewan workers to perform work in other jurisdictions and to the aforementioned Saskatchewan workers.</td>
</tr>
<tr>
<td>Supersedes</td>
<td>n/a</td>
</tr>
<tr>
<td>Complements</td>
<td>POL 08/1999 Coverage, Out of Province/Country</td>
</tr>
</tbody>
</table>
1.9 Coverage – Students in Work-Based Learning Assignments (PRO 12/2012)

Document Date 15 November 2012

Purpose To define circumstances for providing coverage to students in work-based learning assignments.

BACKGROUND

1. POL 12/2012, Coverage – Students in Work-Based Learning Assignments, specifies the circumstances under which students will be covered by the Workers’ Compensation Board (WCB) when participating in work-based learning assignments.

2. This procedure provides specific guidelines for implementing POL 12/2012, Coverage – Students in Work-Based Learning Assignments.

PROCEDURE

1. The Ministry of Education is designated as the employer for students attending Kindergarten to Grade 12 (K-12). The Ministry of Education is responsible for:
   a. Maintaining records of programs and K-12 students eligible for coverage, and
   b. Reporting all injuries to the WCB within the time periods specified in The Workers’ Compensation Act, 2013 (the “Act”).

2. The Ministry of Advanced Education is designated as the employer for students attending post-secondary institutions or courses offered by community-based organizations (CBOs). The Ministry of Advanced Education is responsible for:
   a. Maintaining records of approved programs and post-secondary and CBO students eligible for coverage, and
   b. Reporting all injuries to the WCB within the time periods specified in the Act.

3. The Ministry of Education and the Ministry of Advanced Education must hold a signed Work-Based Learning Consent and Agreement for all participating students.

4. Coverage is not provided for an injury occurring on the education institution’s premises unless the injury arises out of and in the course of a work-based learning assignment, as defined by POL 12/2012, Coverage – Students in Work-Based Learning Assignments, and outlined in the Memorandums of Understanding (MOUs).
5. No payment for loss of earnings will be made during training programs or school terms unless actual loss of earnings is demonstrated.

6. Claim costs will be applied to the cost experience of the Ministry of Education or the Ministry of Advanced Education. The cost of extending coverage to eligible students will be reflected in future premiums charged to the Government of Saskatchewan.

7. Confirmation of coverage for claims involving bona fide students in a work-based learning assignment under the Ministry of Education or the Ministry of Advanced Education will be made by the Employer Services department.

<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>2(1)(l), 2(1)(ii), 3, 20 and 80</th>
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<tbody>
<tr>
<td>Amended</td>
<td>References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013</td>
</tr>
<tr>
<td>Application</td>
<td>All bona fide students participating in approved work-based learning programs sponsored by the Ministry of Education or the Ministry of Advanced Education.</td>
</tr>
<tr>
<td>Supersedes</td>
<td>PRO 06/2007 Coverage – Students in Work-Based Learning Assignments</td>
</tr>
<tr>
<td>Complements</td>
<td>POL 12/2012 Coverage – Students in Work-Based Learning Assignments</td>
</tr>
</tbody>
</table>
1.13 Coverage – First Responders (PRO 07/2005)

Document Date 24 October 2005

Purpose To establish guidelines for coverage of first responders.

PROCEDURE

1. The respective Saskatchewan health region is designated as the “Employer” and will be responsible for maintaining records of approved emergencies and the first responders eligible for coverage under this policy.

2. The respective health region is responsible for reporting all injuries to the Workers’ Compensation Board (WCB).

3. Employer Services will verify, on an annual basis, the list of the health regions with the Saskatchewan Association of Health Organizations (SAHO) as listed in Schedule A to POL 07/2005.

4. In the event of a claim Employer Services will verify with the health regions that the claimant is a registered first responder and the appropriate health region rate code will be used for cost identification purposes.

5. Cost statements will be issued to the appropriate health region and the cost of extending coverage to eligible first responders will be reflected in future premiums charged to the health region.

6. Coverage is in effect from notification of an emergency, and includes travel from the individual's residence or location to the site of the incident and return, provided there is no deviation for personal reasons. Coverage does not extend to situations where a first responder is acting as a “Good Samaritan” without the authority of a call out from a health region.

Act Sec # 2(1)(ii)(ii); The Workers' Compensation Act Exclusion Regulations, 2014 3(gg).

Effective Date 01 November 2005

Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Reference updated 01 May 2015 in accordance with The Workers’ Compensation Act Exclusion Regulations, 2014

Application First Responders of health regions of Saskatchewan.

Supersedes PRO 11/98 Coverage, First Responders

Complements POL 07/2005 Coverage – First Responders
1.16 Coverage – Volunteer Firefighters (PRO 04/2006)

Document Date  8 February 2006

Purpose  To provide coverage for volunteer firefighters.

PROCEDURE

1. The respective Saskatchewan municipality is designated as the “Employer” and will be responsible for maintaining records of volunteer firefighters eligible for coverage under this policy, and for reporting all injuries to the Workers’ Compensation Board.

2. Coverage shall be in effect from the time of notification of a fire and includes travel from the individual’s residence or location to the site of the fire and return provided there are no deviations for personal reasons. Coverage is also in effect while attending volunteer firefighter training.

3. In the event of a claim, Employer Services will verify with the respective Saskatchewan municipality that the claimant is registered as a volunteer firefighter. The cost of the claim will be applied directly to the cost experience of the municipality in which the volunteer firefighter is registered and the appropriate municipality rate code will be used for cost identification purposes.

4. Cost statements will be issued to the respective Saskatchewan municipality and the cost of extending coverage to volunteer firefighters will be reflected in future premiums charged to the Saskatchewan cities, towns, villages and rural municipalities rate code.

Act Sec #  2(1)(ii)(ii), 20(2)(b); The Workers’ Compensation Act Exclusion Regulations, 2014 3(gg).

Effective Date  01 February 2006

Amended  References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Reference updated 01 May 2015 in accordance with The Workers’ Compensation Act Exclusion Regulations, 2014

Application  Claims for volunteer firefighters from Saskatchewan municipalities

Supersedes  Board Directive 25/74 Coverage – Volunteer Fire Brigade

Complements  POL 04/2006 Coverage – Volunteer Firefighters
1.17 Coverage – Migrant Workers (PRO 05/2010)

Document Date 03 March 2010

Purpose To provide Workers’ Compensation Board (WCB) staff and clients with direction around the processes required to adjudicate and administer injury claims made by migrant workers entitled to compensation.

BACKGROUND

1. The WCB has approved POL 05/2010, Coverage - Migrant Workers, which provides staff and clients direction around the process required to adjudicate and administer injury claims made by migrant workers entitled to compensation.

2. The following procedure provides guidance for the implementation of POL 05/2010.

PROCEDURE

1. Where continual contact between the migrant worker and the WCB will be impossible or impractical and the effects of the injury are expected to be short-term (less than four weeks duration), the WCB may issue the migrant worker a complete payment for the estimated period of impairment prior to the migrant worker returning to their home country.

2. The WCB will expedite the process by which medical services are delivered to migrant workers.

3. Where the effects of injury are not expected to be short-term and the migrant worker will be disabled beyond the date of the expiration of the work permit, reports covering the migrant worker’s medical care in their home country will be obtained.

4. The WCB will provide the worker, prior to returning to their home country, a fact sheet that is to be given to health care professionals in the worker’s home country, outlining the information that is to be reported to the Saskatchewan WCB. In keeping with the provisions of Section 36 of the Act, workers will be required to attend treatment and assessments by health care professionals. Reports covering their medical care will be reviewed to determine the extent of ongoing coverage/entitlement. Where there is a delay in obtaining these reports, benefits may be suspended (POL 07/2014, Suspension of Benefits).

5. Where a migrant worker resides outside Canada following a work-related injury, and is entitled to Long-Term Earnings Replacement, the Case Manager (CM) must complete a re-evaluation of the migrant worker’s estimation of earnings capacity.

Coverage  
Section 1 – Page 16  
Doc # 1.17 Coverage – Migrant Workers (PRO 05/2010)
annually. Where the CM is unable to contact the migrant worker during the review process, entitlement will be suspended until contact can be reestablished.

6. Where treatment or assessment of a worker in their home country does not meet the needs of the worker or the WCB’s evaluation of their claim, the Case Management Team will monitor the situation to determine whether the client should return to Saskatchewan (or another jurisdiction providing more convenient, but equivalent service) for medical treatment or a diagnostic examination. Where treatment or an examination is required outside the worker’s home country, it will be at the expense of the WCB.

7. In the event the migrant worker dies as the result of a work-related injury, and the CM is able to contact the worker’s dependent spouse, benefits are to be based on the provisions of Section 81 of the Act. Entitlement is to be reviewed by the CM annually. Similarly, the entitlement of dependent children will also be reviewed annually. If the CM is unable to contact the dependent spouse during the review process, entitlement will be suspended until contact can be reestablished.

8. In accordance with Section 86 of the Act, the CM may recognize persons other than a dependent spouse or children as dependants to whom entitlement may be awarded. Payment to dependants may depend on how long it might reasonably be expected that, had the worker lived, the worker would have continued to contribute to the support of the dependants. Compensation may be made wholly or partly in a lump sum or in any other form that the CM considers most suitable.

<table>
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<tr>
<th>Act Sec #</th>
<th>2(1)(l), 2(1)(ii), 36, 81, 86, 163</th>
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<tr>
<td>Effective Date</td>
<td>01 May 2010</td>
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<tr>
<td>Amended</td>
<td>References updated 01 January 2014 in accordance with The Worker’s Compensation Act. 2013</td>
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<tr>
<td>Application</td>
<td>All migrant workers working in Saskatchewan on and after the effective date</td>
</tr>
<tr>
<td>Supersedes</td>
<td>n/a</td>
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<tr>
<td>Complements</td>
<td>POL 05/2010 Coverage – Migrant Workers</td>
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<td>PRO 04/2012 Translation Services</td>
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<td></td>
<td>POL 07/2014 Suspension of Benefits</td>
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<td>POL 07/2007 Voluntary Relocation Outside Canada</td>
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1.18 Alternative Assessment Procedure for the Interjurisdictional Trucking and Transport Industry (AAP) (PRO 24/2014)

Document Date 10 December 2014

Purpose To outline the process for interjurisdictional trucking and transport employers participating in the AAP.

BACKGROUND


PROCEDURE

AAP Participation

1. To participate in the AAP, employers will:
   a. Determine which jurisdictions are the Assessing Boards and Registering Boards based on where their workers live.
   b. Complete the AAP application and send it to the Assessing Board.
   c. Ensure that all individuals operating trucks or commercial buses in more than one jurisdiction in Canada, including the proprietor, any partners or directors, have coverage.
   d. Report the earnings of workers who drive in more than one jurisdiction to the Assessing Boards.
   e. Report the earnings of all other workers to the jurisdiction where they are employed. Such workers could include:
      i. Local drivers.
      ii. Repair staff.
      iii. Garage staff.
      iv. Warehouse staff, and
      v. Administrative staff.

2. Employers participating in the AAP will pay premiums to the Assessing Boards.

3. Employers participating in the AAP will not report earnings or pay premiums to Registering Boards. However, employers will maintain accounts with all Registering Boards.
AAP Applications – Saskatchewan WCB (SWCB) is the Assessing Board

4. Participation in the AAP starts January 1 of each year. Interjurisdictional trucking and transport employers have until February 28 of that year to apply to participate in the AAP.

5. Interjurisdictional trucking and transport employers who become eligible to participate after January 1 have 60 days from the time they become eligible to apply to participate in the AAP.

6. Appendix E of the IJA lists the industries that are included in the AAP. If eligible, Employer Services will notify the employer. Employer Services will send a copy of the application to each jurisdiction where the employer operates.

Withdrawing from or Non-Participation in the AAP

7. To withdraw from the AAP for the following year, employers will give written notice by December 31 to Employer Services and to any other Assessing or Registering Boards.

8. Employers cannot withdraw from the AAP part way through a year unless they:
   a. Stop interjurisdictional operations, or
   b. Close their business in Saskatchewan.

9. Employer Services will automatically assess employers that do not participate in the AAP based on kilometres driven in each jurisdiction.

Claim Management

10. If a worker who drives in more than one jurisdiction files a claim with the WCB, Employer Services will see if the worker’s employer:
    a. Is participating in the AAP, and
    b. Has designated the WCB as their Assessing or Registering Board.

11. If a worker files a claim with the WCB, Operations will manage the claim in accordance with The Workers’ Compensation Act, 2013.

Information and Disclosure

12. Employers participating in the AAP will give any information that Registering or Assessing Boards need (e.g., records and other documents).

13. Employers participating in the AAP allow the Assessing Board and Registering Boards to share information (subject to POL 15/2013, Privacy of Information).
<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>Effective Date</th>
<th>Application</th>
<th>Supersedes</th>
<th>Complements</th>
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<tr>
<td>22, 34, 35, 36</td>
<td>01 January 2009 – Saskatchewan participation in AAP</td>
<td>Interjurisdictional trucking and transport employers as per the above noted effective dates</td>
<td>PRO 12/2011</td>
<td>POL 24/2014 Alternative Assessment Procedure for the Interjurisdictional Trucking Industry</td>
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<td>01 January 2014 – Section 12 revisions</td>
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<td>POL 15/2013 Privacy of Information</td>
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<td>01 January 2015 – Inclusion of commercial bus operators</td>
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<td>POL 08/2013 Interjurisdictional Agreement on Workers’ Compensation</td>
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<td>01 January 2014 – Saskatchewan participation in AAP</td>
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<td></td>
<td>POL 08/1999 Coverage, Out of Province/Country</td>
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<td>01 January 2014 – Section 12 revisions</td>
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<td></td>
<td>POL 07/2011 Minimum Annual Assessment</td>
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2.1 Registration, Classification & Premiums
2.1.2 Default in Assessment Payment – 2016 (PRO 56/2015)

Document Date 25 November 2015

Purpose To establish the 2016 interest charge for default in assessment payment.

BACKGROUND

1. *The Workers’ Compensation General Regulations, 1985* authorizes the Workers’ Compensation Board to apply an interest charge when an employer fails to pay an assessment when it is due (Section 8).

2. The interest charge is a percentage of the amount in default, including any prior interest charges, and will be equal to:
   a. The Bank of Canada bank rate on October 31 of the prior year, and
   b. Six percent.

3. The Bank of Canada rate effective October 31, 2015 is 0.75%.

PROCEDURE

1. When an employer fails to pay their assessment by the due date, an interest charge will be applied to their account.

2. Effective January 1, 2016:
   a. The annual interest rate will be 6.75%.
   b. The monthly rate will be 0.56%

Act Sec # 152, *The Workers’ Compensation General Regulations* 8

Effective Date 01 January 2016

Application All defaulting employers.

Supersedes PRO 58/2014 Default in Assessment Payment

Complements POL 07/2002 Coverage Within Saskatchewan – Out of Province Employers
2.1.3 Assessable Labour Portion of Contracts (PRO 07/2004)

Document Date 14 October 2004

Purpose To provide guidelines for determining and assessing the labour portion of contracts.

BACKGROUND

1. The WCB has approved POL 07/2004 governing the process for allocating the assessable labour portion of contracts when principals subcontract work.

2. The following procedure provides staff with specific guidance for determining and assessing the labour portion of contracts.

PROCEDURE

1. On receipt of the statement of payroll, the Employer Service Representatives (ESR) will determine whether the contractor/subcontractor is registered with WCB and has the appropriate rate classification.

2. If the ESR determines that the subcontractor does not have a WCB account and the principal has not indicated the actual labour amount of the contract, the ESR will assign a labour percentage based on the attached Assessment Schedule for Contract Labour.

ATTACHMENTS

Schedule A - Assessment Schedule for Contract Labour

| Act Sec # | 8, 122, 131 and General Regulation 4 |
| Effective Date | 01 November 2004 |
| Amended | References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013 |
| Application | All principals and subcontractors |
| Supersedes | n/a |
| Complements | POL 07/2004 Assessable Labour Portion of Contracts |
### Schedule A
#### Assessment Schedule for Contract Labour

<table>
<thead>
<tr>
<th>Service Description</th>
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<tbody>
<tr>
<td>AIRCRAFT TRANSPORTATION</td>
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<tr>
<td>APPLIANCE REPAIR</td>
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<td>CARPET CLEANING</td>
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<td>CENTRAL VAC INSTALLATION</td>
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<td>COMPRESSOR REPAIR</td>
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<td>CORRAL CLEANING</td>
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<td>CONSTRUCTION - BRICKLAYING, CABINET INSTALLATION, CONCRETE/CEMENT WORK, DRYWALL, EAVESTROUGHING, ELECTRICAL, FRAMING, INSULATING, MASONRY, PAINTING, PILING (CAISSON WORK), PLUMBING, SANDBLASTING, SHINGLING, SIDING, STUCCOING, AND WINDOW/DOOR INSTALLATION</td>
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<td>COURIER – HWY (¾ TON &amp; SMALLER)</td>
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</tr>
<tr>
<td>COURIER – HWY (1 TON &amp; LARGER)</td>
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<td>COURIER – URBAN DELIVERY</td>
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<td>CARPET/FLOOR INSTALLATION</td>
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<td>CUSTOM COMBINING</td>
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<td>DEMOLITION</td>
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<td>DRIVER TRAINING</td>
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<td>FENCING (complete material &amp; installation)</td>
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<td>Service</td>
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<td>JANITORIAL</td>
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<td>LAWN MAINTENANCE</td>
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<td>LINE CUTTING – RIGHT OF WAY</td>
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<td>LINE PAINTING (WITH EQUIPMENT)</td>
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<td>LINE PAINTING (NO EQUIPMENT)</td>
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<td>MOBILE MECHANICS</td>
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<td>MOWING</td>
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<td>OIL AND MINING</td>
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<td>ACIDIZING</td>
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<td>BATTERY OPERATING/OILWELL PUMPING</td>
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<td>CHEMICAL SERVICE</td>
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<td>CORE ANALYSIS (LAB ONLY)</td>
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<td>DRILLING/SHOT HOLE DRILLING, WATER WELL DRILLING</td>
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<td>DRILL STEM TESTING</td>
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<td>FENCING</td>
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<td>FIRE PROTECTION</td>
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<td>FLOW EVALUATION</td>
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<td>FRAC WORK</td>
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<td>GEOLOGICAL WORK</td>
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<td>GEOPHYSICAL SURVEY/SEISMIC SURVEY</td>
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<td>INSULATION (PIPELINE)</td>
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<td>LANDMEN/LAND AGENTS</td>
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<td>LEASE CLEARING/RECLAIMING</td>
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<td>LINE CUTTING/SLASHING</td>
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<td>LOGGING</td>
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<td>MUDMEN</td>
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<td>METER SERVICE</td>
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<td>Vacuum Truck</td>
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<td>Well Servicing With Rig</td>
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<td>Well Servicing Without Rig</td>
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<td>Septic Tank Cleaning</td>
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<td>Sign Erection</td>
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<td>Spotting Trailers Locally</td>
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<td>Spraying - Vegetation</td>
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<td>Telephone &amp; Powerline Construction</td>
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<td>Towing</td>
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<td>Trucking</td>
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<td>Upholstering</td>
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<td>Window Washing</td>
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</tr>
<tr>
<td>X-Ray Inspection</td>
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</table>

**Notes:**

1. Where the contractor/subcontractor provides no tools, equipment or materials, the labour portion of the contract is assessed at 100% of the contract amount.

2. Where the contractor/subcontractor provides minor, personal tools or materials, such as hammers or nails, the labour portion is assessed at 85% of the contract amount.
2.1.3.1 Classification, Change of (PRO 09/2007)

Document Date 27 August 2007

Purpose To provide assessment guidance regarding the (re)classification of businesses.

BACKGROUND

1. POL 09/2007, Classification, Change of, has been approved by The Workers’ Compensation Board (WCB).

2. The following procedure provides guidelines for WCB staff where a change of classification is requested.

PROCEDURE

1. Where the nature of a business has changed or where employers believe their industry classification is not correct, employers will inform Employer Services staff in writing of the reason(s) why they believe their current classification is no longer correct or appropriate.

2. Employer Services will review the documentation received from employers and advise them in writing of the classification decision with supporting rationale.

Act Sec # 20, 119
Effective Date 01 September 2007
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All future changes in classification.
Supersedes n/a
Complements POL 09/2007 Classification, Change of
POL 09/2011 Failure to Register a Business
2.1.6 Employer Accounts – Clearances and Letters of Good Standing (PRO 22/2014)

Document Date: 10 December 2014

Purpose: To outline the process for issuing clearances and letters of good standing.

BACKGROUND

POL 22/2014, Employer Accounts – Clearances and Letters of Good Standing, establishes the guidelines for requesting and issuing clearances and letters of good standing.

PROCEDURE

1. A clearance or letter of good standing may be requested by a principal or contractor online (www.wcbsask.com), or by contacting Employer Services by fax, telephone, or email (employerservices@wcbsask.com).

2. Prior to beginning work, a letter of good standing may be requested to advise the principal of the status of a contractor’s account with the Workers’ Compensation Board (WCB). The letter of good standing will provide one of the following statuses:
   a. OK – the contractor’s account is in good standing.
   b. Deemed – the contractor is not registered with the WCB and they will be considered a worker of the principal, or
   c. Denied – the contractor is not in good standing.

3. Before making payment to a contractor for work completed, a principal is required to obtain a clearance. The clearance letter provides the principal with the following statuses:
   a. Cleared – the principal is authorized to pay the contractor for the work completed.
   b. Deemed – the contractor is not registered with the WCB and is considered a worker of the principal, or
   c. Hold – the contractor’s account is not in good standing.

4. When a clearance letter with a “Hold” status is issued, Employer Services staff will notify the contractor to bring their account into good standing. The principal will be notified of any updates on the status of the contractor’s account and should not issue payment until WCB advises the status is cleared. If the contractor fails to bring
their account up to date, the WCB may request that the principal issue payment directly to the WCB from the funds owed to the contractor.

5. Where a clearance is not obtained prior to making payment to a contractor:
   a. The principal will be responsible for premiums relating to the labour portion of the contract up to the amount outstanding on the contractor’s account.
   b. The premium charged to the principal’s account will be calculated based on the contractor’s experience rate, and
   c. The premium charged will remain on the principal’s account and interest will accrue until the payment is made.

Act Sec # 8, 20, 131, 132, 148, 159, 164; 
*The Workers’ Compensation General Regulations* 17; 

Effective Date 01 January 2015.

Application All principals and contractors.

Supersedes n/a

Complements POL 22/2014 Employee Accounts – Clearances and Letters of Good Standing
PRO 07/2002 Out-of-Province Employers – Coverage Within Saskatchewan
POL 03/2014 Coverage – Personal
POL 21/2014 Coverage – Voluntary
2.1.11 Failure to Register a Business (PRO 09/2011)

Document Date 17 August 2011

Purpose To establish guidelines when employers fail to register with the WCB as required.

BACKGROUND

The Workers' Compensation Board (WCB) has approved policy POL 09/2011, Failure to Register a Business, to establish the guidelines for the payment of premiums and penalties when employers fail to register as required under The Workers’ Compensation Act, 2013 (the “Act”) and The Workers’ Compensation General Regulations, 1985 (the “General Regulations”).

PROCEDURE

1. When an employer fails to register within 30 calendar days of employing workers as required by the Act, Employer Services staff will establish an account and will assess the employer's payroll for the current plus preceding three years that the business should have been registered.

2. If there is evidence that an employer deliberately avoided registration, the Manager of Employer Services will review the information and will assess premiums for all years the employer should have been registered. An employer may be considered to have intentionally avoided registration where they have not responded to a registration form sent out to them, an injury claim has been submitted, or by any other means determined by Employer Services.

3. Where intentional avoidance has been determined, the Manager of Employer Services will also refer the employer’s file to Internal Audit for further review. Internal Audit will determine if the employer has breached the Criminal Code.

4. Where a work related injury has occurred and it is determined that the employer intentionally avoided registration, all information regarding this decision will be referred to the Board Members to determine, at their discretion, whether the employer should be held liable for the total cost of all injuries that occurred prior to registration.

5. In addition to the required premiums, the employer will be responsible for submitting the penalties based on the premiums for each year the employer should have been registered. Point 4 of POL 09/2011, Failure to Register a Business, will apply.
6. If the employer does not provide the assessable payroll as requested, Employer Services will assess the employer on an estimated payroll amount and will adjust this amount when the employer provides the actual payroll information.

Act Sec # 3, 20, 122, 123, 124, 139, 148, 152, 153, 155, 158, 159, 170, 180; The Workers’ Compensation General Regulations 3, 4 and 5; The Limitations Act; the Criminal Code.

Effective Date 01 September 2011

Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013.

Application All employers.

Supersedes PRO 07/2010 Failure to Register a Business

Complements POL 09/2011 Failure to Register a Business

POL 07/2002 Coverage Within Saskatchewan – Out of Province Employers
2.1.13 Employer Accounts – Cancellation of Penalties and Interest (PRO 06/2011)

Document Date 16 August 2011

Purpose To establish guidelines for when the Workers’ Compensation Board (WCB) may cancel penalties and interest charges applied to employers’ accounts.

BACKGROUND

The WCB has approved POL 06/2011, Employer Accounts – Cancellation of Penalties and Interest, to establish the guidelines for cancelling penalties and/or interest applied to an employer’s account.

PROCEDURE

1. All penalties and interest are due in 30 days. Any cancellation of penalties and/or interest will only be granted in accordance with POL 06/2011, Employer Accounts – Cancellation of Penalties and Interest.

2. Where an employer issues a cheque and it fails to arrive, the employer will be required to provide the WCB with supporting information which shows the payment was sent prior to the due date. The WCB will accept a copy of the cheque ledger or the immediately preceding and subsequent cheque stubs.

3. Where an employer believes they have an exceptional case under Point 1(f) of POL 06/2011, Employer Accounts – Cancellation of Penalties and Interest, a request for cancellation of penalties or interest must be made in writing to the Manager of Employer Services. The request should outline the specific reason(s) why the situation should be considered an exceptional circumstance.

4. Where an employer’s initial request to remove a penalty or interest is denied by Employer Services staff, the employer may submit an appeal. During the appeal process:
   a. the decision by Employer Services staff remains;
   b. payment will be required by the employer in order to avoid additional penalties and/or interest; and
   c. where payment has been made and the appeal decision is in favor of the employer, all interest and penalties in relation to the decision will be reversed.
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<th>122, 123; <em>The Workers’ Compensation General Regulations</em> 3, 4, 5, 8, 9</th>
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<td>Application</td>
<td>All employer accounts.</td>
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<tr>
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<td>PRO 56/2015 <em>Default in Assessment Payment</em></td>
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<td>POL 07/2001 <em>Interest on Employer Accounts Refunds</em></td>
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<td>PRO 20/2013 <em>Appeals – Employer Accounts</em></td>
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2.2 Cost Relief
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2.2.1 Experience Rating Program (PRO 01/2007)

Document Date 18 January 2007
Purpose To establish procedures for the Experience Rating Program.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 01/2007 – Experience Rating Program.

2. The following procedure provides staff with specific guidance with respect to the administration of the Experience Rating Program.

PROCEDURE

1. The Experience Rating Program will be run at the same time as the annual rate setting process to provide the most comprehensive information to employers regarding their total due premiums.

2. Employer Services will submit an Experience Rating Report to the Vice-President, Prevention and Employer Services by December 31st of each year, which will contain a listing of all surcharged employers.

3. In accordance with POL 15/2013, Employer Services will provide any statistical information regarding surcharged employers to Case Management, Prevention, Occupational Health & Safety Division (OH&S) and the appropriate WCB sponsored industry Safety Associations, as required.

4. Employers may request a review and/or explanation of their experience rating by the Quantitative Research Analyst (QRA).

5. Where employers disagree with the information provided by the QRA, they may formally appeal in writing to the Assessment Committee. Once the Assessment Committee has reviewed all documentation, the decision will be forwarded to the employer in writing.

6. Employers may appeal any decision made by the Assessment Committee (in writing) to the Board Members as the final level of appeal. A copy of the Board Members’ written decision will be forwarded to the employer.
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2.2.3 Second Injury and Re-Employment Reserve (PRO 21/2010)

Document Date 25 August 2010

Purpose To establish guidelines for the Second Injury and Re-Employment Reserve.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved guidelines under POL 21/2010 regarding the use of the Second Injury and Re-Employment Reserve (the “Reserve”).

2. The following guidelines identify the business areas within the WCB responsible for implementing POL 21/2010, along with their key responsibilities.

PROCEDURE

1. Operations staff will be responsible for identifying eligibility for, and the proportion of, cost relief to be charged to the Reserve in each case.

2. Operations staff are to determine the appropriate method for identifying costs to be charged to the Reserve. Depending on the circumstances (e.g., nature of the claim), the appropriate method may be:
   a. a percentage of all or some expenditure codes;
   b. costs incurred after and/or before specified dates; or
   c. some combination of the above.

3. Where eligibility has been verified and the appropriate method determined, the Case Manager or Claims Entitlement Specialist will authorize the Payment Specialist to apply the cost relief.

4. Operations staff will advise the employer of the reason(s) for the transfer to the Reserve and the amount of claims costs to be transferred.

5. Where cost relief has been granted, the credit will be applied to the employer’s account and the cost experience of the industry in the year in which cost relief was granted. The effect of these credits will be to offset claim costs used for the calculation of the employer’s experience rate over the next three years. Employers may request to have their previous years’ experience rating reviewed by Data Governance (POL 01/2007 – Experience Rating Program will apply).
6. With respect to Point 5 of POL 21/2010, prior to the phasing out of cost relief for supernumerary programming starting in 2011, Account Managers will send an initial letter to employers who have accessed supernumerary programming within the last three years prior to the start date of the phasing out period. A fact sheet will be included with the initial letter, explaining the phasing-out of cost relief for supernumerary programming. Further, a follow-up letter will be sent to these employers in each of the years set out in the timeline, reminding them of the change. Finally, Account Managers will also hold face-to-face consultations with employers who have accessed supernumerary programs in the last 3 years.

Act Sec # 145
Effective Date 03 February 2012
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All claims as of the effective date.
Supersedes PRO 14/1999 Second Injury and Re-Employment Reserve
POL 21/2010 Second Injury and Re-Employment Reserve
POL 05/2014 Occupational Disease Reserve
POL 12/2014 Disaster Reserve
POL 08/96 Return-to-Work Plans
POL 01/2000 Pre-Existing Conditions – Section 49
POL 05/2003 Interest on Benefits Accruing From Successful Appeals
POL 11/2003 Injuries – Occupational Disease
POL 01/2014 Funding
POL 01/2007 Experience Rating Program
PRO 13/2007 Injuries – Occupational Disease
POL 01/2008 Suspension of Benefits – Pregnancy
POL 07/2014 Suspension of Benefits
2.2.4 Occupational Disease Reserve (PRO 05/2014)

Document Date 29 April 2014

Purpose To establish guidelines for the Occupational Disease Reserve.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 05/2014, Occupational Disease Reserve.

2. This procedure provides rules on how to apply POL 05/2014.

PROCEDURE

1. An employer may face high claim costs from an occupational disease. The WCB can charge all or a portion of the claim costs to the Occupational Disease Reserve.

2. The Occupational Disease Reserve will be charged costs based on the net costs of a claim. In determining the net costs, Operations staff will consider all relevant:
   a. Recoveries (for example, third party recoveries), or
   b. Relief under the Second Injury and Re-employment Reserve.

3. Operations staff will decide if a disease is:
   a. Occupational, and

4. Operations staff will determine whether a claim meets the conditions for cost relief (POL 05/2014).

5. If the claim meets the conditions for cost relief, Operations staff will determine:
   a. The percentage of costs to be transferred, and
   b. The effective date.

6. All or a portion of the claim costs will be charged to the Occupational Disease Reserve when the claim has a cause and effect link to work known at exposure. Operations staff will determine the portion of costs by comparing the exposure covered by *The Workers’ Compensation Act, 2013* (the “Act”) against the factors identified in Point 2 of POL 05/2014.

7. Operations staff will charge all costs to the Occupational Disease Reserve when the claim does not have a cause and effect link to work known at exposure. Rather, the link establishes from future scientific evidence.
8. Operations staff will advise the employer, in writing, of all decisions regarding cost relief.

9. When the WCB provides cost relief, an employer may request to have their previous years’ experience rating reviewed by a Quantitative Research Analyst (POL 01/2007, Experience Rating Program).

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2.2.5 Disaster Reserve (PRO 12/2014)

Document Date 02 September 2014

Purpose To establish guidelines for the Disaster Reserve.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 12/2014, Disaster Reserve.

2. This procedure provides rules on how to apply POL 12/2014.

PROCEDURE

1. An employer may incur high claim costs from a disaster. The WCB can charge a portion of the claim costs to the Disaster Reserve.

2. The Disaster Reserve will be charged costs based on the net costs of a claim. In determining the net costs, Operations staff will consider all relevant:
   a. Recoveries (for example, third party recoveries), or
   b. Relief under the Second Injury and Re-employment Reserve or the Occupational Disease Reserve.

3. For one claim:
   The WCB claims computer system will transfer costs 10 times above the maximum wage rate at the time of injury to the Disaster Reserve.

4. For an incident resulting in injury to two or more workers of the same employer:
   Information Technology Services (ITS) and Operations staff will find and link claims caused by the same incident. The computer system will transfer costs 20 times above the maximum wage rate at the time of injury to the Disaster Reserve.

5. The WCB will provide the maximum amount of cost relief to the employer. When the calculation under Point 4 does not benefit the employer, the WCB will consider cost relief for the individual claims.

6. Operations staff will advise the employer, in writing, of all decisions regarding cost relief.

7. When the WCB provides cost relief, an employer may request to have their previous years’ experience rating reviewed by a Quantitative Research Analyst (POL 01/2007, Experience Rating Program).
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3.0 INJURIES

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3.1 Type of Injury
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3.1.1 Injuries – Communicable Disease (PRO 02/2010)

Document Date 17 February 2010

Purpose To establish guidelines for communicable disease injury claims.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 02/2010, Injuries – Communicable Disease, which provides staff and clients direction around the process required to adjudicate communicable disease injury claims.

2. The following procedure provides guidance for the implementation of the policy.

PROCEDURE

General Adjudication Guidelines

1. To determine entitlement for communicable disease injury claims, Claims Entitlement staff will review each claim on its own merits, assessing whether an injury occurred and if it arose out of and in the course of employment. Claims Entitlement staff will first determine if the communicable disease arose out of employment (if exposure to the communicable disease occurred), and then whether the worker was in the course of employment when exposure occurred (reviewing the circumstances of exposure).

2. When determining if the communicable disease arose out of and in the course of employment, Claims Entitlement staff may use the following as a general guideline when gathering evidence to confirm exposure:
   a. Confirm with the employer the existence of a communicable disease in the workplace.
   b. Confirm that the worker had the opportunity to be exposed to the communicable disease in the workplace.
   c. Confirm that the incubation period of the communicable disease is clinically compatible with the worker’s symptoms and the timing of the workplace exposure.
   d. Determine if any other workers in the same workplace have contracted the disease.
   e. Establish whether or not the exposure could have occurred outside of the workplace (i.e. was there a documented community outbreak of the disease, of pandemic proportions, and did the outbreak affect the workers immediate family), and
f. Determine if the nature of employment increases the exposure risk of contracting the disease as compared to the general population. The WCB considers occupations that have increased exposure risk to include, but are not limited to:
   i. Health care workers, and
   ii. Long-term care facility workers.

3. Where it is determined that a communicable disease arose out of and in the course of employment, in general the determination of compensability will be made on the basis of a known medical diagnosis provided in a medical report.

Preventative Measures Against Communicable Disease

4. Where the worker suffers an adverse reaction (e.g., allergic) to a compulsory immunization that medically requires the worker to be absent from employment, Claims Entitlement will consider the reaction and its consequences to be compensable.

5. Where the worker suffers an injury that results from an adverse reaction to voluntary immunization, Claims Entitlement will consider the reaction and its consequences as non-compensable because voluntary immunization is not a condition of employment.

**Act Sec #** 2(1)(r), 20(1)(b), 23, 49

**Effective Date** 01 April 2010

**Amended** References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013

**Application** All communicable disease injury claims on and after the effective date

**Supersedes** n/a

**Complements**

- POL 02/2010 Injuries – Communicable Disease
- POL 11/2003 Injuries – Occupational Disease
- PRO 13/2007 Injuries – Occupational Disease
- POL 12/2013 Arising Out Of And In The Course Of Employment
- POL 03/2012 Benefit of the Doubt
- POL 04/2013 Date of Injury
3.1.2 Injuries – Hearing Loss (PRO 11/2012)

Document Date 13 November 2013

Purpose To provide guidelines for the adjudication of traumatic and occupational noise induced hearing loss claims, as well as Permanent Functional Impairment (PFI) awards.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 11/2012, Injuries – Hearing Loss. This policy provides guidelines for the adjudication of traumatic and occupational noise induced hearing loss claims, as well as PFI awards.

2. Terms referenced in this procedure are defined in POL 11/2012.

PROCEDURE

1. The Case Manager or Claims Entitlement Specialist will gather and review all relevant medical (e.g., all audiograms, past and present) and employment reports to verify occupational noise induced or traumatic hearing loss, including whether there are any non-work-related contributors (e.g., history of ear infections, prior traumatic injury, illness, etc.) affecting the acceptability of a claim.

2. In the case of noise induced hearing loss, staff should examine the medical documentation for typical characteristics of this type of impairment, including the following:
   a. The damage is always sensorineural, affecting the hair cells of the inner ear.
   b. The hearing loss is typically bilateral (affecting both ears).
   c. It almost never produces a loss greater than 75 decibels in high frequencies, and 40 decibels in lower frequencies.
   d. Previous noise exposure does not make the ears more sensitive to future noise exposure and hearing loss does not progress (in excess of what would be expected from age-related threshold shifts) once the exposure is discontinued.
   e. In contrast to age-related hearing impairment, the first sign of noise induced loss occurs at higher frequencies (3000, 4000 or 6000 Hertz) producing a ‘notch, or good hook’ on the audiogram, with better hearing at lower frequencies (500, 1000, and 2000 Hertz).

3. For noise induced hearing loss to be acceptable for a PFI award, the exposure criteria under Point 3 from POL 11/2012, Injuries – Hearing Loss, must be met. Staff may request actual worksite readings from Occupational Health and Safety if sufficient information is not available from the employer, industry or other valid
sources to confirm the noise levels. Those claims not meeting the standards outlined in POL 11/2012 will be considered on their own merits.

4. Hearing loss produced by acoustic trauma caused by a single work-related event is generally easier to identify. Normal development of the claim will include gathering information about the circumstances of the incident, including but not limited to:
   a. Whether the worker was wearing appropriate hearing protection (e.g., sudden burst of loud noise causing rupture of the ear drum, excessive pressure or head injury);
   b. Intensity of the noise (sound pressure level);
   c. Type of noise (frequency spectrum);
   d. Character of surroundings in which the noise is produced;
   e. Worker’s distance from the source of the noise;
   f. Position of the ear with respect to sound waves; and
   g. Any relevant medical information including non-work-related causes and treatment following injury.

Staff should note that acoustic trauma can be sensorineural or conductive and usually affects one ear more than the other.

5. Where evidence shows that the worker’s hearing loss arose out of the course of employment, the Case Manager or Claims Entitlement Specialist will ensure that an audiogram is performed by a WCB accredited hearing service provider. Hearing service providers will attach a copy of the audiogram to the Primary Level Authorization to Treat – Hearing Services form, which will be submitted to the WCB. The Case Manager or Claims Entitlement Specialist will provide approval of the submitted authorization form prior to treatment of the worker (e.g., hearing aids, batteries).

6. Where the worker has already had an audiogram performed, the Case Manager or Claims Entitlement Specialist will adjudicate the claim based on the results of that audiogram where the quality of the audiogram is suitable for doing so. Where the results are inconclusive, the Case Manager or Claims Entitlement Specialist will arrange for a repeat audiogram by an accredited hearing service provider.

7. Where the Medical Officer or hearing service provider advises that the current audiogram is unsuitable for determining the acceptability of an injury claim, the Case Manager or Claims Entitlement Specialist will arrange a repeat audiogram.

8. Although the audiogram may reveal hearing impairment at higher frequencies (4000, 5000 and 6000 Hertz), hearing loss, either traumatic or noise induced, will only warrant a PFI award when there is a decibel sum of the hearing threshold levels
(DSHL) totalling 125 or greater in one ear, or 105 or greater in each of both ears. A DSHL totalling 367 in one ear is considered to be a total loss of hearing in that ear.

9. While a worker will not qualify for a PFI award, claim acceptance may be indicated if measurements reveal a DSHL less than 125 in one ear or 105 in each of both ears. Acceptance is dependent on demonstrating some degree of hearing loss attributable to occupational noise exposure or a traumatic work-related injury.

10. If occupational noise exposure or a traumatic work-related injury has resulted in the need for hearing instruments, coverage for the instruments and batteries should be provided in accordance with PRO 50/2015, Medical Fees – Hearing Services. Those benefiting from the use of hearing instruments may have a DSHL less than 125 in one ear or 105 in each of both ears, the minimum amount of hearing loss required to qualify for a PFI award. Typically, individuals with a DSHL less than 100 in one ear will not require hearing aids.

11. The Medical Officer and hearing service provider will be contacted if the typical audiometric pattern is not apparent to staff, or other medical information is required to make a decision as to the acceptability of an injury claim.

12. The Medical Officer assigns the PFI rating for tinnitus if there is documented medical evidence from the attending physician, hearing service provider, and or Otolaryngologist that the ringing in the worker’s ears has been long-standing, distressing and continuous for at least two years. Where tinnitus has been caused by a work-related injury or occupational hearing loss, a rating of up to five percent may be added to the worker’s binaural hearing impairment (hearing impairment of both ears) rating.

13. The WCB will determine the extent of noise induced hearing loss from work-related exposure by reviewing the worker’s audiogram completed while employed or within five years of leaving employment in a high noise industry. Noise induced hearing loss does not progress when noise exposure from work ceases. Therefore, an audiogram completed while employed or within five years of leaving employment would provide an accurate work exposure reading.

14. If no audiogram is available from while the worker is employed or in the immediate five years from leaving employment, the Medical Officer will review the worker’s current audiogram. The Medical Officer will consider audiogram patterns and standard occupational hearing loss calculators when determining the amount of noise induced hearing loss resulting from work-related exposure. However, the claim will not qualify if it is determined that the hearing loss recorded on the current audiogram is predominately age related (presbycusis).

15. Hearing loss claims that are accepted as being predominately noise induced will not have a presbycusis factor deducted in determining the level of the PFI award.
16. Where an interprovincial agreement for occupational noise induced hearing loss exists, the province that initially receives the report of injury is responsible for all costs associated with exposure for parties in the agreement.

17. Except where an interprovincial agreement exists with another jurisdiction, the exposure will be prorated as follows:

\[
\frac{\text{Number of months Saskatchewan exposure}}{\text{Total number of months exposure}} \times 100 = \% \text{ PFI}
\]

Example (where the total PFI assigned is equal to 5%):

\[
\frac{300 \text{ months Saskatchewan exposure}}{400 \text{ total months exposure}} \times 100 = \% \text{ PFI}
\]

5\% (Total PFI) \times 75\% (proration) = 3.75\% (Saskatchewan PFI portion)

18. Injured workers are to be routinely advised of their right to pursue entitlement with other jurisdictions.

19. Charging of costs:
   a. Where there is only one employer, charge to that employer.
   b. Where there is more than one employer within the same industry, charge to that industry by way of a group account established in Employer Services.
   c. Where there is more than one employer and multiple industry groups are involved, charge to the Occupational Disease Reserve.

---

**Act Sec #** 20  
**Effective Date** 01 February 2013  
**Amended** References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*  
**Application** All new hearing loss claims on and after 01 February 2013.  
**Supersedes** PRO 01/2010 Injuries – Hearing Loss  
**Complements** POL 11/2012 Injuries – Hearing Loss  
POL 23/2010 Permanent Functional Impairment (PFI) – General  
POL 23/2010 Permanent Functional Impairment (PFI) – General  
POL 11/2003 Injuries – Occupational Disease  
POL 13/2007 Injuries – Occupational Disease  
POL 50/2015 Medical Fees – Hearing Services  
POL 05/2014 Occupational Disease Reserve  
POL 27/2010 Allowance – Independence  
POL 04/2013 Date of Injury
3.1.3 Injuries – Hernia (PRO 03/2013)

Document Date 12 March 2013

Purpose To establish adjudication guidelines for hernia claims.

DEFINITION

Hernia means a bulge of an organ through the structure that usually contains it. It can be caused by excessive strain or direct trauma.

Pre-existing condition means a non work-related medical condition that existed prior to the work-related injury.

BACKGROUND

1. Under Section 20 of The Workers’ Compensation Act, 2013 (the “Act”), the Workers’ Compensation Board (WCB) will determine:
   a. Whether a condition or death was a result of an injury, and
   b. Whether an injury has arisen out of or in the course of employment.

2. Generally, a hernia develops where a weakness already exists. Therefore, the WCB will treat hernia claims as accelerations of pre-existing conditions (POL 01/2000, Pre-Existing Conditions – Section 49).

PROCEDURE

New Hernia

1. A Claims Entitlement Specialist (CES) will review the hernia claim. An accepted claim will meet the following guidelines.
   a. Indirect/Direct Inguinal Hernia and Femoral Hernia
      These hernias will develop in the groin region. The claimant will have a history of:
      i. Straining activity that would be expected to greatly raise the pressure inside the abdomen, and
      ii. Pain in the groin region during or immediately after the straining activity.

   b. Umbilical and Paraumbilical Hernia
      These hernias will develop in the naval region. The claimant will have a history of:
      i. Straining activity that would be expected to greatly raise the pressure inside the abdomen, and
      ii. Pain in the naval region during or immediately after the straining activity.
c. Incisional Hernia
   An incisional hernia will develop at the site of a surgical scar. The claimant will have a history of:
   i. Straining activity that would be expected to greatly raise the pressure inside the abdomen, and
   ii. Pain at the incision site during or immediately after the straining activity.
   The hernia will not be present before the incident.

d. Hydrocele
   A hydrocele is a collection of fluid in a sac-like cavity. The claimant will have a history of:
   i. A hydrocele resulting from an accepted inguinal hernia claim, or
   ii. Direct trauma to the area of the hydrocele.

2. Other hernia claims may not have a direct link to employment. The CES may refer to a WCB Medical Consultant when determining such claims. For example:
   a. Hiatus hernia.
   b. Diaphragmatic hernia.
   c. Cystocele, rectocele, uterine prolapse and enterocoele hernias.

Pre-Existing Hernia

3. A pre-existing hernia may incarcerate or strangulate due to straining work. The need for repair will predate the work injury. WCB coverage will be limited to surgery and recovery when:
   a. There is an incarceration or strangulation immediately after a specific straining activity, and
   b. Emergency surgery is required.

Recurrent Hernia

4. Prior Hernia Caused by a Work Injury
   a. If a hernia recurs within one year of a work-related hernia repair, the WCB will provide coverage under the original hernia claim.
   b. A recurrence may occur more than one year after a work-related hernia repair. The WCB will provide coverage if the hernia was caused by a new work injury. The criteria for acceptance will be the same as for the original hernia.

5. Prior Hernia Not Caused by a Work Injury
   A recurrence of a non-work-related hernia will be accepted if there is a new work injury. The criteria for a new hernia will apply.
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3.1.4 Injuries – Psychological (PRO 01/2009)

Document Date 10 March 2009

Purpose To establish guidelines for psychological injury claims.

BACKGROUND

1. POL 01/2009, Injuries – Psychological, has been approved that governs the provisions for psychological claims.

2. The following procedure provides guidelines for implementing the policy.

PROCEDURE

1. At time of initial review, the Claims Entitlement Specialist (CES) will determine if the psychological claim is an acute or chronic cause claim.

2. Acute cause claims will have entitlement determined under Points 1 to 3 of POL 01/2009.

3. Chronic cause claims will have entitlement determined under Points 4 to 7 of POL 01/2009.

4. At time of initial review the CES will determine if there is sufficient information on file (from employer, worker, caregivers) to determine entitlement. If additional information is required, the CES will contact any individual(s) who can clarify outstanding issues.

5. For chronic cause claims, it will be determined if the work-related events were excessive or unusual in comparison to the normal pressures and tensions experienced by the average worker in the same or similar occupation or work environment. The investigation may include taking statements, interviewing witnesses, reviewing employment records, reviewing all relevant, available medical documentation and other supporting evidence showing that the events leading to the claim were beyond the normal or typical scope in maintaining employment.

6. The CES will review the Occupational Disease Database for reference information related to the employer and or condition under review. The Database will be updated on a regular basis to ensure the information it contains is current.

7. If the information to be gathered to clarify outstanding issues cannot be done adequately from the office (telephone, letter), the CES may refer the file to a Claims Representative for additional development in the field.
8. In cases of chronic and acute cause claims with delayed onset of injury, where a DSM IV diagnosis has not already been completed, the worker will be referred to Health Care Services to arrange a Mental Health Assessment. Entitlement decisions for these types of claims will generally require the results of the assessment.

9. Where at the time of initial review a decision cannot be made, the CES will contact the worker to explain the policy and procedure, the timeline to decision, and options for financial sources. The CES will provide provisional approval for the worker to be reimbursed for medication and to attend WCB accredited counselling as prescribed by their physician. If the claim is later disallowed as a work injury, the costs for medical treatment will be charged to the WCB Administration Fund.

10. If the claim is accepted as a work-related injury, the CES will advise of the decision, arrange for the initial wage-loss benefits and/or expense payment and where a return-to-work plan has not been developed, refer to Case Management.

11. Case Management will use the recommendations of the Mental Health Assessment as noted in Point 8 to ensure appropriate medical care and to assist in developing a return-to-work (RTW) plan. Where a Mental Health Assessment referral was not made for an acute cause claim, Case Management will determine if a referral is required.

12. The Case Manager (CM) may arrange a further Mental Health Assessment as per Point 8 above at any time to assist in determining ongoing effects of compensable injury, the level of appropriate care or RTW planning.

13. The CES or CM may refer the claim to the Psychological Consultant or a Medical Officer at any time to assist in gathering medical information or clarifying medical issues.

Permanent Functional Impairment (PFI)

14. Where the team member responsible for the injured worker’s case has determined that the psychological injury is chronic and unlikely to improve, a PFI may be awarded in accordance with POL 23/2010, PFI – General. The following will also apply:

   a. The injured worker will be referred to a doctoral psychologist or psychiatrist for evaluation of psychological permanent functional impairment (PFI).

   b. The professional will perform an evaluation of permanent psychological impairment in accordance with the PFI Rating Schedule.

   c. The report of impairment will be provided to a WCB Medical Officer for review.

   d. Based on the evaluation of permanent psychological impairment and the judgment of the WCB Medical Officer, a percent of total body impairment will be applied.
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3.1.5.2 Injuries – Heart Attack (PRO 05/2013)

Document Date 29 October 2013

Purpose To establish adjudication guidelines for heart attack claims.

BACKGROUND

1. POL 05/2013, Injuries – Heart Attack, has been approved by the Workers’ Compensation Board (WCB).

2. The following procedure provides staff with guidelines for determining heart attack claims.

PROCEDURE

1. Operations staff will develop all heart attack claims upon notice of an injury. Development will include details of the circumstances leading up to the initial onset of symptoms and the diagnosis of a heart attack. It may also include details of any prior related condition (POL 01/2000, Pre-Existing Conditions – Section 49).

2. Sources of information may include:
   a. The worker (active lifestyle outside of work, job history and description of duties).
   b. Any witnesses.
   c. The employer (confirmation of description of duties and employment history), and
   d. Relevant medical sources.

3. Operations staff will evaluate the 24 hour period prior to the diagnosis of a heart attack to determine:
   a. If symptom onset occurred within a few hours of the work event, and
   b. Whether the duties performed were excessive and unusual. The work duties prior to the heart attack are to be compared with the typical job demands and the worker’s active lifestyle outside of work.

4. A determination made under Point 3 is not a medical decision.

5. A Medical Consultant may review cases where:
   a. The diagnosis is questioned, or
   b. The claim involves complex medical issues.
### Injuries – Type of Injury

**Act Sec #**

20, 23, 28, 29; *The Workers’ Compensation General Regulations*

22.3

**Effective Date**

01 December 2013

**Amended**

References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

**Application**

All heart attack claims on or after the effective date.

**Supersedes**

PRO 12/2007  Injuries – Cardiac

**Complements**

- POL 05/2013  Injuries – Heart Attack
- POL 11/2003  Injuries – Occupational Disease
- PRO 13/2007  Injuries – Occupational Disease
- POL 06/2012  Injuries – Firefighters
- POL 01/2000  Pre-Existing Conditions – Section 49
- POL 01/2009  Injuries – Psychological
- POL 04/2014  Fatalities, Presumption
3.1.6 Injuries – Occupational Disease (PRO 13/2007)

Document Date 27 November 2007
Purpose To establish guidelines for occupational disease injuries.

BACKGROUND

1. POL 11/2003, Injuries – Occupational Disease requires that a record be maintained of diseases or conditions that are peculiar to particular trades, occupations, industries or employers to assist Operations staff in determining whether a disease has arisen out of and in the course of employment.

2. In addition to the following procedure, staff will review all policies complementing POL 11/2003 and the attached appendices established for specific occupational diseases.

PROCEDURE

1. Operations will regularly maintain and update a database of those industries, occupations, trades and employers that have had multiple claims for the same occupational disease reported. The Occupational Disease Database is made available to Operations staff to use in determining the merits of occupational disease claims and is also posted on the WCB website.

2. Medical Services will review the database; and, where it is revealed there have been several claims made for a disease or condition for which there is no previously known causal link to any workplace, make any necessary investigation to provide an opinion on the medical/scientific evidence for a workplace link.

3. To ensure the most up-to-date information concerning an occupational disease is being applied, the Chief Medical Officer (CMO) will periodically consult with the Chief Occupational Medical Officer (COMO) regarding the most current available research.

4. To determine entitlement when a claim for occupational disease is made, Operations staff will review each claim on its own merits and justice, assessing whether an injury has occurred and if it has arisen out of and in the course of employment. It must first be determined that the disease arose out of employment (determining the causative agent and if exposure occurred), and then whether a worker was in the course of employment (reviewing when, where, and in what circumstance the exposure occurred).

5. Regardless of the nature of the disease, a full assessment of the factors (medical and occupational) that caused or contributed to the disease, both work and non-work
related, will occur. Supporting medical evidence and confirmation of the occupational exposure will be obtained, and the Occupational Disease Database reviewed, to identify any occupational diseases that may be peculiar to the employment or occupation for which the claim is filed. A weighing of the evidence will occur where there are several causative elements present. Simply working in employment peculiar to an occupational disease will not result in automatic acceptance but should be considered when evaluating the evidence to support the claim. Where there is any doubt as to causation of the disease, Operations staff shall consult with Medical Services before denial of a claim.

6. Under Section 28 of The Workers’ Compensation Act, 2013 (the “Act”) and Section 22.3 of The Workers’ Compensation General Regulations, 1985 (the “General Regulations”) conditions for the presumption of occupational disease for firefighters are specified. Applicable policies are POL 06/2012, Injuries - Firefighters, POL 05/2013, Injuries – Heart Attack and Appendix D of the attached guidelines (below) for cardiac conditions. Whether the presumption is met or not, all claims will be developed to determine entitlement (see Points 4 and 5 above).

7. All decisions are subject to review when additional medical, scientific or other information is received.

8. Except in the case of occupational noise induced hearing loss, there will be no pro-rataion of benefits. If there is sufficient exposure to confirm the cause is work related, the claim will be accepted in its entirety and cost relief will be considered under the Occupational Disease Reserve (POL 05/2014) or the Second Injury and Re-employment Reserve (POL 21/2010).

ATTACHMENTS

Introduction – Occupational Disease Guidelines
Appendix A - Allergies
Appendix B – Respiratory Diseases
Appendix C – Dermatitis
Appendix D – Cardiac Conditions
Appendix E – Asbestos Related Cancer
Appendix F – Mercury Poisoning
Appendix G – Repetitive Strain
Appendix H – Raynaud’s Phenomenon
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<thead>
<tr>
<th>Act Sec #</th>
<th>Effective Date</th>
<th>Amended</th>
<th>Application</th>
<th>Supersedes</th>
<th>Complements</th>
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</table>
POL 23/2010 Permanent Functional Impairment (PFI) – General  
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Introduction

Occupational Disease Guidelines

The following appendices are intended to supplement the general adjudication guidelines provided under POL11/2003, Injuries — Occupational Disease when determining whether there is an occupational link between exposure to a harmful substance(s) in the workplace and a specific occupational disease. Guidelines are also provided under specific policies for assessment of permanent functional impairment (PFI).

As a requirement of both the definition of injury and occupational disease, the development of a claim must include gathering the necessary information to determine whether the condition or disease has arisen out of and in the course of employment. All historical, medical and work factors will be reviewed, including length and duration of exposure to a substance, non-work related contributors or underlying or pre-existing conditions (POL 01/2000, Pre-existing Conditions – Section 49) to assess the merits of a claim for occupational disease.

Under Section 23(3) of The Workers’ Compensation Act, 2013 (the “Act”) and POL 03/2012, Benefit of the Doubt, where the evidence in support of the opposite sides of an issue is approximately equal, the Workers’ Compensation Board (WCB) shall resolve the issue in favour of the worker. In other words, application of Benefit of Doubt can only be considered where the matter at issue contains evidence both for and against, and that evidence is relatively equal. Uncertainty about the facts does not constitute doubt, and areas of uncertainty should be clarified wherever possible.

The Occupational Disease Database (available on the WCB website) is used to collect and record information regarding all occupational disease cases. This database is maintained and updated regularly by Operations staff who use it where determining the merits of occupational disease claims. The WCB Medical Consultant also accesses the database for study purposes or evolving disease trends; and where a link can be established, guidelines for the specific disease will be developed.

These appendices are not exhaustive. As new guidelines are developed, they will be added to the appendices and made available to stakeholders.

Claim Development

Consistent with the guidelines provided under POL 11/2003, Injuries, Occupational Disease, when developing a claim for occupational disease staff will ensure the following steps are undertaken:

1. Review of employer, worker and medical reports to determine the type and degree of exposure to a substance during the course of employment.

2. Identify any underlying condition(s) and where it is determined the effects of the condition was enhanced or is now symptomatic due to exposure, Section 49 will apply.
3. Where the matter at issue contains evidence both for and against, and that evidence is relatively equal, the claim will be adjudicated in favour of the worker. However, uncertainty about the facts does not constitute doubt, and areas of uncertainty will be clarified with the WCB Medical Consultant.

4. WCB will continue to accept responsibility until the worker returns to the pre-injury condition.

5. An acceptable claim may involve medical costs and wage loss benefits unless the person is retired and has no earnings loss. Following death, spousal or dependent benefits may be payable.

6. Where eligibility for permanent functional impairment (PFI) occurs, the appropriate policy will be reviewed and the guidelines for calculating the extent of the loss will apply.

7. Reasons for acceptance or denial of claim will be documented to the file and communicated to the injured worker and where appropriate, the employer.
Appendix A
Allergies

Background

1. Allergies are an overreaction of the immune system. The immune system normally protects the body from viruses and bacteria by producing antibodies to fight them. In an allergic reaction, the immune system starts fighting essentially harmless substances like dust mites, airborne pollutants, or a medication as if these substances were trying to attack the body. This overreaction causes problems that affect the skin, nose, lungs, digestive organs and the blood vessels.

2. Typically, workers will not experience an allergic reaction until they have become sensitized to the allergens in their workplace. Some workers will become symptomatic to allergy-causing materials (allergens) when exposed only a few times while others will develop a reaction only after a prolonged period of time.

3. The following provides guidelines for adjudication of claims for allergies. Where a Permanent Functional Impairment (PFI) is considered, Policy 23/2010, PFI - General will apply.

Guidelines

1. Claims will be considered where exposure to an allergen during the course of employment causes an underlying mild allergic sensitivity to become symptomatic.

2. In the workplace, allergic reactions may be caused by a number of substances including but not limited to:
   a. Biological agents (viruses, bacteria, fungi, pollen) that can accumulate in washrooms, humidifiers, de-humidifiers, ventilation pipes and ducts;
   b. Volatile organic compounds that are released by felt-tip markers, correction fluid, cleaning agents, paint and toner from photocopiers, printers and fax machines;
   c. Formaldehyde, which is found in glue, carpeting, some fabrics and furniture made from particleboard or plywood;
   d. Latex gloves used by health care workers to prevent the transmission of infectious diseases.

3. Occupational health specialists recognize that numerous health problems may result from exposure to these substances including: inflammation of sinuses; ear problems; upper respiratory infections (wheezing, chest tightness and coughing); growths in the nose; nose bleeds from allergy symptoms or allergy medication; and, skin infections from scratching itchy skin.

4. Those industries or occupations with a greater risk of developing allergies include but are not limited to the following:
a. Farmers or veterinarians who become allergic to animals;
b. Food industry workers exposed to a number of allergens including shellfish, peanuts, eggs and coffee beans;
c. Hairdressers who become allergic to shampoos, conditioners or colourants they use daily;
d. Physicians, nurse’s aides, pharmacists, laboratory technicians, food service workers and housekeeping personnel who wear latex gloves.
Appendix B
Respiratory Diseases

Background

1. Occupational health specialists recognize a connection between some industrial work environments and respiratory disease where there is exposure to substances such as bacteria, viruses, tobacco smoke, car exhaust and other air pollutants.

2. Common symptoms or signs of respiratory disease include trouble breathing and shortness of breath. Workers will often complain of a long-term cough that will not go away, may cough up blood, or experience pain while inhaling or exhaling. Some substances can cause a worker to have upper respiratory irritation or irritation of their nose and/or throat and cold-like symptoms, such as a runny nose and scratchy throat.

3. The following provides guidelines for adjudication of claims for respiratory diseases.

Guidelines

1. Claims will be considered where exposure during the course of employment cause respiratory diseases; including, asthma, chronic obstructive pulmonary disease (COPD), chronic obstructive lung cancer, chronic bronchitis, emphysema, and heart related conditions.

2. In the workplace, respiratory diseases may be caused by the inhalation of substances including but not limited to:
   a. Dusts from wood, cotton, coal, asbestos, silica, talc, cereal grains, coffee, pesticides, drug or enzyme powders, metals and fibreglass.
   b. Fumes from metals that are heated and cooled quickly.
   c. Smoke from burning organic materials, which can contain a variety of dusts, gases and vapours.
   d. Gases such as formaldehyde, ammonia, chlorine, sulphur dioxide, ozone and nitrogen oxides.
   e. Vapours given off from liquids and solvents. They usually irritate the nose and throat before they affect the lungs.
   f. Mists from paints, hairspray, pesticides, cleaning products, acids, oils and solvents.

3. Some respiratory diseases have specific causes, such as:
   a. Asbestos: The presence of these asbestos fibres within the lungs may result in asbestosis, or forms of lung cancer. The effect of tobacco smoking in
Combination with asbestos exposure can accelerate the cancer by approximately five times.

b. Radon: The lung absorbs particles emitted by the radon and the resulting radiation dose increases the risk of lung cancer. Scientists estimate that the increased risk of lung cancer to smokers from radon exposure is ten to twenty times higher than to people who have never smoked.

c. Carbon Monoxide: Exposure to carbon monoxide reduces the blood's ability to carry oxygen and can cause carbon monoxide poisoning which causes symptoms such as headaches, dizziness, sleepiness, weakness, nausea, vomiting, confusion, and disorientation. At very high levels it causes loss of consciousness and death.

d. Nitrogen Dioxide: Some studies have shown that when people with asthma inhale low levels of nitrogen dioxide while doing physical activity, their lung airways can narrow and become more reactive to harmful inhaled materials.

e. Sulphur Dioxide: At high exposure levels, it causes the lung airways to narrow causing wheezing, chest tightness, and/or breathing problems. People with asthma are particularly susceptible to the effects of sulphur dioxide.

4. Those industries or occupations with a greater risk of developing respiratory diseases include but are not limited to the following:

a. Jobs that involve exposure to fumes from metals and other substances that are heated and cooled quickly including welding, smelting, furnace work, pottery making, plastics manufacture, and rubber operations.

b. Firefighters are at special risk from inhaling of noxious smoke and combustion gases, which can also be found in jobs where chemical reactions occur with high heat operations such as welding, brazing, smelting, oven drying and furnace work. (Also refer to POL 06/2012, Injuries - Firefighters).

c. Painters and auto-body repair technicians breathe in vapours given off from solvents.

d. Hairstylists, artists and exterminators are examples of occupations that could be effected by mists or sprays from hairsprays, cleaning products and oils.
Appendix C
Dermatitis

Background

1. Occupational skin diseases are a widespread problem. According to some statistics, skin disorders comprise more than 45% of all occupationally related diseases. Skin diseases caused by substances and processes used in the workplace are commonly known as dermatitis.

2. Dermatitis is a general term that is used to describe an inflammation of the skin and is divided into two classifications: Allergic Contact Dermatitis and Irritant Contact Dermatitis.

3. The following provides guidelines for adjudication of claims for diseases of the skin.

Guidelines

1. Claims will be considered where contact with substances or chemicals found in the workplace causes Allergic Contact Dermatitis or Irritant Contact Dermatitis.

2. Allergic Contact Dermatitis has to do with the body’s immune system. The immune system protects the body from the things that can make one sick. The cells in the body react when a foreign substance enters it and this foreign substance could be a chemical that is absorbed into the skin. In the case of Allergic Contact Dermatitis, health problems such as inflammation, itching, pain, redness, swelling, and the formation of small blisters or itchy, red circles with a white centre may result.

3. Irritant Contact Dermatitis is an inflammation caused by substances or chemicals in the workplace that come in direct contact with the skin. With Irritant Contact Dermatitis, redness, blisters, scales or crusts on the skin may appear. In the workplace, Irritant Contact Dermatitis can develop after a short, intense exposure or a repeated or prolonged, low level exposure to a substance or chemical.

4. In the workplace, dermatitis may be caused by contact with a number of substances including but not limited to:
   a. Strong irritants such as acids, some metals or organic compounds.
   b. Mild irritants such as soap, detergents, mild acids or alkalis, greases and solvents.
   c. Listed below are some of the more common occupations where Allergic and Irritant Contact Dermatitis can occur as well as some of the allergens and irritants that could cause the diseases.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Allergens</th>
<th>Irritants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carpenters</td>
<td>Stains, glues, woods, turpentine, and varnishes</td>
<td>Detergents, thinners, solvents and wood preservatives.</td>
</tr>
<tr>
<td>Occupation</td>
<td>Allergens</td>
<td>Irritants</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cleaners</td>
<td>Rubber gloves.</td>
<td>Detergents and solvents.</td>
</tr>
<tr>
<td>Construction Workers</td>
<td>Chromates, cobalt, rubber and leather gloves, resins and woods.</td>
<td>Cement.</td>
</tr>
<tr>
<td>Florists &amp; Gardeners</td>
<td>Plants, pesticides and rubber gloves.</td>
<td>Manure, artificial fertilizers and pesticides.</td>
</tr>
<tr>
<td>Mechanics</td>
<td>Rubber gloves, chromates, epoxy resin and antifreeze.</td>
<td>Oils, greases, gasoline, diesel fuel, cleaners and solvents.</td>
</tr>
<tr>
<td>Office Workers</td>
<td>Rubber, nickel and glue.</td>
<td>Solvents from photocopiers and adhesives.</td>
</tr>
<tr>
<td>Painters</td>
<td>Turpentine, thinners, cobalt, chromates, polyester resins, formaldehyde, epoxy resin, adhesives and paints.</td>
<td>Solvents, thinners, wallpaper adhesives and hand cleaners.</td>
</tr>
</tbody>
</table>

5. To produce the damage, the irritant substance must penetrate the outer layer of the skin. Following penetration, the substance or chemical comes into contact with cells and tissues and can react with certain chemicals that are naturally present in these cells and tissues. These reactions produce skin damage. Workers can have many types of reactions and the severity of the reaction depends on:

a. The intensity and duration of exposure or how often there is contact with the allergen/irritant.

b. The presence of any existing skin problems, rashes, cuts, scratches or scrapes.

c. Whether the temperature and humidity in the workplace causes sweating, as perspiration can dissolve chemical powder and enable the allergen to enter the body more quickly.

d. The part of the body that is exposed to the irritant because injury is greater where the skin is thinner such as the face and upper back.
Appendix D
Cardiac Conditions

Emergency Response means those circumstances where firefighters attend at a crisis situation including but not limited to a fire, car crash or other incident as part of their active firefighting duties.

Background

1. Exposure to noxious inhalants and other chemicals including: carbon monoxide, carbon disulfide, halogenated hydrocarbons and nitroglycerin/nitrates may result in cardiac conditions.

2. Carbon monoxide decreases the oxygen-capacity of the blood and reduces the oxygen supply available to the heart. Carbon disulfide, a widely used solvent has been shown to increase the risk of cardiovascular disorders, including coronary artery disease and hypertension. Halogenated hydrocarbons in acute exposures have precipitated sudden death due to abnormal heart rhythms. Exposure to nitroglycerines and nitrates has been shown to lead to increased risk of cardiac chest pain, heart attacks and sudden death.

3. Section 28 of The Workers’ Compensation Act, 2013 (the “Act”) and Section 22.3 of The Workers’ Compensation General Regulations, 1985 (the “General Regulations”) provide the conditions for the presumption of occupational disease and firefighters suffering cardiac injury.

Guidelines

1. Claims will be considered when there are cardiac conditions resulting from the inhalation of noxious gases such as carbon monoxide, carbon disulfide, nitroglycerine and nitrates.

2. In accordance with Section 28 of the Act, where a firefighter suffers a cardiac injury that manifests within 24 hours at an emergency response, it is presumed to be an occupational disease. No minimum period of employment applies (POL 06/2012, Injuries – Firefighters). However, regardless of whether the presumption is met, full file development will occur, which will involve obtaining all relevant medical information and a complete history of the claimant’s professional firefighting duties (POL 11/2003, Injuries – Occupational Disease).

3. For information on cardiac injuries received as a result of occupational hazards such as electric shock, penetrating or non-penetrating chest injuries, unusual physical exertions or strains and acute post-traumatic stress refer to POL 05/2013, Injuries – Heart Attack.
Appendix E
Asbestos Related Cancer

Background

Health Canada has concluded that a valid relationship exists between exposure to asbestos and certain types of cancers including gastrointestinal, laryngeal, lung and mesothelioma.

Guidelines

1. Gastrointestinal cancer (esophagus, stomach, small bowel, colon, and rectum), lung cancer, mesothelioma and laryngeal cancers will be considered compensable when the following conditions apply:
   a. There is a clear and adequate history of occupational or environmental exposure to asbestos dust. Those occupations representing a higher risk for developing asbestos related cancers include:
      i. asbestos mining
      ii. textile manufacturing
      iii. insulation and filter material production
      iv. construction
      v. welding, plumbing and electrical work
      vi. shipyard work.
   b. While the risk of asbestos related cancer is highest among workers with the greatest cumulative exposure, increased risk may be seen even after short but intense exposure.
   c. Depending on the length and intensity of exposure, the interval between onset and the diagnosis of laryngeal or gastrointestinal cancers is generally 10 to 20 years, 10 years for lung cancer and 15 to 30 years for mesothelioma.

2. Claims that do not meet the conditions in Point 1 will be judged on their own merits with consideration to the nature of the occupation, the extent and intensity of the exposure and other factors peculiar to the individual case. The benefit of reasonable doubt applies.

3. Medical Services will be consulted before a claim for asbestos related cancer is denied.
Appendix F
Mercury Poisoning

Background

Workplaces contaminated with metals such as mercury can cause health problems, which may become permanent. The nervous system, blood, intestines, kidneys and the reproductive system can be damaged.

Guidelines

1. Compensation will not be granted to workers who have no symptoms suggestive of mercury poisoning, and a 24-hour urinary mercury excretion of 100 micrograms or less.

2. Entitlement will not be granted except for investigation, and the time loss directly related thereto, where the worker despite symptoms suggestive of mercury poisoning, has a mercury excretion of less than 100 micrograms per 24 hours.

3. Where a worker has symptoms suggestive of mercury poisoning, including physical signs thereof and urinary excretion in excess of 100 micrograms per 24 hours, his claim will be accepted for investigation and for treatment and for any time loss consequent thereon, and relocation in a work environment which does not involve mercury exposure until such time as the signs and symptoms have disappeared and the mercury excretion levels have fallen to normal.

4. Claims for workers who have no symptoms indicative of mercury poisoning but who on routine screening are found to have urinary mercury excretion in excess of 300 micrograms per 24 hours are to be accepted for assistance in relocation in employment not involving mercury exposures until such time as their mercury excretion has dropped to normal levels.
Appendix G

Repetitive Strain Injuries

Background

1. Section 2(1)(r) of The Workers’ Compensation Act, 2013 (the “Act) defines injury as meaning all or any of the following arising out of and in the course of employment:
   (i) the results of a wilful and intentional act, not being the act of the worker;
   (ii) the results of a chance event occasioned by a physical or natural cause;
   (iii) a disabling or potentially disabling condition caused by an occupational disease;
   (iv) any disablement;

2. Section 20(2) of the Act provides the Workers’ Compensation Board (WCB) exclusive jurisdiction to determine whether any condition or death with respect to which compensation is claimed was caused by an injury and whether any injury has arisen out of or in the course of employment.

3. Section 27 of the Act states, “(1) Unless the contrary is proven, if an injury to a worker arises out of the worker’s employment, it is presumed that it occurred in the course of his or her employment. (2) Unless the contrary is proven, if an injury to a worker occurred in the course of his or her employment, it is presumed that it arose out of the worker’s employment.”

4. Although there are highly divergent opinions on the cause and effect relationships within the medical and business communities concerning Repetitive Strain Injuries (RSI), there is evidence that indicates work activities involving varying degrees of force and/or repetition and/or poor ergonomics can cause RSI. This policy provides the WCB with guidelines to determine work relationships for RSI claims.

Guidelines

1. Repetitive Strain Injuries means musculotendinous injuries caused by overload of particular muscle groups from repeated use, force or by the maintenance of constrained postures that result in pain, fatigue and a decline in work performance.

2. RSI includes but is not limited to the following common activity related musculoskeletal or soft tissue injuries: carpal tunnel syndrome (CTS), epicondylitis (tennis or golfer’s elbow), cubital tunnel syndrome, tendonitis, rotator cuff, shoulder impingement syndrome, radial tunnel syndrome, thoracic outlet syndrome, trigger finger and disablements from vibrations.

3. The three major risk factors for RSI in the workplace include:
a. Repetition: The number of times the specific activity(s) is repeated and the percentage of the workday during which it occurs.

b. Force: The weight or impact of the object being handled and/or the force of body action required to carry out the activity.

c. Ergonomics: The body positioning, both static and dynamic, required to do the activity and the set-up of the work area involved.

4. Repetition and force are the primary factors with poor ergonomics increasing the effect of the two primary factors. The following matrix is to be used as the basis for determining the cause and effect relationship to employment:

<table>
<thead>
<tr>
<th>HIGH FORCE/LOW REPETITION</th>
<th>HIGH FORCE/HIGH REPETITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medium to high probability of employment relationship</td>
<td>• High probability of employment relationship</td>
</tr>
<tr>
<td>• Probability increased with poor ergonomics</td>
<td>• Probability increased with poor ergonomics</td>
</tr>
<tr>
<td>• Job examples:</td>
<td>• Job examples:</td>
</tr>
<tr>
<td>o Grinder operators</td>
<td>o Meat cutters/Eviscerators</td>
</tr>
<tr>
<td>o Electricians</td>
<td>o Carpenters</td>
</tr>
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<td></td>
<td>o Jack hammer operators</td>
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</tbody>
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<table>
<thead>
<tr>
<th>LOW FORCE/LOW REPETITION</th>
<th>LOW FORCE/HIGH REPETITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Low probability of employment relationship</td>
<td>• Medium to high probability of employment relationship</td>
</tr>
<tr>
<td></td>
<td>• Probability increased with poor ergonomics</td>
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<td>• Job examples:</td>
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<td></td>
<td>o Typists</td>
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<td></td>
<td>o Cashiers</td>
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<td></td>
<td>o Painters</td>
</tr>
</tbody>
</table>

5. Although they are not to be used as the sole basis for acceptance of the claim, there are other factors, positive and negative, that may influence the decision to accept the claim, such as:

Positive

a. precise symptom onset during work activity,
b. new to the activities in the job,
c. recent increase in activities at work,
d. age of worker and years of activity, and
e. improved symptoms away from work.
Negative
a. symptom onset away from employment,
b. activities performed for many years,
c. recent increase in activities outside work,
d. other medical considerations (medications or therapies),
e. bilateral symptoms without bilateral activity, and
f. continued or increasing symptoms away from work.
Appendix H
Raynaud’s Phenomenon

Background

1. Raynaud’s is a disorder of the small blood vessels that feed the skin. During an attack, these arteries contract briefly, limiting blood flow. The attacks may last from minutes to hours. Extremities, hands and feet, are most commonly affected, but Raynaud's can attack other areas such as the nose and ears.

2. Symptoms include changes in skin color from white to blue to red and the skin temperature of the affected area feels cooler. In extreme cases, there may be swelling, painful throbbing, and ulcerations may develop that can become infected and lead to gangrene.

Guidelines

1. Claims will be considered for occupations such as tree fellers and rock drillers when there is exposure to cold temperatures or there is prolonged use of vibratory tools.

For information on awarding a Permanent Functional Impairment (PFI) for Raynaud's Phenomenon refer to WCB Policy POL 23/2010, PFI - General.
3.2 **Circumstance of Injury**
Injuries, Recreational Activities in Remote Camps (PRO 29/82)

Document Date 14 June 1982

Purpose To establish guidelines for determining entitlement for injuries sustained while participating in recreational activities in remote camp situations.

BACKGROUND

1. By legislation, compensation is payable for injuries "arising out of and in the course of employment."

2. The legislation covers "employment injuries" rather than just "work" injuries, and therefore can encompass other activities related to employment.

3. Not infrequently, recreational injuries occur while employees are off work on their spare time.

4. The employer, in an isolated camp situation, has control over what sort of activities the work force engages in during their off hours.

PROCEDURE

1. In certain situations, the employer's employees are resident employees or captive employees. They have little, if any freedom of choice as to the premises they use or the things which they can do to pass the time when not working.

2. Most Workers' Compensation jurisdictions provide coverage when the source of injury was a risk distinctly associated with the conditions under which the claimant lived because of the requirement of remaining on the premises. Thus, injuries occurring while using bunkhouses, eating facilities, rest facilities, employer provided recreation facilities, etc., would fall within this doctrine.

3. This does not mean that everything is covered. A worker may import into the isolated setting a dangerous risk which is unreasonable to the work setting. For example, someone who has a dangerous hobby such as working with explosives, may well have a claim disallowed if injured while engaged in this hobby on the employer's premises. The link to employment is too tenuous in this example to grant coverage.

4. The second category of recreational injury is employee-sponsored recreation such as fishing, swimming, water skiing, etc. The British Columbia WCB writes, in reported Decision 39, as follows:
"...in a situation such as the work location involved here (isolated camp), the worker does not, like the city worker, move from an employment relationship into a private life which he enjoys in a general society independent of his work environment. Only to a limited extent is the worker at this kind of location free to develop a lifestyle and private life independent of the employer's organization."

The decision further states:

"Cases like the present might be seen as examples of the 'inducement to hire doctrine. The essence of this doctrine is that if an employer establishes a facility, or locates close to a facility, that is one of the attractions inducing workers to come to his place of employment, injuries occurring through the use of that facility are compensable. For example, in one case a residential worker drowned on his day off while swimming in a lake at the employer's camp. Compensation was awarded on the ground that it could be inferred that the fact that the recreational facilities exists was an inducement of hire.'

We do not, however, rest our decision in this case on the inducement of hire doctrine so much as on the broader principle that where a worker is injured in the course of receiving the consideration for which he is working, or in the course of using some facility supplied or provision made by the employer, the acceptance of such consideration and the use of such facility or provision are part of the employment relationship; and injuries resulting therefrom are injuries arising out of and in the course of employment."

Act Sec # 27
Effective Date 23 April 1982
Amended References updated 01 January 2014 in accordance with The Workers' Compensation Act, 2013
Application All related claimants
Supersedes Board Order 15/82 Coverage – Recreational Activities – Captive Workers
Complements POL 29/82 Injuries, Recreational Activities in Remote Camps
POL 12/2013 Arising Out Of and In the Course of Employment
3.2.7 Fatalities, Presumption (PRO 04/2014)

Document Date 29 April 2014

Purpose To establish guidelines for applying presumptive clauses in fatalities.

BACKGROUND

1. The WCB has approved POL 04/2014, Fatalities, Presumption. POL 04/2014 establishes guidelines for applying presumptive clauses in fatalities.

2. If a worker is found dead at work, the following procedure will show WCB staff how to investigate fatalities to determine if Section 29 of The Workers’ Compensation Act, 2013 (the “Act”) applies.

PROCEDURE

1. Operations staff will follow the “Fatality Adjudication Checklist” when reviewing all fatality claims.

2. Employer Services will determine if the worker is:
   a. A worker as defined by the Act, and
   b. Working for an employer covered under the Act.

3. Operations staff will contact the worker’s employer/co-workers. This contact will help Operations staff determine:
   a. How and when the worker was found.
   b. Who found the worker.
   c. When the worker was last seen alive, and
   d. If the worker was in a place at a time the worker had a right to be in the course of their employment (e.g., a worker re-enters a workplace after normal work hours at a time they were not requested or authorized to be there).

4. Operations staff will find out if an autopsy has been ordered (by the usual contact with the next of kin during the claim’s development).

5. If an autopsy is ordered, Operations staff will not make claim decisions or provide benefits until they review the worker’s autopsy report. Often it takes three to six months for the WCB to get autopsy reports from the Office of the Chief Coroner.

6. Operations staff will get the worker’s government issued death certificate from eHealth Saskatchewan’s Vital Statistics registry.
7. Operations staff should be able to determine if the death arose out of and in the course of employment once they:
   a. Determine the sequence of events that led to the worker’s death.
   b. Gather and review all medical reports related to the death of the worker (i.e., autopsy report, government issued death certificate).

8. A Medical Officer will review the medical reports related to the death of the worker if Operations staff need help determining if the cause of death proves the death did not arise out of employment.

9. The Claims Entitlement Specialist III Supervisor or Team Leader will review all fatality claims prior to Operations staff informing the worker’s dependant or next of kin of the claim decision.

10. Following notification of the worker’s dependant or next of kin, Operations staff will ensure the “Fatality Adjudication Checklist” is complete. Operations staff will sign the checklist and send it to the Claims Entitlement Specialist III Supervisor or Team Leader for review and signature. Once signed, Operations staff will scan the checklist to the claim file.

**Act Sec #**
- 2(1)(l), 2(1)(ii), 20, 27, 29, 94, 115

**Effective Date**
- 01 June 2014

**Application**
- All decisions made on claims on and after the effective date, where a worker is found dead.

**Supersedes**
- PRO 16/2010 Fatalities, Presumption

**Complements**
- POL 04/2014 Fatalities, Presumption
- POL 21/2013 Appeals – Claims
- PRO 21/2013 Appeals – Claims
- POL 12/2013 Arising Out Of And In The Course Of Employment
4.0 BENEFITS TO WORKER

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4.1.1 Establishing Initial Wage Base (PRO 29/2010)

Document Date 07 September 2010

Purpose To establish the initial wage base for workers.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved policy guidelines regarding the establishment of an injured worker’s wage base.

2. The following procedure provides WCB staff with guidelines for establishing the initial wage base where the worker has a loss of earnings resulting from an injury.

PROCEDURE

1. In accordance with POL 29/2010, Establishing Initial Wage Base, Operations staff will calculate the worker’s average weekly earnings using the regular rate of pay at the commencement of earnings loss or the amount earned during the 52 week period prior to the commencement of loss of earnings, whichever is greater.

2. Where the worker was employed by the injury employer for a period less than 52 weeks, Operations staff may use a period less than 52 weeks but greater than 13 weeks to calculate the worker’s average gross earnings.

3. When determining the number of weeks to be used in the average gross earnings calculation, Operations staff will include the number of weeks the worker was available for employment. Only unpaid sick leave, maternity or paternity leave, incarceration, full-time school attendance, or time off work due to a work injury (in receipt of benefits for a prior claim) can be considered periods unavailable for employment.

4. Wage loss benefits will be based on information supplied to Operations staff by the employer and or injured worker. Where the worker is employed by two or more employers at the commencement of loss of earnings, the worker’s gross earnings will be based on the combined regular gross earnings from those employers. The gross earnings used to calculate wage loss entitlement will not exceed the maximum amount payable (POL 08/2015, Maximum Wage Rates).

5. Employers are responsible for providing the WCB with the following information regarding a worker’s gross earnings in order to establish the wage base:
   a. Gross earnings paid for overtime, shift differentials, vacation pay and other taxable benefits (e.g., room and board allowance, year end bonuses) that are paid in exchange for the worker’s services;
   b. Tips and gratuities reported to the Canada Revenue Agency;
c. The days of rest associated with the worker’s employment;
d. The gross earnings for up to 52 weeks prior to the commencement of earnings loss;
e. Periods, during the 52 weeks prior to the commencement of earnings loss, the worker was unavailable for employment, if known by the employer; and
f. The worker’s tax exemption status as typically confirmed through completion of the Canada Revenue Agency’s TD1 form.

6. Operations staff will use the following information to calculate the wage base for the injured worker:
   a. The regular rate of pay earned by the worker at the commencement of earnings loss;
   b. The number of days in the worker’s work week;
   c. The average of the worker’s gross earnings prior to the commencement of earnings loss;
   d. The periods the worker was unavailable for employment; and
   e. The worker’s probable deductions for income tax, Canada Pension Plan premiums, and Employment Insurance premiums.

7. Where the worker has been granted personal coverage or is engaged under other employment arrangements (e.g., contractor, learner), Employer Services staff will verify what gross earnings have been reported and what coverage guidelines apply.

Net Earnings

8. Using the current Canada Revenue Agency guidelines, WCB staff will deduct probable contributions for income tax, Canada Pension Plan, and Employment Insurance premiums from the injured worker’s gross earnings to determine the net earnings. As per POL 03/2007, Calculation of Net Compensation Payable, probable deductions will be based upon the information that the worker has authorized the employer to deduct from their gross earnings for income tax purposes and which is available as of the commencement of the loss of earnings.

Calculation of Wage Loss Benefits

9. To calculate the injured worker’s wage loss benefits, WCB staff will multiply the net earnings calculated in Point 8 by 90 percent for injuries sustained on or after September 1, 1985.
ATTACHMENTS

Establishing Initial Wage Base – Examples

Act Sec # 2(1)(k), 20, 37, 68, 69, 70(1), 70(4), 95.
Effective Date 01 November 2010
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All claims.
Supersedes n/a
Complements POL 29/2010 Establishing Initial Wage Base
POL 08/2015 Maximum Wage Rates
POL 08/2007 Compensation Rate – Where no earnings at disablement or death
POL 35/2010 Compensation Rate – Casual and Seasonal Employment – Section 70(4)
POL 28/2010 Compensation Rate - Minimum and Average Weekly Earnings
POL 03/2007 Calculation of Net Compensation Payable
PRO 59/2015 Calculation of Net Compensation Payable
Establishing Initial Wage Base – Examples

Example #1 – Injured worker has worked 52 weeks preceding commencement of loss of earnings:

Gross earnings (for the 52 weeks preceding) $46,800
\[\div 52 \text{ weeks (weekly gross earnings)} = 900.00\]

Probable deductions*

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Weekly net earnings $731.53
Compensation as per Section 68 \(\times 90\%\)
Weekly Wage Loss Benefits $658.38

*assuming worker is married with two dependents; deductions include Canada Pension Plan premiums, Employment Insurance premiums and Income Tax payable (as of 01 January 2008)

Example #2 – Injured worker has less than 52 weeks of regular earning pattern preceding commencement of loss of earnings:

Hourly Wage $10.00
\[\ast \text{ worked } 40 \text{ hours/week for 36 weeks} \times 40\]
Weekly Gross Earnings $400.00

Probable deductions**

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Weekly net earnings $328.25
Compensation as per Section 68 \(\times 90\%\)
Weekly Wage Loss Benefits $295.43

**assuming worker is single with no dependents; deductions include Canada Pension Plan premiums, Employment Insurance premiums and Income Tax payable (as of 01 January 2008)
Determination of a Worker’s Daily Rate of Benefits (PRO 34/2010)

Document Date: 10 November 2010

Purpose: To establish the process by which the WCB converts a worker’s weekly compensation rate to a daily compensation rate.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved policy that provides direction around the process required to determine a worker’s daily rate of benefits.

2. The following procedure provides guidance for the implementation of the policy.

PROCEDURE

1. To determine the number of days worked in a seven day period, and whether the rest days are regular, repeating cycle or irregular, Operations staff that have the designated authority to make payments on behalf of the WCB may use Calendar Worksheets to establish the shift rotations and rest days for injured workers.

2. Regardless of whether the worker has regular, repeating cycle or irregular rest days, a worker’s daily rate of benefits can be determined with the following formula:

   \[
   \text{Number of Days Worked} \times 7 = \text{Work Week (Rounded Down to Lowest ¼ Day)}
   \]

   \[
   \frac{\text{Total Number of Days in Schedule}}{\text{Number of Days Worked}} \times 7 = \text{Work Week (Rounded Down to Lowest ¼ Day)}
   \]

3. If benefits are initially paid based on a predetermined schedule of rest days, and at some point subsequent to injury the employer is no longer able to supply an ongoing list of rest days, the payment of benefits will be converted to a daily rate that represents a seven day work week.

4. In cases where a worker’s rest days are not based on a predetermined schedule and the agreement of hire calls for the worker to work a fluctuating work week based on the amount of work available or weather conditions, the payment of benefits will be based on a daily rate that represents a seven day work week.

ATTACHMENTS

- Rest Days and Work Weeks Examples
<table>
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<tr>
<th>Act Sec #</th>
<th>20, 68, 69, 70, 71 and 72</th>
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<td>Complements</td>
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<td>POL 35/2010 Compensation Rate – Casual and Seasonal – Section 70(4)</td>
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<td></td>
<td>POL 28/2010 Compensation Rate – Minimum and Average Weekly Earnings</td>
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</table>
REST DAYS AND WORK WEEKS EXAMPLES

The following provides four examples by which a worker’s daily rate of benefits can be calculated: regular rest days, repeating cycle rest days, irregular rest days, and a 7 day work week.

Regular Rest Days
Every week a worker works from Monday to Friday, and Saturday and Sunday are the worker’s rest days.

\[
\frac{5 \text{ Days Worked}}{7 \text{ Days in Schedule}} \times 7 = 5 \text{ Day Work Week}
\]

The worker has a 5 day work week. Where the worker’s weekly compensation rate is $400, the worker’s daily rate is \((400/5)\) $80.

Repeating Cycle Rest Days
In a complete work cycle the worker works 3 weeks (21 working days) and has 1 week off (7 rest days).

\[
\frac{21 \text{ Days Worked in Complete Cycle}}{28 \text{ Days in Complete Cycle}} \times 7 = 5.25 \text{ Day Work Week}
\]

The worker has a 5.25 day work week. Where the worker’s weekly compensation rate is $400, the worker’s daily rate is \((400/5.25)\) $76.19.

Irregular Rest Days
The worker’s employer draws up a work schedule 1 month in advance. The schedule for the month prior to injury calls for 20 work days in June (30 total days) with no specific pattern. From month to month, the worker does not have any repeating or patterned rest days.

\[
\frac{20 \text{ Days Worked During June}}{30 \text{ Days in June}} \times 7 = 4.67 \text{ Day Work Week (Rounded to Lowest \(\frac{1}{4}\) Day)}
\]

The worker has a 4.67 day work week, which is rounded to 4.50. Where the worker’s weekly compensation rate is $400, the worker’s daily rate is \((400/4.50)\) $88.89.

7 Day Work Week Conversion
The employer is no longer able to supply an ongoing list of rest days, or the worker’s rest days are not based on a predetermined schedule.

Therefore, the worker is considered to have a 7 day work week. Where the worker’s weekly compensation rate is $400, the worker’s daily rate is \((400/7)\) $57.14.
4.1.3 Determination of Long-Term Loss of Earnings (PRO 15/2014)

Document Date 16 October 2014

Purpose To establish administrative guidelines for determining long-term earnings loss benefits.

BACKGROUND

POL 15/2014, Determination of Long-Term Loss of Earnings establishes the process for determining long-term earnings loss benefits.

PROCEDURE

Determining Earning Capacity

1. In most cases, the Vocational Rehabilitation Specialist (VRS) will prepare an earning capacity report (VSECR) to help the Case Manager (CM) determine the client’s earning capacity. The CM will not need a VSECR to determine the client’s earning capacity in the following situations:

   a. The restrictions imposed by the injury prevent the client from returning to any form of employment. In such cases, the CM will determine that the client does not have an earning capacity.

   b. The client returns to work with a minimal loss of earnings. The CM may determine that the client is at an optimal earning capacity and issue long-term earnings loss benefits based on the client’s actual income.

2. The VRS will complete an employability assessment and transferable skills analysis (QuickNOC Pro) to determine if a client is employable (POL 01/2011, Vocational Rehabilitation – Programs and Services).

3. If the client cannot go back to their pre-injury job, the VRS will determine the client’s earning capacity by researching suitable productive employment opportunities. The VRS will research:


   b. Physical demands.

   c. Skills and abilities (qualifications).

   d. Starting wages, and

   e. Staged wage increases.
4. When researching suitable productive employment opportunities, the VRS will use at least three of the following sources:
   a. Local employment information
   b. QuickNOC Pro (e.g., Labour Market Link, Employment and Social Development (ESDC) Job Bank, etc.)
   c. Saskatchewan Polytechnic Graduate Employment Report
   d. Federal wage data (ESDC – Service Canada average annual income)
   e. Provincial wage data (Ministry of Advanced Education, Employment and Labour – wages and working conditions by occupation)
   f. Local employers of the identified occupation, or
   g. Any other reputable job research source.
   From this data, the VRS will determine the client’s earning capacity.

5. The VRS and client will discuss a number of suitable productive employment opportunities the client should pursue. If the client:
   a. Finds employment that reasonably represents their earning potential, the VRS will recommend in the earning capacity report that long-term earnings loss benefits should be based on the client’s actual earnings.
   b. Does not find employment, or the employment the client obtains is well below their earning potential, the VRS will recommend an estimated earning capacity based on the factors outlined in Points 3 and 4 above.

6. The VRS will prepare an earning capacity report and send it to the CM. The CM will determine and authorize long-term earnings loss benefits, recognizing any difference in the client’s pre-injury wage (adjusted to date) and the amount a client could earn in suitable productive employment.

7. To authorize long-term earnings loss benefits, the VRS, CM, Payment Specialist and Team Leader (TL) will complete their portion of an Earning Replacement Quality Control Review form.

Adjusting Earning Capacity

8. If the WCB determines that the client is able to acquire suitable productive employment that gets staged wage increases, the CM will reduce earnings loss benefits to reflect the staged increases (this includes cases where the wage base is at maximum). Staged increases could include, but may not be limited to, periodic wage increments and annual CPI increases.

9. The timing of staged increases, and the rationale for such adjustments, will be documented on the file when clients are placed on long-term earnings loss benefits. The CM will explain the rationale for the staging to the client.
10. If a client’s earning capacity is determined to be at the minimum wage level and no staged increases are expected, the determination will change in accordance with increases to the provincial minimum wage (POL 26/90, Provincial Minimum Wage, Effect of Increase).

Travelling for Work

11. Clients should be expected to travel to work if suitable productive employment is within 75 km from home. If clients travelled more than 75 km to work before the injury, they may be expected to travel that amount for the new job.

12. When determining if clients can be expected to travel to work, the VRS will consider:
   a. The client’s physical ability to drive to work.
   b. Starting wages for suitable productive employment within an acceptable travel radius, and
   c. Wage potential for suitable productive employment within an acceptable travel radius.

13. If clients do not drive for reasons other than a physical inability (e.g., loss of licence post injury, no licence), the VRS may still expect them to be able to travel to and from work.

Moving for Work

14. If the client cannot find suitable productive employment near their home, the VRS may approve a move to a more suitable place (POL 02/2014, Vocational Rehabilitation – Moving Allowance).

15. If the client does not want to move, the VRS will determine the client’s earning capacity in accordance with suitable productive employment near the client’s home. The VRS will inform the client that their earning capacity may be subject to change in two years. For the first two years, the CM will reduce the client’s earnings loss benefits based on suitable productive employment opportunities within 75 km of the client’s home.

16. If the client still does not want to move after two years, the VRS may (based on the practicality of the worker’s individual circumstances) determine the client’s earning capacity in accordance with suitable productive employment in larger cities or towns. The CM will reduce the client’s earnings loss benefits based on suitable productive employment opportunities in larger cities or towns.

17. If the client wants to move after two years, and the move will reduce the amount of earnings loss benefits that the WCB pays, the VRS may approve the move.
Reduction or Suspension of Benefits

18. If the client does not participate in vocational planning or programming and the VRS is not able to estimate the client’s earning capacity, the CM and TL will authorize the suspension of earnings loss benefits (POL 07/2014, Suspension of Benefits).

Client Notification

19. When a client is placed on long-term earnings loss benefits, the CM will send the client a letter that states the amount of benefits and explains how the WCB determined that amount.

Act Sec # 51, 81, 101
Effective Date 01 December 2014
Application All clients.
Supersedes PRO 26/2010 Determination of Long-Term Loss of Earnings
Complements POL 15/2014 Determination of Long-Term Loss of Earnings
POL 02/2014 Vocational Rehabilitation – Moving Allowance
POL 07/2014 Suspension of Benefits
POL 01/2011 Vocational Rehabilitation – Programs and Services
PRO 01/2011 Vocational Rehabilitation – Programs and Services
POL 39/2010 Expenses – Travel & Sustenance – General
POL 26/90 Provincial Minimum Wage, Effect of Increase
4.1.4 Estimating Earning Capacity – Commissioned Sales and Self-Employment (PRO 09/2013)

Document Date 27 November 2013

Purpose To establish guidelines for estimating the earning capacity of workers in commissioned sales or self-employment.

BACKGROUND


2. The following procedure provides guidance for the implementation of POL 09/2013.

PROCEDURE

1. The Vocational Rehabilitation Specialist, Case Manager and Team Leader will make a joint decision as to whether the worker’s earning capacity should be estimated in accordance with POL 09/2013.

2. The estimated earning capacity will commence the first day of employment.

3. The Vocational Rehabilitation Specialist will explain the impact of the estimation and supply the worker with a detailed calculation of the estimation.

4. The Vocational Rehabilitation Specialist will monitor the actual earnings generated by the worker’s employment. Earnings loss benefits will end when:
   a. The worker’s estimated earning capacity exceeds earnings at the commencement of loss (Consumer Price Index adjusted to date); or
   b. The worker demonstrates the ability to generate actual earnings equal to or in excess of the earnings at the commencement of loss (Consumer Price Index adjusted to date) for a period of time sufficient to reasonable predict future earnings (typically two to four months).

ATTACHMENTS

Estimated Earning Capacity Example

<p>| Act Sec # | 69 |
| Effective Date | 01 January 2014 |
| Application | Claims on and after the effective date |
| Supersedes | n/a |</p>
<table>
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<td>POL 09/2013</td>
<td>Estimating Earning Capacity – Commissioned Sales and Self-Employment</td>
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<td>POL 01/2011</td>
<td>Vocational Rehabilitation – Programs and Services</td>
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<td>PRO 01/2011</td>
<td>Vocational Rehabilitation – Programs and Services</td>
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<tr>
<td>POL 07/2013</td>
<td>Consumer Price Index (CPI) – Annual Indexing</td>
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<td>POL 15/2014</td>
<td>Determination of Long-Term Loss of Earnings</td>
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<td>PRO 15/2014</td>
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<tr>
<td>POL 17/2010</td>
<td>Termination of Compensation Benefits – Notice</td>
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<td>PRO 17/2010</td>
<td>Termination of Compensation Benefits – Notice</td>
</tr>
<tr>
<td>PRO 11/2014</td>
<td>Vocational Rehabilitation – Self-Employment Plans</td>
</tr>
</tbody>
</table>
Estimated Earning Capacity Example

On January 4, 2012 the worker begins a job in commissioned sales or becomes self-employed. The WCB estimates the worker’s earning capacity to be zero until July 31, 2012.

August 1, 2012 to July 31, 2013 the worker’s earning capacity is estimated to be 50 percent of the average weekly wage.

August 1, 2013 to July 31, 2014 the worker’s earning capacity is estimated to be 75 percent of the average weekly wage.

August 1, 2014 to July 31, 2015 the worker’s earning capacity is estimated to be 100 percent of the average weekly wage.

August 1, 2015 to July 31, 2016 the worker’s earning capacity is estimated to be 125 percent of the average weekly wage.

August 1, 2016 and thereafter the worker’s earning capacity is estimated to be 150 percent of the average weekly wage.
4.1.5 Compensation Rate – Apprentices and On-The-Job Training (PRO 25/2014)

Document Date 10 December 2014

Purpose To establish guidelines for compensating workers who are injured while undergoing training or instruction.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 25/2014, Compensation Rate – Apprentices and On-The-Job Training.

2. The following procedure provides guidelines on calculating and adjusting the earnings base for a worker who was injured while participating in an apprenticeship or on-the-job training program.

PROCEDURE

1. A signed contract of agreement from the employer or the Saskatchewan Apprenticeship and Trade Certification Commission (SATCC) will be acquired by Operations staff to determine:

   a. The length of the worker’s program.
   b. The effective dates for wage increases.
   c. The anticipated end date, and
   d. The probable earnings the worker would have earned had the worker continued with, and successfully completed, the program.

2. In order to qualify for compensation, the effects of the injury must permanently prevent the worker from completing the apprenticeship or on-the-job training program. Workers who are able to resume their pre-injury apprenticeship or on-the-job training program will not qualify.

3. The worker’s earnings at the time of the injury will be used to establish the initial compensation benefits. The worker’s pre-injury earnings pattern may also be used to help predict the effective dates for wage increases and the anticipated end date for the apprenticeship or on-the-job training program.

4. Workers are to be advised in writing of their eligibility under Section 50 of The Workers’ Compensation Act, 2013 (the “Act”) and provided with an outline of their probable earnings and the dates in which their earnings will be adjusted.
5. Once eligibility is confirmed, the increases under Section 50 will reflect the increases and intervals found in the apprenticeship or on-the-job training agreement. On the anniversary of the commencement of loss of earnings, Consumer Price Index (CPI) adjustments will be applied to the increases under Section 50. A prorated CPI adjustment will apply if the adjusted amount has been in effect less than 12 months at the time of the CPI review.

6. Throughout the apprenticeship or on-the-job training program, Operations staff will perform a required comparison between the Section 50 increases (including any applicable CPI adjustments) and the original CPI-adjusted earnings. The worker’s benefits will be based on the greater of these two amounts.

7. On the first anniversary of the commencement of loss of earnings following the final Section 50 increase, a prorated adjustment based on the number of months between the final increase and the CPI review date will be required. Subsequent CPI adjustments will be based on the full CPI amount.

8. In addition to the comparison outlined in point 6, Operations staff will perform a comparison between the original CPI-adjusted earnings and the prorated adjustment stated in point 7. The greater of these two amounts will be the basis for the worker’s benefits.

Act Sec # 50, 69
Effective Date 01 January 2015.
Application All workers injured while participating in an Apprenticeship or On-the-Job Training program.
Supersedes PRO 21/2001 Compensation Rate – Apprentices and On-the-Job Training
Complements POL 25/2014 Compensation Rate – Apprentices and On-the-Job Training
POL 07/2013 Consumer Price Index (CPI) – Annual Indexing
PRO 60/2015 Consumer Price Index (CPI) – Annual Increase
4.1.8 Maximum Wage Rates – 2016 (PRO 08/2015)

Document Date 26 November 2015

Purpose To provide guidelines for adjusting the maximum wage rates.

BACKGROUND

Policy POL 08/2015, Maximum Wage Rates – 2016, has been approved which implements the maximum wage rates and annual adjustments.

PROCEDURE

Maximum Wage Rate Annual Adjustments

1. Increases to the maximum wage rates are calculated using Saskatchewan’s average weekly wage (AWW) published by Statistics Canada as of June of the preceding year.

2. For injuries sustained prior to January 1, 2014, the maximum wage rate is increased annually in accordance with the percentage increase in the AWW.
   a. Data Governance will calculate the percentage increase using the following formula:

   \[
   \text{Adjusted Amount} = \frac{\text{Amount to Be Adjusted}}{\text{Average Weekly Wage (current year)}} \times \frac{\text{Average Weekly Wage (current year)}}{\text{Average Weekly Wage (previous year)}}
   \]

   b. If the ratio between the average weekly wage for the current year and the average weekly wage for the previous year is less than 1.0, there will be no adjustment.

3. For injuries sustained on or after January 1, 2014, Data Governance will calculate the adjusted maximum wage rate each year in steps so that it is equal to 165% of Saskatchewan’s average wage for 2019.
   a. Every year thereafter, simple application of the annual percent change of AWW will ensure that this maximum wage rate remains at 165% of the AWW.

4. The adjusted maximum wage rates will be rounded to the nearest dollar.

Benefits and Annual Review Adjustments

5. An injured worker’s wage loss benefits at the commencement of loss will be based on the worker’s gross earnings prior to the commencement of loss of earnings (POL...
29/2010, Establishing Initial Wage Base) and will not exceed the maximum wage rate in effect when the injury occurred.

6. Workers with an injury date prior to January 1, 2014, will not qualify for the 2016 maximum of $58,941 until their anniversary date of commencement of loss.

7. Workers with an injury date on or after January 1, 2014 will not qualify for the 2016 maximum of $69,242 until their anniversary date of commencement of loss.

8. When calculating average weekly earnings for recurrent injuries that were initially sustained prior to January 1, 2014, the earnings will be subject to the maximum in effect during the year of the recurrence (see Table B or C below, subject to original injury date).

ATTACHMENTS

Table A – Maximum Wage Rate Adjustment Table

Table B – Maximum Wage Rate Table – Injuries On or After January 1, 2014

Table C – Maximum Wage Rate Table – Injuries September 1, 1985 to December 31, 2013

Table D – Maximum Wage Rate Table – Injuries Prior to September 1, 1985

<table>
<thead>
<tr>
<th>Act</th>
<th>Sec #</th>
<th>Effective Date</th>
<th>Application</th>
<th>Supersedes</th>
<th>Complements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2(1)(b), 2(1)(u), 37, 69, 72, 182</td>
<td>01 January 2016</td>
<td>All workers.</td>
<td>PRO 17/2014</td>
<td>Maximum Wage Rate – 2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>POL 08/2015</td>
<td>Maximum Wage Rate – 2016</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>POL 07/2013</td>
<td>Consumer Price Index (CPI) – Annual Indexing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>POL 07/2015</td>
<td>Maximum Assessable Wage Rate – 2016</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>POL 01/2007</td>
<td>Experience Rating Program</td>
<td></td>
</tr>
</tbody>
</table>
Table A
Maximum Wage Rate Adjustment Table

<table>
<thead>
<tr>
<th>Year</th>
<th>Provincial Average Weekly Wage (AWW)¹</th>
<th>Provincial Average Annual Wage</th>
<th>Section 182 AWW Percentage Change²</th>
<th>Section 37(3) Index Factor for Maximum Wage Rate on or After January 1, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>915.08</td>
<td>47,584.16</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2014</td>
<td>948.97</td>
<td>49,346.44</td>
<td>3.704%</td>
<td>n/a</td>
</tr>
<tr>
<td>2015</td>
<td>980.65</td>
<td>50,993.80</td>
<td>3.338%</td>
<td>10.390%</td>
</tr>
<tr>
<td>2016</td>
<td>977.91</td>
<td>50,851.32</td>
<td>-0.279%¹</td>
<td>6.310%</td>
</tr>
</tbody>
</table>

9. Uses June revised average weekly wages which are available in Bureau of Statistics October Statistical Review.

10. The percentage adjustment will be rounded to three digits. Third digit to be increased by one unit if fourth digit is greater than four (Section 182(2)).

11. It is the Board’s intent that if the ratio between the average weekly wage for the current year and the average weekly wage for the previous year is less than 1.0, there will be no adjustment.
Table B
Maximum Wage Rate – Injuries On or After January 1, 2014

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Maximum Wage Rate</th>
<th>Maximum Monthly Wage</th>
<th>Maximum Monthly Compensation</th>
<th>Maximum Weekly Wage</th>
<th>Maximum Weekly Comp</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 01, 2014</td>
<td>59,000</td>
<td>4,916.67</td>
<td>4,425.00</td>
<td>1,134.62</td>
<td>1,021.15</td>
</tr>
<tr>
<td>January 01, 2015</td>
<td>65,130</td>
<td>5,427.50</td>
<td>4,884.75</td>
<td>1,252.50</td>
<td>1,127.25</td>
</tr>
<tr>
<td>January 01, 2016</td>
<td>69,242</td>
<td>5,770.17</td>
<td>5,193.15</td>
<td>1,331.58</td>
<td>1,198.42</td>
</tr>
</tbody>
</table>

12. As per Sections 2(1)(k) and 68 of the Act, a worker’s net earnings will be calculated based on gross earnings from employment, less the probable deductions for tax credits and/or tax exemptions. Probable deductions will be based upon the information that the worker has authorized the employer to deduct from his/her employment earnings for income tax purposes and which is available as of the commencement of the loss of earnings (POL 03/2007 and PRO 60/2013, Calculation of Net Compensation Payable).

13. Adjusted maximum wage rates will be rounded to the nearest dollar (Section 182(3)).
Table C
Maximum Wage Rate – Injuries September 1, 1985 to December 31, 2013

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Maximum Wage Rate</th>
<th>Maximum Monthly Wage</th>
<th>Maximum Monthly Compensation</th>
<th>Maximum Weekly Wage</th>
<th>Maximum Weekly Comp</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 1, 1985</td>
<td>48,000</td>
<td>4,000.00</td>
<td>3,600.00</td>
<td>923.08</td>
<td>830.77</td>
</tr>
<tr>
<td>January 01, 2003</td>
<td>51,900</td>
<td>4,325.00</td>
<td>3,892.50</td>
<td>998.08</td>
<td>898.27</td>
</tr>
<tr>
<td>January 01, 2004</td>
<td>53,000</td>
<td>4,416.67</td>
<td>3,975.00</td>
<td>1,019.23</td>
<td>917.31</td>
</tr>
<tr>
<td>January 01, 2005</td>
<td>55,000</td>
<td>4,583.33</td>
<td>3,437.50</td>
<td>1,057.70</td>
<td>951.93</td>
</tr>
<tr>
<td>January 01, 2006</td>
<td>55,000</td>
<td>4,583.33</td>
<td>3,437.50</td>
<td>1,057.70</td>
<td>951.93</td>
</tr>
<tr>
<td>January 01, 2007</td>
<td>55,000</td>
<td>4,583.33</td>
<td>3,437.50</td>
<td>1,057.70</td>
<td>951.93</td>
</tr>
<tr>
<td>January 01, 2008</td>
<td>55,000</td>
<td>4,583.33</td>
<td>3,437.50</td>
<td>1,057.70</td>
<td>951.93</td>
</tr>
<tr>
<td>January 01, 2009</td>
<td>55,000</td>
<td>4,583.33</td>
<td>3,437.50</td>
<td>1,057.70</td>
<td>951.93</td>
</tr>
<tr>
<td>January 01, 2010</td>
<td>55,000</td>
<td>4,583.33</td>
<td>3,437.50</td>
<td>1,057.70</td>
<td>951.93</td>
</tr>
<tr>
<td>January 01, 2011</td>
<td>55,000</td>
<td>4,583.33</td>
<td>3,437.50</td>
<td>1,057.70</td>
<td>951.93</td>
</tr>
<tr>
<td>January 01, 2012</td>
<td>55,000</td>
<td>4,583.33</td>
<td>3,437.50</td>
<td>1,057.70</td>
<td>951.93</td>
</tr>
<tr>
<td>January 01, 2013</td>
<td>55,000</td>
<td>4,583.33</td>
<td>3,437.50</td>
<td>1,057.70</td>
<td>951.93</td>
</tr>
<tr>
<td>January 01, 2014</td>
<td>57,037</td>
<td>4,753.08</td>
<td>4,277.78</td>
<td>1,096.87</td>
<td>987.18</td>
</tr>
<tr>
<td>January 01, 2015</td>
<td>58,941</td>
<td>4,911.75</td>
<td>4,420.58</td>
<td>1,133.48</td>
<td>1,020.13</td>
</tr>
<tr>
<td>January 01, 2016³</td>
<td>58,941</td>
<td>4,911.75</td>
<td>4,420.58</td>
<td>1,133.48</td>
<td>1,020.13</td>
</tr>
</tbody>
</table>

14. As per Sections 2(1)(k) and 68 of the Act, a worker’s net earnings will be calculated based on gross earnings from employment, less the probable deductions for tax credits and/or tax exemptions. Probable deductions will be based upon the information that the worker has authorized the employer to deduct from his/her employment earnings for income tax purposes and which is available as of the commencement of the loss of earnings (POL 03/2007 and PRO 60.2013, Calculation of Net Compensation Payable).

15. Adjusted maximum wage rates will be rounded to the nearest dollar (Section 182(3)).

16. It is the Board’s intent that if the ratio between the average weekly wage for the current year and the average weekly wage for the previous year is less than 1.0, there will be no adjustment. Therefore, the 2016 maximum wage rate for injuries sustained prior to January 1, 2014 will remain at $58,941.
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Maximum Wage Rate</th>
<th>Monthly Wage</th>
<th>Monthly Compensation</th>
<th>Weekly Wage</th>
<th>Weekly Comp</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 01, 1948</td>
<td>3,000</td>
<td>250.00</td>
<td>187.50</td>
<td>57.69</td>
<td>43.27</td>
</tr>
<tr>
<td>January 01, 1953</td>
<td>4,000</td>
<td>33.33</td>
<td>250.00</td>
<td>76.92</td>
<td>57.69</td>
</tr>
<tr>
<td>July 01, 1956</td>
<td>5,000</td>
<td>416.67</td>
<td>312.50</td>
<td>96.15</td>
<td>72.11</td>
</tr>
<tr>
<td>July 01, 1960</td>
<td>6,000</td>
<td>500.00</td>
<td>375.00</td>
<td>115.38</td>
<td>86.54</td>
</tr>
<tr>
<td>July 01, 1968</td>
<td>6,600</td>
<td>550.00</td>
<td>412.50</td>
<td>126.92</td>
<td>95.19</td>
</tr>
<tr>
<td>July 01, 1972</td>
<td>8,400</td>
<td>700.00</td>
<td>525.00</td>
<td>161.54</td>
<td>121.16</td>
</tr>
<tr>
<td>July 01, 1974</td>
<td>10,000</td>
<td>833.33</td>
<td>625.00</td>
<td>192.31</td>
<td>144.23</td>
</tr>
<tr>
<td>January 01, 1976</td>
<td>14,000</td>
<td>1,166.67</td>
<td>875.00</td>
<td>269.23</td>
<td>201.92</td>
</tr>
<tr>
<td>January 01, 1977</td>
<td>16,000</td>
<td>1,333.33</td>
<td>1,000.00</td>
<td>307.69</td>
<td>230.77</td>
</tr>
<tr>
<td>January 01, 1978</td>
<td>18,000</td>
<td>1,500.00</td>
<td>1,125.00</td>
<td>346.15</td>
<td>259.61</td>
</tr>
<tr>
<td>January 01, 1979</td>
<td>20,000</td>
<td>1,666.67</td>
<td>1,250.00</td>
<td>384.62</td>
<td>288.47</td>
</tr>
<tr>
<td>January 01, 1980</td>
<td>22,000</td>
<td>1,833.33</td>
<td>1,375.00</td>
<td>423.08</td>
<td>317.31</td>
</tr>
<tr>
<td>January 01, 1981</td>
<td>24,000</td>
<td>2,000.00</td>
<td>1,500.00</td>
<td>461.54</td>
<td>346.16</td>
</tr>
<tr>
<td>January 01, 1982</td>
<td>26,000</td>
<td>2,166.67</td>
<td>1,625.00</td>
<td>500.00</td>
<td>375.00</td>
</tr>
<tr>
<td>January 01, 1983</td>
<td>29,000</td>
<td>2,416.68</td>
<td>1,812.50</td>
<td>557.69</td>
<td>418.27</td>
</tr>
<tr>
<td>January 01, 1984</td>
<td>33,000</td>
<td>2,750.00</td>
<td>2,062.50</td>
<td>634.62</td>
<td>475.97</td>
</tr>
<tr>
<td>January 01, 1985</td>
<td>33,000</td>
<td>2,750.00</td>
<td>2,062.50</td>
<td>634.62</td>
<td>475.97</td>
</tr>
<tr>
<td>January 01, 1986</td>
<td>34,000</td>
<td>2,833.33</td>
<td>2,125.00</td>
<td>653.85</td>
<td>490.39</td>
</tr>
<tr>
<td>January 01, 1987</td>
<td>34,000</td>
<td>2,833.33</td>
<td>2,125.00</td>
<td>653.85</td>
<td>490.39</td>
</tr>
<tr>
<td>January 01, 1988</td>
<td>35,000</td>
<td>2,916.67</td>
<td>2,187.49</td>
<td>673.08</td>
<td>504.81</td>
</tr>
<tr>
<td>January 01, 1989</td>
<td>37,000</td>
<td>3,083.33</td>
<td>2,312.50</td>
<td>711.54</td>
<td>533.66</td>
</tr>
<tr>
<td>January 01, 1990</td>
<td>37,000</td>
<td>3,083.33</td>
<td>2,312.50</td>
<td>711.54</td>
<td>533.66</td>
</tr>
<tr>
<td>January 01, 1991</td>
<td>37,000</td>
<td>3,083.33</td>
<td>2,312.50</td>
<td>711.54</td>
<td>533.66</td>
</tr>
<tr>
<td>January 01, 1992</td>
<td>40,000</td>
<td>3,333.33</td>
<td>2,500.00</td>
<td>769.24</td>
<td>576.93</td>
</tr>
<tr>
<td>January 01, 1993</td>
<td>41,000</td>
<td>3,416.66</td>
<td>2,562.49</td>
<td>788.46</td>
<td>591.34</td>
</tr>
<tr>
<td>January 01, 1994</td>
<td>41,000</td>
<td>3,416.66</td>
<td>2,562.49</td>
<td>788.46</td>
<td>591.34</td>
</tr>
<tr>
<td>January 01, 1995</td>
<td>41,000</td>
<td>3,416.66</td>
<td>2,562.49</td>
<td>788.46</td>
<td>591.34</td>
</tr>
<tr>
<td>January 01, 1996</td>
<td>42,000</td>
<td>3,500.00</td>
<td>2,625.00</td>
<td>807.70</td>
<td>605.77</td>
</tr>
<tr>
<td>Effective Date</td>
<td>Maximum Wage Rate</td>
<td>Monthly Wage</td>
<td>Monthly Compensation</td>
<td>Weekly Wage</td>
<td>Weekly Comp</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------</td>
<td>--------------</td>
<td>----------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>January 01, 1997</td>
<td>43,000</td>
<td>3,583.33</td>
<td>2,687.50</td>
<td>826.93</td>
<td>620.20</td>
</tr>
<tr>
<td>January 01, 1998</td>
<td>43,000</td>
<td>3,583.33</td>
<td>2,687.50</td>
<td>826.93</td>
<td>620.20</td>
</tr>
<tr>
<td>January 01, 1999</td>
<td>44,000</td>
<td>3,666.67</td>
<td>2,750.00</td>
<td>846.15</td>
<td>634.61</td>
</tr>
<tr>
<td>January 01, 2000</td>
<td>45,000</td>
<td>3,750.00</td>
<td>2,812.50</td>
<td>865.38</td>
<td>649.04</td>
</tr>
<tr>
<td>January 01, 2001</td>
<td>46,000</td>
<td>3,833.33</td>
<td>2,875.00</td>
<td>884.62</td>
<td>663.47</td>
</tr>
<tr>
<td>January 01, 2002</td>
<td>47,000</td>
<td>3,916.67</td>
<td>2,937.50</td>
<td>903.85</td>
<td>677.89</td>
</tr>
<tr>
<td>January 01, 2003</td>
<td>49,000</td>
<td>4,083.33</td>
<td>3,062.49</td>
<td>942.31</td>
<td>706.73</td>
</tr>
<tr>
<td>January 01, 2004</td>
<td>51,000</td>
<td>4,250.00</td>
<td>3,187.50</td>
<td>980.78</td>
<td>735.58</td>
</tr>
<tr>
<td>January 01, 2005</td>
<td>52,000</td>
<td>4,333.33</td>
<td>3,250.00</td>
<td>1,000.01</td>
<td>750.01</td>
</tr>
<tr>
<td>January 01, 2006</td>
<td>54,000</td>
<td>4,500.00</td>
<td>3,375.00</td>
<td>1,038.47</td>
<td>778.85</td>
</tr>
<tr>
<td>January 01, 2007(^1)</td>
<td>55,000</td>
<td>4,583.33</td>
<td>3,437.50</td>
<td>1,057.70</td>
<td>793.28</td>
</tr>
<tr>
<td>January 01, 2014</td>
<td>57,037</td>
<td>4,753.08</td>
<td>3,564.81</td>
<td>1,096.87</td>
<td>822.65</td>
</tr>
<tr>
<td>January 01, 2015</td>
<td>58,941</td>
<td>4,911.75</td>
<td>3,683.81</td>
<td>1,133.48</td>
<td>850.11</td>
</tr>
<tr>
<td>January 01, 2016(^2)</td>
<td>58,941</td>
<td>4,911.75</td>
<td>3,683.81</td>
<td>1,133.48</td>
<td>850.11</td>
</tr>
</tbody>
</table>

1. Maximum was subject to Section 38.1 of The Workers’ Compensation Act, 1979 that limited the maximum compensation rate to $55,000 from 2007 to 2013.

2. It is the Board’s intent that if the ratio between the average weekly wage for the current year and the average weekly wage for the previous year is less than 1.0, there will be no adjustment. Therefore, the 2016 maximum wage rate for injuries sustained prior to January 1, 2014 will remain at $58,941.
DEFINITION

**Average Weekly Wage** is determined by the Workers' Compensation Board (WCB) for a calendar year. The average weekly wage is Saskatchewan’s industrial composite wage published by Statistics Canada as of June of the preceding year (Section 2 of *The Workers’ Compensation Act, 2013* (the “Act”)).

BACKGROUND

1. Each year the WCB reviews the minimum average earnings of a worker injured on or after January 1, 1980 (Section 70(5)).
2. Starting January 1, 1983, minimum average weekly earnings are not to be less than two-thirds of the average weekly wage as of June the year before the benefit review for any worker who is:
   a. Injured on or after January 1, 1980, and
   b. Is in receipt of benefits for at least 24 consecutive months.
3. The provincial average weekly wage as of June 2015 was $977.91, which is a decrease from the 2015 average weekly earnings of $980.65. It is the Board’s intent that if the ratio between the average weekly wage for the current year and the average weekly wage for the previous year is less than 1.0, there will be no adjustment.

PROCEDURE

Effective January 1, 2016, the minimum average weekly earnings for any worker who is:
   a. Injured on or after January 1, 1980, and
   b. Is in receipt of benefits for a period of at least 24 consecutive months,
will not be less than $653.77.
ATTACHMENTS

Minimum Average Weekly Earnings Table for Injured Workers in Receipt of Compensation for at Least Twenty-Four Consecutive Months

<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>2(1)(b), 70(5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Date</td>
<td>01 January 2016</td>
</tr>
<tr>
<td>Application</td>
<td>All claims occurring on or after January 1, 1980 for workers receiving compensation for at least 24 consecutive months.</td>
</tr>
<tr>
<td>Supersedes</td>
<td>POL 56/2014 Minimum Average Weekly Earnings – Section 70(5) – 2015</td>
</tr>
<tr>
<td>Complements</td>
<td>POL 28/2010 Minimum Average Weekly Earnings – Section 70(5)</td>
</tr>
<tr>
<td></td>
<td>PRO 57/2015 Minimum Compensation – Section 75 – 2016</td>
</tr>
</tbody>
</table>
### Minimum Average Weekly Earnings Table for Injured Workers in Receipt of Compensation for at Least Twenty-Four Consecutive Months

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Annual Earnings</th>
<th>Monthly Earnings</th>
<th>Weekly Earnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 January 1985</td>
<td>13,500.24</td>
<td>1,125.02</td>
<td>259.62</td>
</tr>
<tr>
<td>01 January 1986</td>
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* Saskatchewan’s average weekly wage decreased; therefore the 2016 minimum average weekly earnings is maintained at the 2015 level.
DEFINITION

Average Weekly Wage is determined by the Workers’ Compensation Board (WCB) for a calendar year. The average weekly wage is Saskatchewan’s industrial composite wage published by Statistics Canada as of June of the preceding year (Section 2 of The Workers’ Compensation Act, 2013).

Totally unable to work (Section 75) means that due to the injury, the worker cannot:
   a. Perform any work, or
   b. Take part in a return-to-work (RTW) plan, or part-time or supernumerary work.

Absences for medical appointments are not considered being totally unable to work.

BACKGROUND

1. Each year the WCB will review the minimum benefits for any worker who is:
   a. Injured on or after January 1, 1980, and
   b. Is totally unable to work.

2. Starting January 1, 1983, minimum benefits will be:
   a. Not less than 50 percent of the average weekly wage as of June in the year before the benefit review, or
   b. Where the worker’s average earnings are less than that amount, the amount of those earnings.

3. The provincial average weekly wage as of June 2015 was $977.91, which is a decrease from the 2015 average weekly earnings of $980.65. It is the Board’s intent that if the ratio between the average weekly wage for the current year and the average weekly wage for the previous year is less than 1.0, there will be no adjustment.
PROCEDURE

1. Effective January 1, 2016, minimum benefits for any worker who is totally unable to work will be:
   a. Not less than $490.33 per week, or
   b. The amount of the worker's average earnings.

ATTACHMENTS

Minimum Compensation Table for Workers Totally Unable to Work

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Supersedes

- PRO 57/2014 Minimum Compensation (Section 75) – 2015

Complements

- POL 28/2010 Compensation Rate – Minimum and Average Weekly Earnings
- POL 35/2010 Compensation Rate – Casual and Seasonal Employment – Section 70(4)
- PRO 58/2015 Minimum Average Weekly Earnings (Section 70(5)) – 2016
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Note: Numbers may not sum to totals due to rounding.

* Saskatchewan’s average weekly wage decreased; therefore the 2016 minimum average weekly earnings amount is maintained at the 2015 level.
**4.1.13 Offset of Canada or Quebec Pension Plan Disability Benefits (PRO 24/2013)**

**Document Date** 18 December 2013

**Purpose** To establish guidelines for deducting Canada or Quebec Pension Plan (CPP/QPP) Disability Benefits from loss of earnings benefits.

---

**BACKGROUND**

The Workers’ Compensation Board (WCB) establishes its authority under POL 24/2013 to reduce benefits if the client is receiving Canada or Quebec Pension Plan benefits related to the compensable work injury or death.

**PROCEDURE**

1. On the first anniversary of the commencement of loss of earnings, 50 percent of CPP/QPP benefits will be considered as wages in calculating the compensation paid by the WCB. Operations staff will use this amount to offset loss of earnings benefits.
   
   a. For an injured worker who is receiving CPP/QPP benefits related to the compensable work injury, offset will be effective on the first anniversary of the commencement of loss of earnings.
   
   b. For the surviving spouse who is receiving CPP/QPP benefits related to a compensable death, offset will be effective on the first anniversary of the spousal benefits.

2. Operations staff will not reduce WCB payments without first determining, either by documentation from the Canada or Quebec Pension Plan or a signed declaration from the worker or the worker’s surviving spouse indicating that he/she is actually receiving CPP/QPP benefits, and at what level.

3. If a client is entitled to receive CPP/QPP benefits but is not yet in receipt of them, wage loss benefits will be paid to the worker or the worker’s surviving spouse without offset until the client receives the CPP/QPP benefits. However, clients will be told in advance of the possibility of an overpayment created by retroactive entitlement to CPP/QPP benefits.

4. Overpayments created through retroactive CPP/QPP benefit entitlement will be recovered in accordance with PRO 38/2010, Overpayment Recovery – Compensation.
Indexing

5. CPP/QPP benefits are subject to CPI increases determined by Employment and Social Development Canada (ESDC – Service Canada) effective January 1st of each year. However, Operations staff will adjust the amount of CPP/QPP offset on the client’s anniversary of the commencement of loss of earnings during annual review.

6. If a worker’s or the worker’s surviving spouse’s CPP/QPP benefits are decreased by the Canada or Quebec Pension Plan, Operations staff will adjust wage loss benefits during annual review to reflect the new CPP/QPP amount.

Indexing When Client Not Subject to Full CPP/QPP Offset

7. Benefits indexed for annual CPI adjustments are not to exceed the maximum wage rate at the time of calculation (POL 08/2015, Maximum Wage Rates). Where the CPI adjustment is limited during the annual benefit review, Operations staff will complete a partial offset of CPP/QPP benefits.

8. In situations where the worker’s or the worker’s surviving spouse wage loss benefits were not subject to a full CPP/QPP offset at the previous review due to the maximum wage rate, Operations staff will adjust the CPP/QPP offset at the current review to reflect only the latest CPP/QPP rate increase.

9. Operations staff will:
   a. Adjust the CPP/QPP offset by applying the percentage increase for the CPP/QPP that was set January 1 prior to the client’s annual review, to the client’s CPP/QPP level that was established at their prior year’s annual review.
   b. The adjusted offset will be effective on the date the client’s wage base is adjusted.
   c. The CPP/QPP offset will continue to be adjusted by the annual CPP/QPP percentage increase in each year the worker or worker’s surviving spouse qualifies for an increase in their wage base.

Indexing When Client Receives Estimate Wage Loss Benefits

10. Where a worker qualifies for CPP/QPP benefits and is in receipt of WCB estimated wage loss benefits (less than full benefits), Operations staff will pro-rate the amount of CPP/QPP benefits:

\[
\text{Pre-injury wage base (weekly)} - \frac{\text{Estimated wage earning capacity (weekly)}}{\text{Pre-injury wage base (weekly)}} \times \text{CPP Benefit Payment}
\]
Example
Worker’s pre-injury wage base (weekly): $500
Worker’s estimated wage earning capacity (weekly): $300
Difference $200

\[
\frac{200}{500} = 40\%
\]

40% X CPP benefit payment = CPP benefits payable for a work injury or death.

50 percent of the CPP/QPP benefits payable for a work injury or death are considered earnings for offset purposes.

Minimum Compensation

11. Operations staff will not deduct CPP/QPP benefits if the worker or the worker’s surviving spouse is receiving minimum wage loss benefits or actual earnings, if less.

12. Partial offset will occur if full offset would reduce wage loss benefits below minimum compensation.

Dependents

13. Operations staff will not include any CPP/QPP benefits payable to, or on behalf of, dependent children when calculating the offset.

Act Sec # 2(1)(i), 67, 69, 70(5), 74, 75, 77, 81(1)(b), 83, 84, 85, 89, 95
Effective Date 01 January 2014
Application All claims
Supersedes

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<td>Maximum Earners – Consumer Price Index and Canada Pension Plan Benefits</td>
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Complements

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Benefits to Worker – Benefit Calculations Section 4 – Page 37
4.1.16 Adjusting Original Wage – Injuries Before 1980 (PRO 03/2015)

Document Date
16 March 2015

Purpose
To show how to adjust the original wage base of a worker injured before 1980.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 03/2015, Adjusting Original Wage – Injuries Before 1980.

2. This procedure provides rules on how to apply POL 03/2015.

PROCEDURE

1. From the year of injury to 1979, the Payment Specialist will increase the original wage by the percentage change in the average weekly wage.

2. On the date of injury each year after 1979, the Payment Specialist will increase the original wage by changes in the Consumer Price Index (CPI).

ATTACHMENTS

Adjusting Original Wage by CPI: Calculation Sheet

Act Sec # 2(1)(b), 69(2), 72, 76, 95
Effective Date 01 May 2015
Application Workers under the age of 65 on January 1, 1983, injured prior to January 1, 1980, that qualify for earnings loss entitlement after January 1, 1983 and are under the age of 65
Supersedes N/A
Complements POL 03/2015 Adjusting Original Wage – Injuries Before 1980
PRO 60/2015 Consumer Price Index (CPI) – Annual Increase
POL 07/2013 Consumer Price Index (CPI) – Annual Indexing
POL 08/2015 Maximum Wage Rates
POL 24/2013 Offset of Canada or Quebec Pension Plan Disability Benefits
Adjusting Original Wage by CPI: Calculation Sheet

(A) Weekly wage at injury $_____________/Week

(B) Maximum weekly wage based on date of injury – 1930 to 1979

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<td>1958</td>
<td>$98.34</td>
</tr>
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<td>$102.56</td>
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<td>$115.38</td>
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<td>$115.53</td>
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<td>$121.83</td>
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<td>$127.35</td>
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<table>
<thead>
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<th>Year</th>
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<td>1966</td>
<td>$127.35</td>
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<td>$133.50</td>
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</table>

(C) Increasing factor based on date of injury – 1930 to 1979

<table>
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<td>1942</td>
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<td>5.91</td>
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<td>1954</td>
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<td>1955</td>
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<table>
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<th>CPI Factor</th>
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</thead>
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<td>1961</td>
<td>3.71</td>
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<td>1962</td>
<td>3.58</td>
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<td>1963</td>
<td>3.48</td>
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<td>1964</td>
<td>3.40</td>
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<td>3.25</td>
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<td>1966</td>
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<tr>
<td>1967</td>
<td>2.88</td>
</tr>
<tr>
<td>1968</td>
<td>2.70</td>
</tr>
</tbody>
</table>
(D) Original wage adjusted to 1979

\[
\frac{\text{Original wage}}{\text{Lesser of (A) or (B)}} \times \frac{x}{\text{(C)}} = \frac{\text{Lesser of (A) or (B)}}{\text{(D)}}
\]

(E) Original wage adjusted to December 31, 1984

1. \[
\frac{(D)}{\text{(1979 CPI)}} \times 10.00\% = \frac{\text{(Increase)}}{\text{(D)}} + \frac{\text{(Increase)}}{\text{(1980 adjusted wage)}}
\]
2. \[
\frac{(G)}{\text{(1980 CPI)}} = \frac{\text{Lesser of}}{\text{(G)}} + \frac{\text{Lesser of (H) or (G)}}{\text{(1981 adjusted wage)}}
\]
3. \[
\frac{(H)}{\text{(1981 CPI)}} \times 11.00\% = \frac{\text{(Increase)}}{\text{(H)}} + \frac{\text{Lesser of (I) or (H)}}{\text{(1982 adjusted wage)}}
\]
4. \[
\frac{(I)}{\text{(1982 CPI)}} \times 7.20\% = \frac{\text{(Increase)}}{\text{(I)}} + \frac{\text{Lesser of (J) or (I)}}{\text{(1983 adjusted wage)}}
\]
5. \[
\frac{(J)}{\text{(1983 CPI)}} \times 6.00\% = \frac{\text{(Increase)}}{\text{(J)}} + \frac{\text{Lesser of (K) or (J)}}{\text{(1984 adjusted wage)}}
\]

**The WCB will continue this calculation to date**
BACKGROUND

1. POL 06/2009, Benefits – Clients in Transition from WCB to SGI Benefits outlines the responsibilities for SGI and the WCB, under the Memorandum of Agreement for the Benefit Determination Process, with respect to payment of benefits to workers who have been injured in a non-work-related motor vehicle accident either prior, or subsequent, to sustaining a work-related injury.

2. This procedure provides guidelines to ensure compliance with the Memorandum of Agreement for the Benefit Determination Process between SGI and the WCB.

PROCEDURE

1. Where notification is received that a worker has been involved in a motor vehicle accident, and Operations staff determine that the worker qualifies for benefits under Injuries – Travelling for or Attending Medical Aid or Return-to-Work Programming (POL 04/2011), benefits for any injuries sustained as result of the motor vehicle accident will be the responsibility of the WCB as the first payer.

2. Where the worker is currently receiving benefits from the WCB and is involved in a non-work-related motor vehicle accident, the WCB will continue to be the first payer of benefits. Operations staff will contact SGI to make a joint decision as to which injury is the primary disabling factor and, as a result, which agency will be responsible for issuing benefits.

3. Operations staff will obtain and review all relevant medical records in order to determine whether the injuries sustained in the motor vehicle accident will prolong recovery from the work injury (POL 01/2000, Pre-Existing Conditions – Section 49).

4. Once a joint decision has been made between SGI and the WCB distinguishing between work-related and motor vehicle injuries, the WCB will notify SGI where any benefits have been paid in regards to the non-work-related injury. Payments received from SGI in recognition of this are to be handled by Finance and are to be credited to the work injury claim to ensure the employer's cost experience rating is not negatively affected.
5. Where payment is not received by SGI, costs will be charged to the Second Injury and Re-Employment Fund and a determination of ongoing benefit entitlement will be made.

6. If WCB and SGI staff cannot agree on which injury is the intervening cause preventing the worker from returning to employment, the issue will be decided in accordance with the escalation process outlined in the agreement between SGI and the WCB.

Act Sec # n/a
Effective Date 01 September 2009
Amended References updated 01 January 2014 in accordance with The Worker’s Compensation Act, 2013
Application All workers who are attempting to establish entitlement to SGI benefits as a result of a non-work-related motor vehicle accident
Supersedes n/a
Complements

| POL 06/2009 | Benefits – Clients in Transition from WCB to SGI Benefits |
| POL 01/2000 | Pre-Existing Conditions – Section 49 |
| POL 04/2011 | Injuries – Travelling for or Attending Medical Aid or Return-to-Work Programming |
| POL 07/2014 | Suspension of Benefits |
| PRO 07/2014 | Suspension of Benefits |
**4.1.20 Compensation Rate - Casual and Seasonal Employment – Section 70(4) (PRO 35/2010)**

**Document Date** 17 November 2010

**Purpose** To establish the wage base for part-time, casual and seasonal workers.

**BACKGROUND**

1. The Workers’ Compensation Board (WCB) has approved policy guidelines regarding the establishment of the appropriate wage rate for part-time, casual and seasonal workers.

2. This procedure provides guidelines to establish a wage rate for part-time, casual and seasonal workers.

**PROCEDURE**

1. The Claims Entitlement Specialist or Case Manager will base wage loss benefits on the worker’s gross earnings prior to the commencement of earnings loss or recurrence. PRO 29/2010, Establishing Initial Wage Base, will apply.

2. The Claims Entitlement Specialist or Case Manager will identify the potential Section 70(4) adjustment by entering a notation in the folder notes, “Potential 70(4).”

3. Case Management Support – 2 to 6 weeks from the commencement of earnings loss:
   
   a. Case Management Support, at time of file review following referral from Claims Entitlement Services, will enter a notation in the Recovery and Return to Work Summary (RRWS), identifying the potential Section 70(4) adjustment.
   
   b. Case Management Support will create an activity, for 13 weeks following first date of loss.

4. Case Manager – 2 to 6 weeks from the commencement of earnings loss:
   
   a. Following referral from Case Management Support, where it has been indicated there is potential for a Section 70(4) adjustment, Case Managers will review and determine whether the original wage base at the commencement of earnings loss or recurrence is inequitable as defined in POL 35/2010, Compensation Rate – Casual and Seasonal Employment – Section 70(4). They will record their decision and reasoning in their Recovery and Return to Work Plan (RRP).
   
   b. Case Managers, where an adjustment has been identified, will include a paragraph in the Letter of Claims Acceptance (LCA) to explain the Section 70(4)
provisions indicating that an adjustment to wage loss benefits, including the reasons for the adjustment, may be necessary.

5. Case Management Support – 13 weeks from the commencement of earnings loss:
   a. Case Management Support will review the work activity at 13 weeks following the commencement of earnings loss. The RRP will be reviewed to determine whether the Case Manager considered the original wage base inequitable as defined in POL 35/2010, Compensation Rate – Casual and Seasonal Employment – Section 70(4).
   b. Where Section 70(4) of the Act applies and the wage base is considered inequitable, Case Management Support will gather wage information for 12 month gross earnings for a worker regularly employed in similar employment. In cases where the injured worker was regularly employed with the employer for more than 12 months, albeit on a seasonal basis, the earnings of the injured worker with this employer for the 12 months prior to the injury may be used to establish the wage base under Section 70(4) of the Act. Otherwise, the wage information should be based on an average of several workers in that type of employment and should be determined sequentially as follows:
      i. The first effort will be with the injury employer;
      ii. The second level effort, where the first is unsuccessful, will be with several employers in the same geographical region; and
      iii. Where levels one and two are not successful, a wage table developed from Statistics Canada or other relevant agencies will be consulted. The table will be available to workers when used to establish a wage base;
   c. For comparative purposes, Case Management Support will ensure information is obtained regarding the injured worker’s gross earnings from all sources for the full 12 months prior to the commencement of earnings loss as called for by Section 70(1)(a) of the Act;
   d. Case Management Support will refer the wage information to the Payment Specialist.

6. Payment Specialist – 14 weeks from the commencement of earnings loss:
   a. The Payment Specialist will use the wage information from Case Management Support to calculate the new wage base and compensation rate and ensure the information is placed on file;
   b. The effective date of the adjusted wage base is to be the 1\textsuperscript{st} workday of the 27\textsuperscript{th} week of compensation;
   c. The Payment Specialist will create a work activity for 24 weeks from the commencement of earnings loss and refer the file back to Case Management Support.

7. Case Management Support – 15 weeks from the commencement of earnings loss:
a. Case Management Support will review the activity from the Payment Specialist and issue the Section 70(4) form letter that will provide the adjusted wage loss benefit amount and an explanation of the reasons for the adjustment to wage loss benefits.

8. Case Manager – 24 weeks from the commencement of earnings loss:

a. The Case Manager will confirm the effective date of the new wage base with the injured worker making certain that the reasons for the adjustment are explained.

**Act Sec #** 18, 20, 23, 68, 70(1), 70(4)

**Effective Date** 01 January 2011

**Amended** References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

**Application** All claims for casual, part-time and seasonal workers.

**Supersedes** PRO 10/2003 Average Weekly Earnings – Section 70(4)

**Complements** POL 35/2010 Compensation Rate – Casual and Seasonal Employment – Section 70(4)

POL 29/2010 Establishing Initial Wage Base

POL 29/2010 Establishing Initial Wage Base

POL 28/2010 Compensation Rate – Minimum and Average Weekly Earnings

POL 24/2013 Offset of Canada or Quebec Pension Plan Disability Benefits

POL 18/87 Compensation Rate – Excluded Earnings

POL 08/2007 Compensation Rate – Where no earnings at disablement or death

POL 08/2015 Maximum Wage Rates

PRO 58/2015 Minimum Average Weekly Earnings – Section 70(5)

PRO 57/2015 Minimum Compensation – Section 75
4.1.21 Consumer Price Index (CPI) – Annual Increase (PRO 60/2015)

Document Date 18 December 2015
Purpose To increase 2016 benefits based on changes to the CPI.

BACKGROUND

1. Section 69 of The Workers’ Compensation Act, 2013 (the “Act”) requires that compensation being paid for loss of earning capacity under Sections 68(1), 71 and 72 be adjusted annually by the percentage increase in the Consumer Price Index (CPI).

2. The basis for the annual CPI adjustment is the average of percentage increases in the Regina and Saskatoon All-Items CPI for the 12 months ending on November 30 in each year. In any given year, if there is no change in the CPI, or if it decreases, it will not be adjusted for that year.

3. CPI adjustments will also be made to the following expenses and allowances:
   a. Burial expense, rounded to the nearest dollar (Section 80).
   b. Dependent and sole dependent children (Sections 83 and 85(1)).
   c. Spousal supplement, former Act claims (Section 89(2)).
   e. Eyeglass frames, rounded to the nearest dollar (POL 17/2008, Expenses – Orthotics/Appliances – Provision, Replacement and Repair).
   f. Personal Care Allowance, rounded to the nearest dollar (POL 05/2000, Allowance – Personal Care).
   g. Travel and sustenance allowances for vocational rehabilitation programs (POL 39/2010, Expenses – Travel and Sustenance – General).
   h. Minimum annuity amount (POL 13/2013, Annuities).

4. Adjustments to compensation benefits and other allowances that are based on the CPI increase can be implemented on the written instruction of the Chief Executive Officer.

PROCEDURE

The increase in the CPI, effective January 1, 2016, is 2.1%.
ATTACHMENTS

Consumer Price Index Calculation

Historical Summary

Dependent and Sole Dependent Children’s Expense

Spousal Supplement Expense (Old Act Claims)

Lump Sum Burial Expense

Eye Glasses Frames Expense

Clothing Allowances

Personal Care Allowances

Vocational Rehabilitation Expenses – Travel and Sustenance

Minimum Annuity Amount

<table>
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<th>Effective Date</th>
<th>Application</th>
<th>Supersedes</th>
<th>Complements</th>
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<tbody>
<tr>
<td>68(1), 69, 71, 72, 80, 83(4), 83(5), 85(1), 89</td>
<td>01 January 2016</td>
<td>All claimants who are eligible for the benefits and allowances as identified in the procedure.</td>
<td>POL 60/2014 Consumer Price Index (CPI) – Annual Increase</td>
<td>POL 07/2013 Consumer Price Index (CPI) – Annual Indexing</td>
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</table>

POL 13/2013 Annuities

POL 19/2010 Allowance – Clothing

POL 39/2010 Expenses – Travel and Sustenance – General

POL 17/2008 Expenses – Orthotics/Appliances – Provision, Replacement and Repair

POL 10/2014 Allowance – Personal Care
### Consumer Price Index Calculation

<table>
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<tr>
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<th>Regina</th>
<th>Saskatoon</th>
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<tbody>
<tr>
<td>November 2015</td>
<td>132.40</td>
<td>132.00</td>
</tr>
<tr>
<td>Less November 2014</td>
<td>129.90</td>
<td>129.10</td>
</tr>
<tr>
<td>Change in CPI</td>
<td>2.50</td>
<td>2.90</td>
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<tr>
<td>% change in CPI:</td>
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<td></td>
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<tr>
<td>Change in CPI x 100 =</td>
<td>2.50 x 100</td>
<td>2.90 x 100</td>
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<tr>
<td>November 2014</td>
<td>129.90</td>
<td>129.10</td>
</tr>
<tr>
<td>Average % change:</td>
<td>1.92 + 2.25 = 4.17 = 2.1% CPI</td>
<td></td>
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<tr>
<td>Regina + Saskatoon =</td>
<td>2 2 2</td>
<td>2.1% CPI</td>
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### Historical Summary – CPI Calculation

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<tr>
<td>1997</td>
<td>0.4%</td>
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<tr>
<td>1998</td>
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Benefits to Worker – Benefit Calculations

Dependent and Sole Dependent Children Expense

<table>
<thead>
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<th>Dependent Children</th>
<th>Sole Dependent Children</th>
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<tr>
<td>01 January to 31 December 1980</td>
<td>$90.00</td>
</tr>
<tr>
<td>01 January to 31 December 1981</td>
<td>$100.00</td>
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<td>01 January to 31 December 1982</td>
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<td>$130.00</td>
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<tr>
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<td>$130.00</td>
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<tr>
<td>01 January to 31 December 1985</td>
<td>$140.00</td>
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<tr>
<td>01 January to 31 December 1986</td>
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<td>01 January to 31 December 1987</td>
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<tr>
<td>01 January to 31 December 1991</td>
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<td>01 January to 31 December 1992</td>
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<tr>
<td>01 January to 31 December 1993</td>
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<td>01 January to 31 December 1997</td>
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<td>01 January to 31 December 2001</td>
<td>$287.73</td>
</tr>
<tr>
<td>01 January to 31 December 2002</td>
<td>$293.48</td>
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</tbody>
</table>

Year Ending November 30 1999  1.7%
Year Ending November 30 2000  1.5%
Year Ending November 30 2001  2.0%
Year Ending November 30 2002  4.2%
Year Ending November 30 2003  1.3%
Year Ending November 30 2004  3.0%
Year Ending November 30 2005  1.2%
Year Ending November 30 2006  1.4%
Year Ending November 30 2007  4.3%
Year Ending November 30 2008  3.3%
Year Ending November 30 2009  0.9%
Year Ending November 30 2010  1.9%
Year Ending November 30 2011  2.8%
Year Ending November 30 2012  1.0%
Year Ending November 30 2013  1.3%
Year Ending November 30 2014  2.1%
Year Ending November 30 2015  2.1%
### Consumer Price Index (CPI) – Annual Increase (PRO 60/2015)

<table>
<thead>
<tr>
<th>Period</th>
<th>Dependent Children</th>
<th>Sole Dependent Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 January to 31 December 2003</td>
<td>$305.81</td>
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</tr>
<tr>
<td>01 January to 31 December 2004</td>
<td>$309.79</td>
<td>$328.67</td>
</tr>
<tr>
<td>01 January to 31 December 2005</td>
<td>$319.08</td>
<td>$338.53</td>
</tr>
<tr>
<td>01 January to 31 December 2006</td>
<td>$322.91</td>
<td>$342.59</td>
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<tr>
<td>01 January to 31 December 2007</td>
<td>$327.43</td>
<td>$347.39</td>
</tr>
<tr>
<td>01 January to 31 December 2008</td>
<td>$341.51</td>
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</tr>
<tr>
<td>01 January to 31 December 2009</td>
<td>$352.78</td>
<td>$374.28</td>
</tr>
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Benefits to Worker

Benefit Calculations

Section 4

Consumer Price Index (CPI) – Annual Increase (PRO 60/2015)

Burial Expense (lump sum)

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* Supplement indexed January 1, 1986 onward.
** Corrected figures due to incorrect CPI - no adjustment required.

Eyeglass Frames Expense

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* Burial expense increased due to legislation, not CPI.
## Consumer Price Index (CPI) – Annual Increase (PRO 60/2015)

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*Eye glass frames expense not increased by CPI.*
### Consumer Price Index (CPI) – Annual Increase (PRO 60/2015)

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#### Personal Care Allowance

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Vocational Rehabilitation – Travel and Sustenance Expense (per month)

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Minimum Annuity Amount*

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<td>2015</td>
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*rounded up to nearest $100 as per POL 13/2013.
4.1.23 Benefits on Concurrent Claims (PRO 22/2010)

Document Date 25 August 2010

Purpose To establish guidelines on how to provide compensation to workers that experience concurrent earnings loss claims.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 22/2010, Benefits on Concurrent Claims, which establishes guidelines on how to provide compensation to workers that experience concurrent earnings loss claims.

2. The following procedure provides guidance for the implementation of POL 22/2010.

PROCEDURE

1. Where the worker has two or more concurrent earnings loss claims and has been in receipt of earnings loss benefits for 24 consecutive months on the most current claim, the wage base on that claim may be subject to an adjustment under Section 70(5) of the Act.

2. Where the wage base on the most current claim is subject to an increase called for by Section 70(5) or 69(2) of the Act, WCB staff will review the amount of earnings deducted on the initial claim. Where the earnings deduction used in the calculation of earnings loss benefits on the initial claim are found to be less than the adjusted wage base on the most current claim, the amount deducted as earnings on the initial claim will be increased to an amount equal to the adjusted wage base on the most current claim.

3. Where the wage base on the most current claim increases above the earnings deduction on the initial claim, either due to the application of Section 70(5) or Section 69(2) of the Act, WCB staff will calculate earnings loss benefits on the initial claim with the following formula:

   \[ \text{90 percent of the } \frac{\text{net wage base}}{\text{90 percent of net earnings based on the amount of the adjusted wage base on the most current claim}} \]

4. The Case Manager will provide the worker with a full explanation of any adjustments made in accordance with POL 22/2010, Benefits on Concurrent Claims.

ATTACHMENTS

Concurrent Claims Example
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<tr>
<td>Amended</td>
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<tr>
<td>Application</td>
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Concurrent Claims Example

The following example emphasizes the adjudication process WCB staff are to follow when there are two or more concurrent claims, and the most current claim is subject to Section 70(5) of the Act. To provide undemanding calculations, the example will consider 90 percent of the net earnings to be equal to 75 percent of the gross earnings.

- The worker is initially injured at a job that pays $800 a week.
- The injury results in permanent restrictions and the worker is only able to return-to-work at a new job earning $300 a week. Under Section 68(1) of the Act, earnings loss benefits are based on 90 percent of net earnings ($600) minus 90 percent of the net earnings from the new job ($225), which equals $375 in earnings loss benefits payable to the worker.
- At the new job, the worker suffers an injury that is completely unrelated to the initial injury. Earnings loss benefits on the most current claim are paid in accordance with the worker’s current wage ($300).
- Once the worker has been in receipt of earnings loss benefits on the most current claim for 24 consecutive months, on the first day of the 25th consecutive month Case Management will ensure that the most current claim’s earnings loss benefits are not less than two-thirds of the industrial composite in accordance with Section 70(5) of the Act, which in this case is $500.
- Full compensation on the new claim would be 90 percent of the net of $500 or $375. Thus the worker would receive $375 on the initial claim and $375 on the most current claim for a total of $750, which would be $150 in overcompensation.
- The correct calculation on the initial claim should be 90 percent of the net earnings from the first claim ($600) less 90 percent of the net from the revised wage base on the most current claim ($375) or $225. Thus the total payment would be $375 + $225 = $600, which is the equivalent to full compensation on the initial claim.
4.1.24 Calculation of Net Compensation Payable (PRO 59/2015)

Document Date 15 December 2015
Purpose To publish a table of earnings for the purpose of calculating net compensation payable.

BACKGROUND

POL 03/2007, Calculation of Net Compensation Payable directs the publication of a table of earnings for the purpose of calculating net compensation payable.

PROCEDURE

1. In accordance with POL 03/2007, Operations will ensure the attached table of earnings for calculating net compensation payable is updated and published on each occasion where there is a legislated change on income tax deductions either federally or provincially.

2. Using Canada Revenue Agency (CRA) guidelines, net earnings are calculated as set out by POL 03/2007.

ATTACHMENTS

Table of Net Compensation Payable – Example 1
Table of Net Compensation Payable – Example 2

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Table of Earnings for Calculating Net Compensation Payable
Calculation Example 1
Effective January 1, 2016

A married individual with two dependants and a weekly gross employment salary of $900.00*

*Based on January 1, 1970 as claimant’s date of birth.

Weekly gross earnings $900.00
Probable deductions:
Income tax $59.33
Canada Pension Plan $41.22
Employment Insurance $16.92
Weekly net earnings $782.53
Compensation as per Section 68(1)(b) x 90%
Weekly earnings loss benefits $704.28

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Procedure Manual
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Benefits to Worker – Benefit Calculations
Doc # 4.1.24

Calculation of Net Compensation Payable (PRO 59/2015)

CPP

EI

Section 4 – Page 60


**Procedure Manual**

**Benefits to Worker – Benefit Calculations**

**Section 4 – Page 61**

**Doc # 4.1.24 Calculation of Net Compensation Payable (PRO 59/2015)**

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Table of Earnings for Calculating Net Compensation Payable

Example 2
Effective January 1, 2016

A single individual with one dependant and a weekly gross employment salary of $600.00*

* Based on January 1, 1970 as claimant's date of birth.

Weekly gross earnings $600.00
Probable deductions:
- Income tax $14.81
- Canada Pension Plan $26.37
- Employment Insurance $11.28
Weekly net earnings $547.54
Compensation as per Section 68(1)(b) x 90
Weekly earnings loss benefits $492.79

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Benefits to Worker – Benefit Calculations
Doc # 4.1.24

Calculation of Net Compensation Payable (PRO 59/2015)

Section 4 – Page 63


### Calculation of Net Compensation Payable (PRO 59/2015)

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4.2 Allowances
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4.2.1 Allowance – Personal Care (PRO 10/2014)

Document Date 25 June 2014

Purpose To establish administrative guidelines for determining and providing personal care allowances (PCA).

BACKGROUND

The WCB has approved POL 10/2014, Allowance – Personal Care, which establishes personal care allowances (PCA).

PROCEDURE

General

1. When it becomes apparent that the worker needs personal care, the Case Manager (CM) will refer the worker to the Vocational Rehabilitation Specialist (VRS) for a personal care assessment. The CM will:
   a. Tell the VRS if the worker is to be assessed for a temporary or permanent PCA, and
   b. Give the VRS any relevant medical information.

2. The VRS will recommend the:
   a. Level of PCA.
   b. Recipient of PCA.
   c. Duration of PCA, and
   d. Effective date of PCA.

   The VRS will use the criteria noted in the appendix to determine the level of PCA. If the VRS is uncertain about the level or duration of PCA needs, the VRS can get help from the Medical Officer.

3. The VRS will confirm all decisions about PCA in writing.

4. PCA will not provide payment for services associated with the following allowances:
   a. POL 15/2008, Allowance – Temporary Additional Expense, and

Temporary Need for Personal Care

5. The VRS will base the temporary care assessment on:
a. The medical information on file.
b. An in-person visit with the worker (when possible), and
c. Other inquiries that may be necessary (e.g., the worker’s doctor, family members, Medical Officer).

6. The VRS will review the amount of PCA the WCB pays based on medical reports confirming the worker’s progress and recovery.

Permanent Need for Personal Care

7. If the worker needs permanent care, the VRS will ask a homecare agency in the worker’s local health region to assess the worker’s needs. If a local agency cannot assess the worker’s needs, the VRS will ask an agency from another health region to do the assessment. The WCB will pay for the assessor’s travel and meals (PRO 54/2015, Expenses – Travel and Sustenance – PSC Rates).

8. The VRS will give the agency any medical information it needs to do the assessment (e.g., extent of the worker’s injury, other conditions that may affect personal care needs).

9. Agencies will use the tool that is approved by the Saskatchewan Ministry of Health for doing assessments (currently MDS-Home Care).

10. In addition to the assessment, the VRS may make more inquiries about the worker’s personal care needs when necessary (e.g., the worker’s doctor, family members, Medical Officer).

11. The VRS will review the amount of PCA the WCB pays based on medical reports confirming the worker’s progress and recovery. If the worker’s recovery plateaus, the VRS will review the PCA (e.g., level, eligibility) at the end of December each year.

Payment for Personal Care

12. The WCB will pay PCA on a monthly basis to the:
   a. Individual or agency providing care, or
   b. Worker (i.e., if there are multiple care providers).

13. Homecare agencies will direct bill the WCB.

14. The VRS will review bills and authorize payments. The WCB will only pay for reasonable costs. If the VRS pays less than the amount billed, the VRS will give a written explanation.

15. If the worker does not need certified nursing care, the WCB will pay PCA in accordance with PRO 60/2015, CPI – Annual Increase.
16. There can be cases where the worker's care need is serious or unique enough that additional special care costs may be considered. PCA above level IV will require approval by a Team Leader.

**Provisions for Individuals Providing Personal Care**

17. If the worker gets care from a person (not a business) that becomes unavailable, the VRS will suspend PCA if worker does not get care for more than 30 consecutive days.

18. Individuals providing care may take up to 30 days of vacation per year without an interruption to their PCA. The VRS may suspend PCA if the person is away for more than 30 days.

19. The VRS will pay someone else to provide care while the individual is away.

**ATTACHMENTS**

**Appendix – Levels of PCA**

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<th>Effective Date</th>
<th>Application</th>
<th>Supersedes</th>
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<td>POL 15/2008 Allowance – Temporary Additional Expense</td>
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</tbody>
</table>
Appendix
Levels of PCA

The WCB will provide the worker with the level of PCA that best describes the worker’s needs.

Level I

i. The worker needs care at specific times (e.g., putting on an appliance or clothing once or twice daily).

ii. The worker needs cleaning or laundry services because of fecal or urinary incontinence.

iii. The worker uses but is not confined to a wheelchair.

iv. The worker has a loss of vision in both eyes requiring occasional assistance.

v. Supervision is required.

Level II

i. The worker needs care because of bowel or bladder malfunction.

ii. The worker is confined to a wheelchair and requires assistance to get in and out of the bathtub or bed.

iii. The worker has double arm amputations below the elbow requiring additional help due to limited use of prostheses.

iv. The worker has a loss of vision in both eyes, as well as another work-related disability (e.g., hearing loss, amputation, etc.), requiring a need for assistance.

Level III

i. The worker has quadriplegia with limited mobility and impairment of bowel and bladder function.

ii. The worker needs custodial care due to a cognitive disability, cannot be left alone at any time, and needs assistance with washing, shaving, dressing and feeding.

iii. The worker has double arm amputations above the elbow.

iv. The worker is confined to a wheelchair and requires assistance to get in and out of the bathtub or bed, with additional needs due to pressure sores, severe spasticity, or other complications.
Level IV

i. The worker is periodically placed in a wheelchair, and requires assistance for dressing, feeding, enemas and bladder care, and requires constant supervision (e.g., a worker with high lesion quadriplegia).

ii. The worker is completely bedridden requiring constant attendance and nursing care.
4.2.3 Allowance – Temporary Additional Expense (PRO 15/2008)

Document Date 04 November 2008

Purpose To establish guidelines for paying additional, incidental expenses related to the work injury.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved guidelines for reimbursement of temporary additional expenses.

2. The following procedure is the implementation of the provisions under POL 15/2008, Allowance – Temporary Additional Expense.

PROCEDURE

1. The Operations staff responsible for managing the worker’s file will review the circumstances with the worker to identify his/her entitlement to temporary additional expenses under POL 15/2008. The expense must be reasonable to maintain a worker’s pre-injury or current standard of living, not to improve upon it.

2. Expenses must be preauthorized and confirmed in writing. The worker will be required to provide proof of the additional expense (i.e., receipts).

3. These expenses are temporary and will not be reimbursed for expenses incurred outside of the time periods during which the eligible circumstances occur. Therefore, a worker may no longer be eligible for this allowance when:
   a. Recovered sufficiently such that the need and circumstances covered by Point 1 of POL 15/2008 are no longer applicable; and/or,
   b. Eligibility for Independence Allowance (IA) (POL 27/2010) has been established. Should there be any duplication of payments for expenses under POL 15/2008 and IA, deduction from future entitlement to IA will be made.
   c. Where applicable, Personal Care Allowance (POL 10/2014) may be paid at the same time as temporary additional expense, but staff will ensure there is no duplication of payments under POL 10/2014 and POL 15/2008.
### Act Sec #
111, 115

### Effective Date
01 December 2008

### Amended
References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

### Application
All injured workers who as a result of a temporary work injury, as well as those waiting for a PFI assessment, incur additional expenses not covered by any other WCB policy.

### Supersedes
PRO 04/2000 Allowance – Temporary Additional Expense (Child Care, etc.)

### Complements
- POL 15/2008 Allowance – Temporary Additional Expense
- POL 27/2010 Allowance – Independence
- POL 10/2014 Allowance – Personal Care
- POL 23/2010 Permanent Functional Impairment (PFI) – General
Document Date: 16 October 2012

Purpose: To establish guidelines for providing clothing allowances.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 19/2010, Allowance – Clothing, which establishes guidelines for providing clothing allowances for eligible workers under The Workers’ Compensation Act, 2013 (the “Act”).

2. The following provides detailed guidance for the implementation of the policy.

PROCEDURE

1. The Case Manager will identify clothing allowance eligibility in accordance with the following criteria:
   a. The worker requires a prosthetic device for upper, lower or both upper and lower limb amputations;
   b. The worker requires a rigid back, neck, leg or full-length brace or similar rigid supportive device; or
   c. The worker is confined to a wheelchair as the result of a compensable injury.

2. Initial eligibility for clothing allowance begins as of the date of the provision of the prosthesis, brace or wheelchair, and does not require proof of repair or damage to clothing.

3. Payment for rigid braces or supports is contingent on the identification of need provided by the attending physician, and periodic confirmation that the worker continues to wear the device.

Temporary Allowance

4. Where the worker requires rigid braces or supports on a temporary basis, the WCB will issue clothing allowance monthly. Where the worker initially qualifies for clothing allowance, entitlement will begin on the date the worker starts wearing the device. Following initial qualification, monthly payments will continue until the device is no longer required, or medical evidence shows that the worker permanently requires the use of the device.

For example, the worker begins wearing the device August 13, 2010. The worker is paid from August 13 to 31, 2010 ($18/31 x monthly clothing allowance). Thereafter, the worker is paid monthly until the device is no longer required.
5. For temporary clothing allowance, the Case Manager will provide authorization for payment. The authorization will indicate the type of allowance payable (e.g., upper limb) and the duration for monthly payments. The Case Manager will diarize the claim for the end of the authorization period to determine if there is a need to extend the duration of payment for clothing allowance.

Permanent Allowance

6. Where the attending physician directs that the worker permanently requires an appliance, the WCB will issue clothing allowance on an annual basis. Where the worker initially qualifies for clothing allowance, entitlement will begin on the date the worker starts wearing the device, and continue for the period up to the end of the year (December 31). Beginning the following January and in January of every year thereafter, the worker will receive an annual clothing allowance payment covering a period of 12 months.

   For example, the worker begins wearing the device August 13, 2010. The worker is paid from August 13, 2011 to December 31, 2011 ([18/31 x monthly clothing allowance] + [4 months of clothing allowance]). In January 2012, and in January of each year thereafter, the worker receives an annual clothing allowance payment covering a period of 12 months.

7. Annual indexing of clothing allowance will be applied in January of each year (increases effective January 1st).

8. The Case Manager will review the worker’s eligibility for clothing allowance annually. If eligibility continues, authorization will be provided and 12 months of clothing allowance will be issued by the end of January.

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| Complements | POL 19/2010 Allowance – Clothing  
PRO 60/2015 Consumer Price Index (CPI) – Annual Increase |
4.2.5 Allowance – Independence (PRO 27/2010)

Document Date

Purpose To establish guidelines for the payment of independence allowance.

BACKGROUND

1. POL 27/2010, Allowance – Independence has been approved by the Workers’ Compensation Board (WCB).

2. The following procedure provides staff with specific guidance when providing independence allowances to eligible workers.

PROCEDURE

1. The Case Manager is responsible for determining eligibility for the independence allowance.

2. Workers with one or more claims resulting in a Permanent Functional Impairment (PFI) rating of 10 percent or greater are to be considered for eligibility to the independence allowance, according to the criteria in the policy.

3. Workers should be informed as soon as possible after the PFI rating has been determined (e.g., at the PFI interview), that they may be entitled to an independence allowance, and should be asked about:
   a. their principal residence;
   b. what, if any, routine maintenance of their residence they are no longer able to perform due to the impairment, and how they are arranging (who, cost) to get that maintenance done (e.g., hiring someone to cut grass, remove snow, or perform interior cleaning; have moved into condominium or other accommodation where specific fees are charged for basic maintenance of the property); and
   c. whether they have additional costs, as a result of the impairment, in order to maintain a reasonable degree of independence (e.g., hiring of taxis for transportation).

4. The restricted activities and additional costs of maintenance or independence must be related to the worker’s compensable impairment, as documented in their file. For example:
   a. The worker needs to hire someone or now arrange for family members to shovel their snow, cut grass, etc.
b. The worker moves from a detached dwelling to a condominium dwelling because he or she is restricted from repetitive bending and heavy lifting as a result of the compensable impairment.

c. The worker is no longer able, as a result of the impairment, to drive a vehicle or to ride regular public transportation.

5. Normally, regardless of the amount of PFI rating, the worker should provide some corroboration of the additional costs he or she is claiming (e.g., receipts for work done, transportation provided or condominium fees paid, or the names of family members providing additional assistance with maintenance or transportation). Corroboration of exact costs is not necessary, however, as the amount of the allowance is determined according to the formulas contained in POL 27/2010.

6. Where the worker has been receiving reimbursement under POL 15/2008, Allowance – Temporary Additional Expense, any payment for expenses that are covered by an independence allowance will be deducted from the worker’s initial independence allowance payment.

7. Independence allowances will be paid annually on the anniversary of the commencement of loss of earnings.

8. The worker’s eligibility for independence allowance will be verified annually. Once confirmed, the Case Manager will authorize the Payment Specialist to issue independence allowance in accordance with the time frames and formulas contained in the policy.

9. If there is a subsequent increase in the PFI award, workers who have qualified for a prorated independence allowance under POL 27/2010, will be entitled to an adjustment of any allowance already paid that year. The adjustment will be based on the additional percentage of PFI and whatever portion of the annual payment period remains, commencing with the first of the month following the date the PFI award was increased.

10. Where multiple PFI awards have been granted on more than one claim, costs for independence allowance will be prorated among each of the claims based on the percentage of PFI attributable to each claim. As a result, each employer is only responsible for the independence allowance costs associated with the percentage of PFI attributable to injury that the worker sustained while employed by that employer. The Case Manager responsible for the claim with the highest PFI rating will be responsible for determining independence allowance entitlement.

Example:

A worker has two claims in which there is a PFI award. On one claim, 10 percent PFI is awarded and 15 percent PFI is awarded on the other. Therefore, the aggregate total is 25 percent PFI. Costs for the first claim will be charged as follows: 10/25 x
independence allowance costs. Costs for the second claim will be charged as follows: 15/25 x independence allowance costs.

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4.3 Travel & Medical Aid Expenses
4.3.1 Expenses – Travel and Sustenance – General (PRO 39/2010)

Document Date 21 December 2010

Purpose To establish guidelines for the reimbursement of travel and sustenance requirements.

DEFINITION

Authorizing Agent means a Claims Entitlement Specialist (CES), Case Manager or Vocational Rehabilitation Specialist who is authorized to approve travel and sustenance requirements for injured workers on behalf of the Workers’ Compensation Board (WCB).

BACKGROUND

1. The WCB has approved POL 39/2010, Expenses – Travel and Sustenance – General, which establishes guidelines for the reimbursement of travel and sustenance requirements.

2. The following provides detailed guidance for implementation of the policy.

PROCEDURE

1. Case Management Support (CMS) or the CES is responsible for identifying the worker’s normal pre-injury employment travel requirement that occurs outside the resident community. The following formula allows CMS or the CES to determine the worker’s normal pre-injury employment travel requirement over a complete work cycle, and average the sum into a weekly amount:

\[
\text{Normal Pre-Injury Employment Travel Requirement} = \frac{\text{Total Number of Kilometres Traveled in Complete Work Cycle}}{\text{Total Number of Days in Complete Work Cycle}} \times 7
\]

CMS will provide the Payment Specialist (PS) with the calculated normal pre-injury employment travel requirement.

2. CMS or the CES will be responsible to communicate to the worker that depending on the worker’s average weekly expenses normally incurred prior to the work-related injury, the worker may not be eligible for any reimbursement for travel unless the travel required for medical care exceeds the worker’s normal pre-injury employment travel requirements outside the resident community.

3. Where the worker’s travel for medical care outside the resident community exceeds the worker’s normal pre-injury employment travel requirements outside the resident community.
community, the PS or CES will calculate entitlement by subtracting the worker’s normal pre-injury employment travel requirement, over an average seven day week, from the travel requirements associated with the worker’s medical care for the corresponding period of time.

4. An authorizing agent will advise the worker of the travel requirements that the WCB will reimburse. Where the reimbursements are less than the amount claimed by the worker, an authorizing agent will provide the worker with a written explanation.

5. Where necessary, an authorizing agent may grant reasonable transportation and sustenance on the behalf of a donor.

6. An authorizing agent may pre-approve travel and sustenance for attendants other than qualified medical personnel where it is considered essential by reason of the worker’s injury and confirmed by the treating physician and or the WCB Medical Consultant. The maximum hourly rate of reimbursement payable to an attendant will be calculated as follows:

   Current maximum annual wage base (defined by Section 37 of the Act) / 52 weeks
   40 hours per week

ATTACHMENTS

Kilometre Entitlement Examples

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Supersedes: n/a

Complements: POL 39/2010 Expenses – Travel and Sustenance – General
POL 60/2015 Consumer Price Index (CPI) – Annual Increase
POL 54/2015 Expenses – Travel and Sustenance – PSC Rates
POL 07/2007 Voluntary Relocation Outside Canada
PRO 07/2007 Voluntary Relocation Outside Canada
POL 02/2014 Vocational Rehabilitation – Moving Allowance
POL 02/2012 Expenses – Travel & Sustenance – PSC Rates
Kilometre Entitlement Examples

Example A

Where the worker’s normal pre-injury employment travel requirement outside of the resident community over a 5 day work week (5 working days and 2 rest days) is 250 km, and the worker has to travel 300km for medical care over a 7 day week, the worker would be reimbursed 50km for additional travel entitlement.

Accordingly, where the worker’s normal pre-injury employment travel requirement outside the resident community over a 7 day week is 250km, but the worker makes three 60km trips over a 7 day week for medical treatment (180km – 250km), no entitlement will be paid to the worker because the worker’s medical treatment travel requirement is less than what the worker would experience over an average 7 day week.

Example B

Where a worker resumes work and their travel requirements for employment outside of the resident community match their normal pre-injury employment travel requirements, and they travel for medical care outside the resident community in addition to travelling to and from work, the worker will be reimbursed for the travel over and above the travel for work.

For example, where a worker returns to pre-injury employment outside the resident community, working their normal number of days over an average 7 day week, and the worker is required to travel from work to medical treatment, the distance traveled from work to the treatment center and back to work should be reimbursed.

Example C

Where a worker’s return-to-work does not match the normal pre-injury employment travel requirement, a combination of travel for work and travel for medical care should be compared with the normal pre-injury employment travel requirements for an average 7 day work week.

For example, a worker was working outside of the resident community 5 days per week pre-injury and now is working outside the resident community 3 days per week and travelling outside the resident community 2 days per week for medical care. The total amount traveled should be compared with the travel required outside of the resident community in an average 7 day week. If the post injury travel exceeds the pre-injury distance, reimbursement should be provided.
Example D

Where the worker’s normal pre-injury employment travel requirement over an average 7 day week is within the resident community, and the worker has to travel outside of the resident community for medical care, the worker would be reimbursed in full, with no deduction for normal pre-injury employment travel requirement, for the additional travel entitlement.

Example E

Where the worker’s normal employment travel requirement over an average 7 day week is within the resident community, and the worker travels within the resident community for medical care, no entitlement will be paid to the worker.
4.3.2 Expenses – Travel and Sustenance – PSC Rates (PRO 54/2015)

Document Date 06 October 2015

Purpose To establish travel and sustenance allowances.

BACKGROUND

1. Historically, the Workers’ Compensation Board (WCB) has paid the same rates as the Saskatchewan Public Service Commission (PSC) for travel and sustenance allowances. These rates are applicable to both WCB clients and staff.

2. POL 02/2012, Expenses – Travel and Sustenance – PSC Rates, gives the Chief Executive Officer (CEO) of the WCB authority to revise travel and sustenance allowance rates.

3. In accordance with POL 02/2012, WCB travel and sustenance rates will be rounded to the nearest cent.

PROCEDURE

1. Effective November 1, 2015, the rate for using one’s personal vehicle for WCB business are as follows:

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Subject to the minimum allowance of $5.00 per day, prorated for shorter periods at $1.50 per hour for actual usage to a maximum of $6.00 per day or 42¢km, whichever is the greater.

2. Meal rates, which include GST and gratuities, are as follows (effective since January 1, 2005):

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<tr>
<td>Supper</td>
<td>19.00</td>
<td>24.00</td>
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3. Reasonable and actual reimbursement for hotel accommodation will be authorized when supported by receipts, for:
a. Employees travelling on WCB business. Employees are encouraged to use businesses that have established competitive government rates or request government rates for lodging wherever possible.

b. Clients requiring accommodation in order to attend WCB authorized medical treatment or vocational programming.

4. The rate for private accommodations is $35.00 per night and remains at this rate until further notice (effective since July 1, 2007).

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<tr>
<th>Act Sec #</th>
<th>16, 18, 115</th>
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<td>PRO 51/2015 Expenses – Travel and Sustenance – PSC Rates</td>
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<td>POL 39/2010 Expenses – Travel and Sustenance – General</td>
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</table>
4.3.4 Reimbursement for Medications (PRO 10/2011)

Document Date 13 September 2011

Purpose To establish guidelines for the reimbursement of the cost of medications.

BACKGROUND

1. The Board has approved policy guidelines regarding the reimbursement of the cost of medications.

2. The following procedure outlines the steps to be used for the approval and payment process.

PROCEDURE

Reimbursement – General

1. Where a time loss claim is accepted by the Workers' Compensation Board (WCB), Operations staff will forward a letter of acceptance to the worker. The letter will outline entitlement for expenses related to the compensable injury, such as prescription and non-prescription medications prescribed or recommended by the treating physician.

2. Where a no time loss claim is accepted by the WCB, reimbursement of medications may also be provided.

3. The Case Manager Support (CMS)/Claims Entitlement Specialist (CES) will authorize the reimbursement of a prescription/non-prescription medication expense in accordance with POL 10/2011, Reimbursement of Medications. An original receipt for the medication will be required.

4. Medication expenses authorized by a CMS will be issued by a Payment Specialist. Medication expenses authorized by a CES may be issued by the CES. Direct billings from a pharmacy will be paid by a Medical Accounts Specialist, subject to authorization provided by a CMS/CES.

5. A CMS or CES can authorize a pharmacy to direct bill the WCB for a worker’s medication. The authorization provided to the pharmacy will specifically identify the type of medication the WCB will reimburse. The authorization provided will be documented on the claim file.

6. Where the pharmacy bills the WCB directly, the Medical Payment Specialist will reimburse the expense based on a review of the authorization provided by the CMS/CES. Where reimbursement is made in error, the CMS/CES will:
7. Where the CMS/CES determines the need for a medication is not related to the accepted work injury, the CMS/CES will inform the injured worker directly. If a CMS/CES is uncertain the need for a medication is related to, and appropriate for, the accepted work injury (e.g., a new prescription not in *The Saskatchewan Formulary*), a Medical Services review will be requested.

8. Where the denial of payment for a medication has been subject to a review by Medical Services, the CMS/CES will provide the injured worker and the treating physician written reasons for the decision to refuse payment of prescription or non-prescription medications. If an explanation relating the medication to the accepted work injury is received from the treating physician, and this is judged to be acceptable by the WCB Medical Consultant, the payment will then be made.

9. The WCB will not reimburse the costs of obtaining, growing, or using medical marijuana (i.e., the smoked form). Requests for payment of marijuana derivatives will be subject to a WCB Medical Consultant review. The WCB Medical Consultant will determine if the marijuana derivatives are listed in *The Compendium of Pharmaceuticals and Specialties*, and are prescribed for the listed indications (e.g., intractable nausea).

**Opioid Treatment Management**

10. Where the WCB authorizes opioid drug coverage, treatment will be monitored to ensure the opioids continue to be effective in improving function and reducing pain.

   a. Operations staff will record the date the opioids were first prescribed and the name of the prescribing physician on the claim file.

   b. Opioid use beyond four weeks post operative or post injury will require a case management review, which may include a referral of the file to a WCB Medical Consultant. At this time, the WCB Medical Consultant may confer with the prescribing physician.

   c. Opioid use beyond eight weeks post operative or post injury will require a referral to an assessment team, which will include a pain management specialist.

   d. Opioid use beyond 12 weeks post operative or post injury will require a mandatory case management review and a referral to an assessment team, which will include a pain management specialist and a registered doctoral psychologist.

**Overuse or Abuse**

11. The CMS/CES will be alert to potential problems of drug overuse/abuse or drug interaction, particularly where controlled drugs such as opioids are prescribed or
where several drugs or a single drug is being used in large quantities. Where questions arise, the CMS/CES will refer the claim to Medical Services for review. The WCB Medical Consultant may:

a. request the treating physician to limit the use of the drug;
b. authorize payment of a restricted amount; or
c. refuse to authorize payment.

Addiction

12. Even when used appropriately, opioids can lead to addiction. Where medical evidence supports that the addiction resulted from treatment for the accepted work injury, the WCB will reimburse the cost of an opioid dependency treatment program or strategy.

Act Sec # 2(1)(v), 19(1)(b), 31(1), 103(1), 115(c)
Effective Date 01 October 2011
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All claims.
Supersedes PRO 09/2001 Reimbursement for Medications
Complements POL 10/2011 Reimbursement for Medications
PRO 53/2006 Medical Aid Billings – Payment
PRO 07/2012 Procurement Procedure
POL 05/96 Health Care Services
4.4 Permanent Functional Impairment (PFI) & Pensions
4.4.2 Pension Commutations (The Workers’ Compensation Act, 1974) (PRO 11/2010)

Document Date 03 March 2010
Purpose To establish guidelines for the commutation of pensions under The Workers’ Compensation Act, 1974.

BACKGROUND


2. The following procedure provides guidelines for the commutation of pensions under The Workers’ Compensation Act, 1974.

PROCEDURE

1. Requests for pension commutations (both full and partial) are to be decided by Case Managers. Any appeals against decisions made by Case Managers will be handled in accordance with POL 21/2013, Appeals – Claims.

2. Payment of a commutation cannot be considered without a written request signed by the client.

3. In accordance with POL 11/2010, Case Managers are responsible for sending an annual letter to workers receiving pensions under The Workers’ Compensation Act, 1974. The letter will remind eligible workers that they have the option of commuting their pension. However, as set out in Point 6 of POL 11/2010, workers in receipt of wage loss benefits and dependent spouses receiving pension benefits will not receive the annual letter.

4. Case Managers will include the criteria to be met before a pension commutation will be approved and the current value of a full commutation (keeping in mind the value changes daily and is dependent on the eventual date of issuance) in the annual letter, as well as information as to how clients may request a pension commutation.

5. Where a client is interested in the commutation of his/her pension, Case Managers are responsible for ensuring sufficient information is gathered from, or supplied by, clients in order to determine whether the criteria for approval outlined in POL 11/2010 has been met.

6. To ensure clients understand the full financial ramifications of a pension commutation, Case Managers will provide clients with letters that explain the financial impact of a pension commutation. Case Managers will also recommend...
that clients should seek independent financial advice before they make a decision regarding a pension commutation. The WCB will not fund independent financial advice.

7. Case Managers will inform clients that they will remain eligible for any WCB benefits applicable to their particular situations.

8. Case Managers will approve the payment of pension commutations up to the amount allowed by their approved payment authorization level. Pension commutations that exceed that amount will be subject to Team Leader approval.

9. The WCB Internal Actuary will be responsible for ensuring that the information used to convert the monthly pension into a lump sum payment is updated as necessary on a periodic basis to reflect current interest and life expectancy rates.

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<tr>
<th>Act Sec #</th>
<th>76(1); <em>The Workers’ Compensation Act, 1974</em> 82</th>
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<td>Application</td>
<td>All requests for pension commutations under the Old Act.</td>
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<td>Supersedes</td>
<td>PRO 14/2007 Pension Commutations (Old Act)</td>
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<td>Complements</td>
<td>POL 11/2010 Pension Commutation</td>
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<td>POL 21/2013 Appeals – Claims</td>
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4.4.3 Disfigurement Award Assessments (PRO 01/2015)

Document Date 14 January 2015

Purpose To establish the process for acquiring photographs from injured workers for the purpose of assessing and rating disfigurement.

DEFINITION

Disfigurement means a conspicuous alteration or abnormal change in the features of the face, neck, hands, torso, and upper and lower extremities and or substantial and permanent scarring of these areas. Disfigurement is related to the cosmetic appearance of the body and not the loss of bodily function.

BACKGROUND


2. In accordance with POL 23/2010 and the most current edition of The American Medical Association: Guides to the Evaluation of Permanent Impairment, Medical Officers will provide PFI evaluations for disfigurement awards.

PROCEDURE

1. Linear scarring that is caused by surgical intervention or work-related injuries (e.g., lacerations) may not qualify for a PFI award unless the scarring is on the front of the worker’s neck or face. Where there is frontal neck or facial scarring, the worker should submit digital colour photographs of the disfigurement to the WCB.

2. The worker should also submit colour digital photographs where, as the result of a work-related injury, the worker has:
   a. extensive scarring from a burn, pigment change or permanent rash;
   b. surgical skin graft (photographs should be taken of the graft and donor site); or
   c. severe skin deformity;
   on any part of their body. Such disfigurements may be acceptable for a PFI award.

3. Scarring that is caused by an amputation will not qualify for a separate cosmetic PFI award because the PFI rating for amputations already includes a cosmetic factor.

4. Where colour digital photographs are required, the photographs must be taken and provided to the Case Manager two years from the date of injury or the worker’s most current surgery. It is recommended that the photographs be provided as:
a. Email photo attachment;
b. Compact disk;
c. Portable flash drive; or
d. Other electronic method.

Colour photographs on photographic paper may be acceptable in some situations. The WCB will reimburse all reasonable costs associated with providing photographs.

5. The Case Manager will attach colour digital photographs to the worker's electronic claim file. Once the photographs are attached, the Case Manager will send a referral to the Medical Officer, who will complete a PFI rating.

6. Where the disfigurement involves body parts of a sensitive nature, the Case Manager will contact the Medical Officer to determine if colour digital photographs of the disfigurement are required. Sensitive photographs will be delivered directly and securely to the Medical Officer.

Act Sec # 20, 66, 115(j)
Effective Date 01 February 2015
Application Claims for disfigurement assessed on or after the effective date
Supersedes N/A
Complements POL 23/2010 PFI – General
PRO 23/2010 PFI – General
4.4.4 Permanent Functional Impairment (PFI) – General (PRO 23/2010)

Document Date 01 September 2010

Purpose To establish guidelines for assessing Permanent Functional Impairment (PFI) awards.

BACKGROUND


2. The following procedure provides guidelines for assessing Permanent Functional Impairment (PFI) awards.

PROCEDURE

1. Medical Services will provide PFI evaluations based on the most current edition of The American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides).

2. Where medical reports in the claimant’s file are inadequate to determine a PFI rating, Medical Services will first request that updated medical, including recent examination results, be provided by the attending caregiver(s). If updated medical reports are still inadequate to evaluate the permanent impairment, Medical Services will request that an examination be arranged by either:
   a. a WCB accredited community caregiver familiar with conducting injury related physical or mental health examinations; or
   b. a WCB consultant.

   In all cases, the whole person impairment will be reviewed and rated by an experienced WCB consultant trained in the use of the AMA Guides.

3. For disfigurement evaluation, the worker may be requested to provide color photographs of the affected areas. All reasonable costs associated with providing these photographs will be reimbursed to the worker.

4. Payment of a PFI award is based on a percentage rating applied to the maximum award. As per points 3 and 4 of POL 23/2010, PFI – General, the amount payable is determined by the thresholds in effect at the time of the determination of the award.

5. In a situation where a worker suffers multiple injuries from a single incident, the WCB consultant will apply the AMA Guides’ Combined Values Chart (CVC) to rate the impact of the injuries on the overall whole person impairment (WPI).
6. Workers with a PFI rating of 10 percent or greater are to be considered for the Independence Allowance. PFI awards for hearing loss or disfigurement will not be eligible. POL 27/2010, Allowance – Independence will apply.

7. In cases of progressive impairment due to disease or repetitive trauma (e.g., progressive post traumatic osteoarthritis or post surgical fibrosis), each stage of development of the impairment will not be compensated. These situations are to be handled as increases to the original injury rather than as new injuries. As a result, the difference between the former rating and the recent rating will be calculated according to the established legislation at the time of assessment.

8. Where a rating falls within the minimum range and a minimum lump sum award is provided, no further award shall be paid until the condition exceeds the minimum percentage applicable.

9. The lump sum award is to be expressed to the worker in terms of both dollars and percentage.

10. Workers are to be informed as to how their PFI award has been calculated and that the amount they receive may differ from others with the same PFI. The amount payable is dependent on the legislation in effect when a decision is made to pay an award. This also applies in cases of a minimum award, where workers with apparently more, or less, functional impairment may have received different amounts.

11. The Chief Medical Officer (CMO) will review POL 23/2010, PFI – General, and this procedure on an annual basis to ensure the correct edition of the AMA Guides is being used to determine PFI awards.

Act Sec #
19(1), 20, 66, 76(1), 81, 93

Effective Date
01 September 2010

Amended
References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013

Application
All (re) assessments for PFI or disfigurement on or after the effective date.

Supersedes
PRO 05/2007 PFI - General
PRO 10/2007 Disfigurement Awards

Complements
POL 23/2010 Permanent Functional Impairment (PFI) – General
POL 27/2010 Allowance – Independence
PRO 27/2010 Allowance – Independence
PRO 01/2015 Disfigurement Award Assessment
POL 15/2008 Allowance – Temporary Additional Expense
POL 11/2012 Injuries – Hearing Loss
PRO 11/2012 Injuries – Hearing Loss
POL 21/2010 Second Injury and Re-Employment Reserve
POL 11/2003 Injuries – Occupational Disease
PRO 13/2007  Injuries – Occupational Disease
POL 01/2009  Injuries – Psychological
POL 03/2011  Worker’s Death Prior to Issuance of Entitlement
4.4.5 Annuities (PRO 13/2013)

Document Date 17 December 2013

Purpose To provide guidelines for the administration of annuities.

BACKGROUND

1. Sections 73 and 81 of The Workers’ Compensation Act, 2013 (the “Act”) provide for the creation of annuities for eligible workers and dependent spouses when they reach age 65.

2. Board policy POL 13/2013 gives additional guidelines regarding the administration of the annuity program. The following procedure details the steps for its ongoing operation.

PROCEDURE

1. When the Annuity Management System verifies that the qualifying period has been met and contributions are being set aside, a letter informing clients that they have qualified is prepared automatically through the computer system, and forwarded to Strategic Finance for mailing.

2. Annual adjustments to the minimum annuity amount are noted in PRO 60/2015, Consumer Price Index (CPI) – Annual Increase.

3. Inquiries about the annuity program and amounts that are set-aside in a client’s annuity account are to be referred to Strategic Finance.

4. In the first quarter of every year, Strategic Finance will forward a statement to all annuity clients showing their annuity balances.

5. 60 days before an annuity first becomes payable at age 65, Strategic Finance will inform the client in writing:
   a. Of the approximate amount standing to their credit at age 65.
   b. Whether they will be required to purchase an annuity (where the total for amounts on all claims is equal to or greater than the minimum annuity amount), or may elect to receive a lump sum payout in lieu of purchasing an annuity (where the total for amounts on all claims is less than the minimum annuity amount).
   c. Of the process to follow when purchasing an annuity and additional information regarding changes to their credited amount should the annuity not be purchased until the month after it becomes payable.
d. That for amounts less than the minimum annuity amount), unless the client informs the WCB of his or her intention to purchase an annuity, Strategic Finance will payout those amounts as a lump sum payment.

6. Strategic Finance will inform clients over the age of 65, that in accordance with Point 11 of POL 13/2013, an annuity is payable as a result of an adjustment to compensation benefits. Strategic Finance will then notify clients:
   a. Of the amount standing to their credit.
   b. Whether, in accordance with Policy Point 11, they will be required to purchase an annuity or may elect to receive a lump sum payout.
   c. That interest will cease to accrue in accordance with Policy Point 11.
   d. Of the process to follow for purchasing an annuity and the provisions of Procedure Point 4(d) above.

7. After each month end, a report is to be produced for Strategic Finance that identifies all the annuity eligible clients but have not yet purchased an annuity as required or elected. These clients are to be reminded that six months following the date of first notification, their accounts will no longer be earning any interest. Thereafter, if no response is obtained, only annual reminders to purchase an annuity will be forwarded to clients.

8. In recognition of unusual circumstances where a life annuity would not appropriately meet the objective of replacing the client’s lost pension, Strategic Finance will consider proposals submitted from clients for:
   a. An alternate form of annuity that:
      i. Confirms the alternate annuity is for the purposes of providing retirement income.
      ii. Details the terms, conditions and carrier of the alternate annuity.
      iii. Guarantees the alternate annuity will:
         (a) Return the principal portion of the annuity.
         (b) Is payable from a non-registered fund.
         (c) Is payable for at least 10 years.
         The Controller will approve the alternate annuity as long as it meets all of the requirements of a life annuity.
   b. Something other than a life annuity. The Controller will make decisions on such requests on a case by case basis.

Reconsideration of a decision will only be made by the Board Members and is not subject to the regular appeal process.
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<td>Workers injured on or after January 1, 1980</td>
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<td>Dependent spouses on or after January 1, 1989</td>
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<td><strong>Supersedes</strong></td>
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<td><strong>Complements</strong></td>
<td>POL 13/2013 Annuities</td>
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<td>POL 28/2010 Compensation Rate - Minimum and Average Weekly Earnings</td>
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<td>POL 07/2014 Suspension of Benefits</td>
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<td>PRO 60/2015 Consumer Price Index (CPI) – Annual Increase</td>
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4.4.6 Capitalization of Claims (PRO 14/2010)

Document Date 30 March 2010

Purpose To establish the guidelines to capitalize a claim receiving long-term earnings replacement.

BACKGROUND

The Workers' Compensation Board (WCB) has approved POL 14/2010, Capitalization of Claims to establish the guidelines for the capitalization of claims receiving long-term earnings replacement (LTER) payments.

PROCEDURE

1. Where LTER is implemented under POL 15/2014, Determination of Long-Term Loss of Earnings, capitalization will be applied the following month in most situations except for the following:
   a. where the worker has a decreasing staged earnings replacement which is expected to result in the elimination of earnings loss; or.
   b. where the LTER is expected to be paid for a period of less than one year; or.
   c. where the worker has a staged earnings replacement with ongoing LTER, the Case Manager will delay capitalization until staging is complete and the LTER has stabilized.

2. Where it has been determined that the claim should be capitalized, the file will be referred to the Case Manager.

3. The Case Manager will ensure the information is placed on file and the net present value amount is calculated to determine the amount of funds to be set aside in order to pay for the expected wage loss in the future until the worker has reached age 65. Medical and rehabilitation costs will not be capitalized.

4. The net present value amount of the injured worker’s future LTER benefits will be charged to the employer’s cost experience as a capitalized cost in the year the amount is determined.

5. For experience rating purposes, Employer Services will include this capitalized amount in the employer’s cost experience. However, the total cost used in the calculation will be limited to an amount equal to the maximum assessable wage. Policy POL 01/2007, Experience Rating Program, will apply.

6. The Case Manager will annually review and verify the worker’s earnings to determine if adjustments to the LTER benefits are required. If the LTER is adjusted
on the basis of a review (POL 12/2010, Verification of Earnings), the Case Manager will adjust the capitalized amount.

7. Where the capitalized amount is adjusted, any variance will be recorded in the employer's cost experience in the year that it is applied.

8. When LTER benefits are capitalized, the amount will be shown on the employer's monthly cost statement in the month that it is applied. Since the future value of medical and rehabilitation costs cannot be projected, these costs will continue to be included in future cost statements.

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| Application        | Long-term earnings replacement claims |
| Supersedes         | n/a                                |
| Complements        | POL 14/2010 Capitalization of Claims |
|                    | POL 01/2007 Experience Rating Program |
|                    | PRO 01/2007 Experience Rating Program |
|                    | POL 15/2014 Determination of Long-Term Loss of Earnings |
|                    | POL 09/2013 Estimating Earning Capacity – Commissioned Sales & Self-Employment |
|                    | POL 12/2010 Verification of Earnings |
|                    | PRO 12/2010 Verification of Earnings |
|                    | PRO 01/2011 Vocational Rehabilitation – Programs and Services |
4.5 Reduction, Suspension, or Termination
4.5.1 Suspension of Benefits (PRO 07/2014)

Document Date 29 April 2014

Purpose To establish guidelines for the suspension of benefits.

BACKGROUND

The Saskatchewan Workers’ Compensation Board (WCB) has approved POL 07/2014, Suspension of Benefits. The following procedure provides specific guidelines for WCB staff when determining whether to suspend benefits under POL 07/2014.

PROCEDURE

1. The WCB will ensure that clients understand their responsibilities regarding attendance. Operations staff will provide clients with information about POL 07/2014 in a Letter of Claims Acceptance (LCA) at the start of their treatment program and individualized vocational plan (IVP).

2. Clients on surgical wait lists will be sent a letter outlining the possible consequences of missing a surgery date. This may include a retroactive suspension when the client fails to provide prompt notice to the WCB.

3. Clients will provide the reason(s) for their absence to Operations staff or the health care facility. If the client fails to provide the reason within a reasonable time, Operations staff will consider establishing an overpayment of any wage-loss benefits paid beyond the start of the client’s absence.

Absence for Good Reason

4. Clients that provide a good reason for their absence may receive wage loss benefits during a notice period of up to four weeks or until they qualify for an alternate source of support, whichever occurs first. A good reason includes, but is not limited to:
   a. Severe illness or disablement caused by conditions such as heart attack, pneumonia, hospitalization or treatment for substance abuse, or
   b. A pressing necessity or bereavement leave that the WCB would accept for its own staff.

5. In cases of chronic or prolonged absences, the WCB may require medical verification of the severe illness or disablement.

6. Prior to determining the notice period, Operations staff will contact the employer to determine:
   a. Benefit eligibility, and
b. The effective date for other forms of support (for example, employer sick leave, and other private or government long or short-term disability plans). Operations staff will not consider vacation pay as an alternate form of support.

7. When the worker’s alternate form of support does not cover the entire four week notice period, Operations staff will reinstate benefits for the remaining balance of the notice period.

8. During the notice period, a client who received partial wage loss benefits prior to an absence from health care or an IVP will continue to receive benefits in the amount paid prior to the absence.

9. Typically, the WCB will not suspend benefits for short term casual absences that do not serve to extend the health care or IVP (Appendix A). Suspension may occur if the number of absences reaches a point in which Operations staff may reasonably expect the absences to prolong the health care or IVP.

10. In general, the WCB will only provide a notice period once during the lifetime of a claim. However, the WCB may provide an additional notice period if the client has a new good reason for further absence. The good reason must be unrelated to the circumstances associated with the original suspension.

Suspension of Benefits

11. Before suspending benefits, Operations staff must consider whether the absence was for good reason and if it will increase or prolong the loss of earnings.
   a. When the absence was for good reason, reinstatement will occur when the client is once again available for or fit to resume the health care or IVP.
   b. When the absence was not for good reason, reinstatement will occur when the client actually resumes the health care or IVP.

12. In deciding to suspend benefits, Operations staff must determine whether the outcome of the claim would involve ongoing loss of earnings, regardless of the absence. If so, Operations staff will:
   a. Estimate what the earnings loss would be had the client completed the health care or IVP, and
   b. Arrange for payment accordingly.

13. If Operations staff cannot determine if a client will qualify for wage loss entitlement after the conclusion of the health care and IVP, suspension of benefits may occur in full until the client returns to the treatment or programming.

14. Operations staff will make a retroactive adjustment when a client with a full suspension later qualifies for a long term earnings replacement. The adjustment will reflect the worker’s long term earnings capacity.
15. The WCB will not assume costs relating to an illness or disability not associated with the work injury. This includes costs for:
   a. Health care or travel, or
   b. The obtainment of a medical certificate.

16. When appropriate, Operations staff will provide non-financial assistance. For example:
   a. Referral to an appropriate support agency, or
   b. Assistance with completion of an application for an alternate source of support.

17. In the case of a lengthy suspension, Operations staff will attempt to return the client to an acceptable program as soon as possible. This may include arranging a suitable alternate health care or IVP.

18. Operations staff will provide the client with a written explanation for the suspension of benefits.

Program Review

19. Operations staff will refer to the Medical and Health Care Services Unit (MHSU) if a health care facility submits two or more client absentee reports indicating that the client’s absence(s) will not extend the treatment program. MHSU will evaluate:
   a. The need for ongoing medical treatment, or
   b. The length of the current program.

   Operations staff will provide the results of the program review to the treatment team. The treatment team will modify the treatment program in accordance with MHSU’s recommendation.

Evaluation

20. Team Leaders or Claims Entitlement Supervisors will approve and monitor all suspensions of benefits to ensure compliancy with The Workers’ Compensation Act, 2013 (the “Act”) and POL 07/2014. This includes monitoring:
   a. The circumstances of the suspension, and
   b. The staff involved in the suspension decisions.
## ATTACHMENTS

### Appendix A – Casual Absences - Good Reason Guidelines

<table>
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<th>Application</th>
<th>Supersedes</th>
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<td>PRO 03/2009</td>
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<td>POL 01/2008</td>
<td>Suspension of Benefits – Pregnancy</td>
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GENERAL

Where possible, clients should seek approval prior to missing an appointment. An Operations staff member (for example, Case Manager, Claims Entitlement Specialist, Vocational Rehabilitation Specialist) may grant this approval if it is for a good reason. The WCB considers a good reason to be circumstances or matters beyond the client’s control. An employer would normally find such a reason and the length of absence from work to be acceptable.

GUIDELINES

The following are good reasons for casual absences from health care or an IVP and are of the same type that the WCB would accept from its own staff:

1. Court Appearance/Jury Duty
   The WCB will allow clients to miss appointments where they receive a summons or subpoena to appear in Court as a witness or for jury duty.

2. Illness
   The WCB will allow clients to miss appointments for less severe illness (for example, flu). If such an illness extends for three or more days, medical verification may be required from a health care provider.

3. Voting
   The WCB will allow clients to miss appointments to vote in either a provincial or federal election.

4. Severe Weather Restricting Travel

5. Reasons of Pressing Necessity
   The WCB will allow clients to miss appointments for other urgent matters requiring their personal attendance. Examples include:
   - Sickness, grave illness or death of an immediate family member (for example, the client’s spouse, parent, grandparent, child, sister, brother, mother-in-law, father-in-law, as well as the siblings, children, grandparents or grandchildren of the client’s spouse).
   - Death in client’s extended family (for example, first cousin, aunt, uncle).
   - Attendance at funeral for non-family member.
   - Moving.
- Birth of child.
- Babysitting predicament (for example, the babysitter is sick or quits).
- Family legal matters.
- Medical appointments, or
- Home emergencies.
4.5.7 Termination of Compensation Benefits – Notice (PRO 17/2010)

Document Date 31 March 2010

Purpose To establish guidelines for providing notice of termination of compensation benefits.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved policy that establishes guidelines for providing notice of termination of compensation benefits.

2. The following procedure provides detailed guidance for implementation of the policy.

PROCEDURE

1. Operations staff will provide the worker with a minimum of two weeks notice of termination, commencing on the date of notice, for every 12 consecutive months a worker is in receipt of wage loss benefits, up to a maximum of six months notice.

2. Where Operations staff verbally notifies the worker of termination (e.g., face to face or over the phone), prior to written notification, notice of termination will commence on the date of the verbal notification. Verbal notification confirming contact with the worker must be followed by written notice and documented on the worker’s file in order for the notification to be considered valid.

3. Operations staff will ensure that the written notice directs that if the worker returns to employment prior to the termination of compensation benefits, the worker must immediately notify the WCB.

4. Where the worker returns to employment prior to the expiry of the notification period, the Case Manager will terminate compensation benefits at the earlier date.

5. Operations staff may make workers aware that there may be options for the worker to access alternative support programs.

Act Sec # 101(1)(a)
Effective Date 01 May 2010
Amendment References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All claims with benefits paid 12 consecutive months or longer, deemed “fit” but with no employment to return to
Supersedes n/a
Complements POL 17/2010 Termination of Compensation Benefits – Notice
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5.0 BENEFITS TO DEPENDENTS

5.1 Initial Entitlement and (Re)Employment Assistance – Dependent Spouses (PRO 33/2010).............................................................................................................. 3

5.3 Dependent Spouses, Children with a Disability and Other Dependants of Fatally Injured Workers (PRO 03/2010)........................................ 6

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5.5 Dependent Children Attending School (PRO 19/96)................................. 10
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5.1  Initial Entitlement and (Re)Employment Assistance – Dependent Spouses (PRO 33/2010)

Document Date  09 November 2010
Purpose  To establish guidelines for providing benefits and (re)employment assistance to dependent spouses.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 33/2010, Initial Entitlement and (Re)Employment Assistance – Dependent Spouses, which establishes guidelines for providing benefits and (re)employment assistance to dependent spouses.

2. The following procedure provides guidance for the implementation of POL 33/2010.

PROCEDURE

General

1. Where it is not initially apparent as to which benefits the dependent spouse may be entitled (Section 81 or 93), the WCB will provide benefits to the dependent spouse, for at least three months, until a decision is realized.

Death of the Worker is Due to a Work-Related Injury – Section 81

3. Where the death of the worker is due to a work-related injury, in accordance with Section 81 of the Act, the WCB will provide compensation to the dependent spouse on a monthly basis for an initial period of five years.

4. Where there are dependent children, the WCB will provide compensation to the dependent spouse on a monthly basis until the youngest dependent child reaches age 16, or age 18 if attending school full time.

5. Following the initial periods of compensation noted above, the WCB will provide compensation on a monthly basis until the dependent spouse reaches age 65, in an amount equal to the difference between;

   a. 90 percent of the deceased worker’s average weekly earnings at the time of injury or death, indexed pursuant to Section 69(2) of the Act; and

   b. The dependent spouse’s actual earnings or, if called for by Section 101 of the Act, the spouse’s estimated earnings.
Death of Worker is Not Due to a Work-Related Injury – Section 93

6. The Case Manager and Vocational Rehabilitation Specialist will make a joint decision as to whether the dependent spouse will qualify for (re)employment assistance.

7. Where the death of the worker is not due to a work-related injury and worker was in receipt of benefits for less than 24 consecutive months, in accordance with Section 93(1) of the Act, the WCB will provide benefits to the dependent spouse, or other dependants where there is no dependent spouse, for a period of three months. The payee will be given the choice of receiving a one time lump-sum payment or three monthly payments. Where Section 93(1) of the Act applies, the WCB will not provide (re)employment assistance.

8. Where the worker was in receipt of benefits for 24 consecutive months or greater, in accordance with Section 93(3) of the Act, the WCB will provide benefits on a monthly basis to the dependent spouse for a period of 12 months. During this 12 month period, the Case Manager and Vocational Rehabilitation Specialist will make a joint decision as to whether the dependent spouse will qualify for (re)employment assistance.

9. In instances where Section 93(1) or 93(3) of the Act apply, entitlement will not be indexed. The extension of payment is based on the level of benefits payable at the time of the worker’s death.

Application of (Re)Employment Assistance

10. Where the Case Manager and Vocational Rehabilitation Specialist make a joint determination that (re)employment assistance will benefit the dependent spouse, the Vocational Rehabilitation Specialist will develop an Individualized Vocational Plan in accordance with the provisions of POL 01/2011, Vocational Rehabilitation – Programs and Services.

Annuities for Dependent Spouses

11. Once the dependent spouse is in receipt of benefits for a period exceeding 24 consecutive months, Finance will provide an annuity to dependent spouses in accordance with POL 13/2013, Annuities.

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<td>19(1)(d), 69(2), 81(1), 81(2), 81(5), 81(6), 92, 93, 101(1), 101(2), 111(c), 115(f)</td>
<td>01 January 2011</td>
<td>References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013.</td>
<td>All dependent spouses on and after the effective date.</td>
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### Benefits to Dependents

**Section 5** – Page 5

**Doc # 5.1**  
*Initial Entitlement and (Re)Employment Assistance – Dependent Spouses (PRO 33/2010)*

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<td>Vocational Rehabilitation – Programs and Services</td>
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5.3 Dependent Spouses, Children with a Disability and Other Dependents of Fatally Injured Workers (PRO 03/2010)

Document Date 17 February 2010
Purpose To establish guidelines for the payment of benefits to dependants of fatally injured workers.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved guidelines for the payment of benefits to dependent spouses, children with a disability and other dependants of fatally injured workers.

2. The following procedure provides guidance for the implementation of the policy.

PROCEDURE

1. Where a fatally injured worker was providing financial support to a child with a disability at the time of death, Operations staff will review the child’s circumstances when the child reaches the age of majority (18) to determine if benefits are payable under Section 85(5) of The Workers’ Compensation Act, 2013 (the “Act”). Operations staff will review the file on an annual basis to determine whether the medical circumstances related to the physical and or mental restriction leading to the child’s disability still exist. Operations staff may be required to obtain medical reports or information from care givers regarding the child’s condition.

2. Where Operations staff determine that the child, having reached the age of majority, is capable of maintaining full-time employment earning a wage equal to or greater than the current provincial minimum wage, the child will no longer be considered restricted by their disability. Operations will provide written notification to the child and or the child’s authorized representative that WCB benefits provided under Section 85(5) of the Act will cease as of a specified date.

3. Operations will determine whether a surviving common law spouse meets the criteria set out in Section 2(1)(gg) of the Act. Operations staff will gather all relevant information required to verify the common law relationship. Where the relationship is verified, Operations will ensure that the common law spouse receives all benefits to which a dependent spouse would be entitled in the same circumstances.

4. Where the worker is survived by a dependent spouse and one or more additional dependants as described by Section 82 of the Act, Operations will calculate the apportioned amount of WCB benefits payable to those dependants under the Act. The combination of payments made to dependent spouses, not including entitlement for dependent children or children with a disability issued under Sections 83 and
85(5) of the Act, cannot exceed the equivalent of full spousal benefits called for by Section 81(1) of the Act. Payments made to dependent children or children with a disability under Sections 85(4) and 90 of the Act will be deducted from the amount of spousal benefits payable under Section 81(1) of the Act.

5. Where the worker and the worker’s spouse and or children were separated (i.e., still married but living separate) at the time of the worker’s death, Operations staff must obtain verification that financial support was being provided or actively pursued at the time of death before a separated spouse and or children can be considered as dependants of the worker. Typically this will involve obtaining financial records and or copies of separation agreements. The WCB will not provide benefits to cover the amount of support payments that may have been in arrears at the time of death.

6. Operations will review each file on its own merits to determine whether compensation should be provided to other dependants (e.g., parents, grandparents). The amount of benefits and the method of payment made by the WCB should reflect the financial support being provided by the worker to other dependants at the time of the worker’s death.

7. Where Operations staff determine that other dependants are eligible for compensation in accordance with the death of the worker, the amount of benefits paid to other dependants under Section 86(1) of the Act will reduce spousal benefits by the corresponding amount.

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| 2(1)(j), 2(1)(gg), 25, 55, 81, 82, 85, 86, 87, 88, 90, 93 | 01 April 2010 | References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013.* | All new fatality claims on and after the effective date. | n/a | POL 03/2010 Dependent Spouses, Children with a Disability and other Dependents of Fatally Injured Workers  
POL 02/2015 Compensation – Dependent Spouse After Initial Entitlement  
POL 04/2010 Attachment of Compensation  
PRO 04/2010 Attachment of Compensation  
POL 03/2007 Calculation of Net Compensation Payable  
POL 33/2010 Initial Entitlement and (Re) Employment Assistance – Dependent Spouses |

Effective Date
01 April 2010

Amended
References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013.*

Application
All new fatality claims on and after the effective date.

Supersedes
n/a

Complements
POL 03/2010 Dependent Spouses, Children with a Disability and other Dependents of Fatally Injured Workers  
POL 02/2015 Compensation – Dependent Spouse After Initial Entitlement  
POL 04/2010 Attachment of Compensation  
PRO 04/2010 Attachment of Compensation  
POL 03/2007 Calculation of Net Compensation Payable  
POL 33/2010 Initial Entitlement and (Re) Employment Assistance – Dependent Spouses
5.4 Support – Family of Seriously Injured Workers (PRO 06/2014)

Document Date 29 April 2014

Purpose To provide administrative guidelines for WCB staff giving support to the family of seriously-injured workers.

DEFINITION

Family member means a spouse, parent, legal guardian, grandparent, child, grandchild, or sibling (Section 2(1)(y) of The Workers’ Compensation Act, 2013).

Serious injury, for the purpose of this procedure, means a life-threatening injury, or an injury that results in a permanent loss of function or significant disfigurement. Serious injuries may include, but are not limited to, the following:

- Quadriplegia.
- Paraplegia.
- Upper limb amputation.
- Lower limb amputation.
- Severe head injury.
- Severe burns.
- Blindness.

BACKGROUND

POL 06/2014, Support – Family of Seriously Injured Workers allows the WCB to provide support to the family of seriously-injured workers.

PROCEDURE

Travel

1. Case Managers (CMs) may give travel support to family members of seriously injured workers in an effort to reduce the short-term stress and hardship that may be caused as a result of their need to attend the treating facility.

2. CMs will provide up to seven calendar days of travel support. If a life-threatening condition persists, support may extend past seven days.
3. The CM will inform the injured worker’s family that travel, lodging and meal rates are subject to WCB travel rates (PRO 54/2015, Expenses – Travel and Sustenance – PSC Rates).

Counselling

4. If the family needs help coping with the serious injury and its consequences, the CM will pay for counselling.

5. The CM will give travel support to family members that need to travel outside their home community for counselling sessions.

Child Care

6. The CM will pay for child care costs that exceed what the family paid prior to the worker’s injury. This includes costs resulting from:
   a. Traveling to see the worker in hospital.
   b. Hospital attendance.

Additional Support

7. If needed, the CM may pay for such things as:
   a. Family member earnings loss.
   b. Laundry.
   c. Parking.

8. The CM will pay for family member earnings loss if the family member’s employer does not provide them with paid leave to go see the injured worker. Family member earnings loss is subject to attendant salary limits noted in POL 39/2010, Expenses – Travel and Sustenance – General.

Act Sec #  2(1)(y), 103(1), 115(j)
Effective Date 01 June 2014
Application Family of workers that are seriously injured
Supersedes n/a
Complements POL 06/2014 Support – Family of Seriously Injured Workers
       POL 54/2015 Expenses – Travel and Sustenance – PSC Rates
       POL 39/2010 Expenses – Travel and Sustenance – General
       POL 15/2008 Allowance – Temporary Additional Expense
       PRO 15/2008 Allowance – Temporary Additional Expense
5.5  Dependent Children Attending School (PRO 19/96)

Document Date 02 December 1996

Purpose To establish detailed procedures for Educational Allowance payments.

BACKGROUND

Section 83 of The Workers’ Compensation Act, 2013, provides educational allowances for dependent children at least 18 years of age and in full time attendance at a secondary or post-secondary institution.

PROCEDURE

1. Where the dependent child is in full time attendance at a secondary or post-secondary institution, a maximum of 36 months allowance plus tuition is payable for actual attendance.

2. Allowance is not payable for summer months if not in full-time attendance.

3. Tuition will be paid as long as the allowance is paid for at least one month of the school term.

4. Monthly allowances will not be prorated. Where tuition is paid for full time attendance, the student is eligible to receive a full monthly allowance.

Act Sec # 83
Effective Date 01 January 1997
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application Educational Allowances for Dependent Children
Supersedes POL 02/85 Compensation While Dependent Child Furthering or Bettering Education
Complements POL 03/97 Allowances – Educational
6.0 ADMINISTRATIVE GUIDELINES

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6.2 Employer Late Reporting of Injury Claims (PRO 02/2009)

Document Date 10 March 2009

Purpose To establish guidelines for the prosecution of employers for late reporting of work-related injuries.

BACKGROUND

1. The Workers' Compensation Board (WCB) has approved policy that applies to Section 54 of The Workers' Compensation Act, 2013 (the “Act”) – Offence for failure to report injury.

2. The following procedure provides guidance for implementation of the policy.

PROCEDURE

1. Operations will monitor all employers to ensure compliance under Section 52(1) of the Act. Due to the Board’s directive noted in POL 02/2009, Employers Late Reporting of Injury Claims, employers with a chronic pattern of late reporting will prompt punitive measures.

2. Where an employer is identified to be non-compliant with Section 52(1) of the Act and has a chronic pattern of late reporting of work-related injuries, the employer’s current injury reporting situation will be referred to the Prevention Department for follow up. A representative from the Prevention Department will contact the employer in question regarding the current reporting situation. A three month grace period will be allowed before any further action is taken against this employer. This grace period will provide the Prevention Department time to work with the employer to identify reporting problems, and to correct them. Extensions to the grace period will be authorized or recommended by the Prevention Department in certain situations.

3. Where there is subsequent occurrences of late reporting of work-related injuries following the three month grace period, Operations will issue a “Final Notice Letter” to the employer.

4. Where an employer continues to be late in reporting work-related injuries in spite of the “Final Notice Letter,” a referral will be made via the Legal Department, to the Crown Prosecutor, to determine if the employer breached Section 52(1) of the Act and has a chronic pattern of late reporting of work-related injuries, and if charges should be laid in accordance with Section 54 of the Act.

5. Once the Crown Prosecutor has reviewed the information provided and determined that charges will be laid, the Crown Prosecutor will provide that information to a WCB representative. These documents will be verified true by a Justice of the
Peace. Following verification, the documents will be referred through the Legal Department to the Crown Prosecutor, who will serve the charges.

6. Revenue acquired from fines levied on employers by the Crown Prosecutor shall form part of the injury fund in accordance with Section 180(3) of the Act.

| Act Sec # | 21(r), 2(1)(r), 52(1), 54, 163(1), 180(3) |
| Effective Date | 1 April 2009 |
| Amended | References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013 |
| Application | All employers reporting work injuries |
| Supersedes | n/a |
| Complements | POL 02/2009  Employer Late Reporting of Injury Claims |
6.4 Funding (PRO 02/2013)

Document Date 05 March 2013

Purpose To establish guidelines for the maintenance of a fully funded status.

BACKGROUND

1. POL 01/2014, Funding, has been approved. This policy provides guidelines for maintaining the appropriate reserve balances and the Injury Fund balance.

2. The following procedure provides guidance for the implementation of POL 01/2014.

PROCEDURE

1. At the end of each fiscal year, Finance will calculate reserve levels based on actuarially determined benefit liabilities. Once the reserve levels have been determined for the year, the Injury Fund balance will be reviewed to determine if it is within the targeted funding range of 105 percent to 120 percent of the previous year’s benefit liabilities as actuarially determined.

2. Where the funded status falls below 103 percent, the Workers’ Compensation Board (WCB), at its discretion, will make a decision on how to replenish the Injury Fund. The replenishment may be accomplished through a charge to the premium rates over a period not to exceed five years.

3. Where the funded status rises above 122 percent, refunds will be distributed to employers, at the WCB’s discretion, over a period not to exceed five years until the fund reaches 120 percent.

4. To maintain stable funding levels and premium rates under International Financial Reporting Standards (IFRS), unrealized gains and losses on investments will not be considered in the determination of the WCB’s funded status.

Act Sec # 114, 116, 117, 134, 145
Effective Date 31 December 2013
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application Injury Fund and Second Injury and Re-Employment Reserve levels.
Supersedes PRO 08/2012 Funding
Complements POL 01/2014 Funding
POL 21/2010 Second Injury and Re-Employment Reserve
POL 05/2014 Occupational Disease Reserve
POL 12/2014 Disaster Reserve
6.5 Determination of a Worker’s Right to Bring Action (PRO 01/2013)

Document Date 22 January 2013
Purpose To establish guidelines for determining if a right of action exists.

BACKGROUND

POL 01/2013, Determination of a Worker’s Right to Bring Action, establishes the Board Members’ exclusive responsibility in determining applications for right of action under Section 169 of The Workers’ Compensation Act, 2013 (the “Act”).

PROCEDURE

1. As per POL 13/2014, Third Party Actions, Operations staff and the Subrogation Administrator will attempt to identify claims where a worker has a right of action against a third party. Where the possibility of an action is raised, Operations staff will consider the issue and advise the claimant if they feel, in their opinion, the facts available are likely to provide the basis for an action.

2. Where there is a dispute on whether a right of action exists, any party to an action may request a ruling on whether the action is barred by the Act. It is not necessary for a compensation claim to have been initiated for a ruling to be made under Section 169.

3. All inquiries concerning a Section 169 ruling should be forwarded to the Board Services department.

4. On straightforward matters, Board Services may contact the party making the inquiry and inform them of WCB practice and previous rulings in similar cases. This may allow the party to avoid the necessity of a full Section 169 ruling. The advice provided by Board Services will not remove the party’s right to request a ruling and is not intended to suggest the Workers’ Compensation Board (WCB) has prejudged the case.

5. An application for a Section 169 ruling must be in writing and no application will be considered unless an action has been commenced. It is necessary for the WCB to have all the details of the grounds for the action in order to make a ruling.

6. On receipt of an application, Board Services will contact all parties requesting their submissions. Board Services will ensure the parties are provided copies of all the submissions and are given the opportunity to submit rebuttal arguments. Appropriate timeframes for submissions will be established.
7. Any party to the action may request an in person hearing and any such request will be considered by the Board Members.

8. The Board Members will make their ruling once:
   a. all submissions are received; and
   b. if indicated, an in person hearing has occurred.

   Each party to the application will receive an original signed decision.

| Act Sec #  | 43, 167, 168, 169 |
| Effective Date | 01 February 2013. |
| Amended      | References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013* |
| Application  | All applicants desiring to bring an action. |
| Supersedes   | n/a |
| Complements  | POL 01/2013 *Determination of a Worker’s Right to Bring Action*  
              | POL 13/2014 *Third Party Actions*  
              | PRO 13/2014 *Third Party Actions* |
6.6 Third Party Actions (PRO 13/2014)

Document Date 03 September 2013

Purpose To provide guidelines for the management of third party actions.

BACKGROUND

The Workers’ Compensation Board (WCB) has approved POL 13/2014, Third Party Actions. The following procedure provides WCB staff with guidelines for the management of these claims.

PROCEDURE

1. Operations staff members are responsible for identifying claims for work injuries that involve third parties. This includes, but is not limited to:
   a. Motor vehicle collisions.
   b. Fatality claims.
   c. Claims involving product liability (for example, asbestos related injuries, equipment failures, premature air bag inflations).
   d. Aircraft crashes.
   e. Claims involving assault (physical or psychological) against an injured worker, including dog/animal attacks.
   f. Claims involving negligence by a third party (for example, exposure to environmental/dangerous hazards, lack of fire alarms or firefighting equipment), and
   g. Slip and fall claims.

2. Operations staff will refer such claims to the Subrogation Administrator (SA) if:
   a. The claim has been accepted, and
   b. The general limitation period of two years for starting an action has not expired.

3. Operations staff will not refer claims for workers covered under the Government Employees Compensation Act (GECA). Employment and Social Development Canada (ESDC – Labour Program) manages federal government third party actions.

4. Operations staff will assist the SA in determining the future costs of claims (for example, benefit, medical and vocational rehabilitation costs):
   a. Operations staff will determine future costs by reviewing the cost history of the claim, expected recovery tables, and the medical prognosis.
b. Where the client is receiving long term earnings replacement, Operations staff will use wage loss capitalization to project future benefit costs (POL 14/2010, Capitalization of Claims).

5. The SA will contact the client or their representative to determine if:
   a. They have started a third party action, or
   b. Plan to take action.

6. If the client chooses to take action, the SA will advise the client or their representative of the WCB’s claim in the third party action.

7. If the client chooses not to take action, the SA will refer the claim to the Corporate Solicitor. The Corporate Solicitor will review the case to determine whether the WCB should take action to recover the costs of the claim. This includes considering factors such as:
   a. The amount of damages the WCB could recover.
   b. The cost effectiveness of proving the case, and
   c. How successful the WCB might be in collecting the judgment.

Employer Cost Relief

8. When the WCB’s action is successful, the SA will send the award to the Finance department. Finance staff will deposit the award so the WCB can provide cost relief for the respective employer. The cost relief will equal the lesser of:
   a. The claims costs charged against the employer (less legal fees), or
   b. The amount of the settlement.

Compromised Settlements

9. The WCB must provide written approval for a settlement that is for an amount less than the claim costs. Clients or their legal representatives must submit requests for approval to the Corporate Solicitor.

Reporting

10. The SA will provide a quarterly report to the Chief Executive Officer (CEO). The report will indicate missed subrogation opportunities.

11. The Service Excellence team will ensure ongoing training is provided to Operations staff for identifying claims that involve third parties.
Act Sec # 2, 38, 39, 40, 41, 42, and 43
Effective Date 01 November 2014.
Application All claims involving third parties.
Supersedes PRO 04/2007 Third Party Actions/Subrogation
Complements POL 13/2014 Third Party Actions
                 POL 01/2013 Determination of a Worker’s Right to Bring Action
                 POL 14/2010 Capitalization of Claims
6.7 Compensation – Layoff, Strike or Lockout (PRO 02/2008)

Document Date 16 January 2008

Purpose To establish guidelines for determining entitlement where the worker’s return-to-work plan is disrupted by layoff, strike, or lockout.

BACKGROUND

1. POL 02/2008, Compensation – Layoff, Strike or Lockout provides guidelines for determining entitlement to compensation benefits for injured workers who are unable to participate in their return-to-work (RTW) plan due to a layoff, strike or lockout.

2. The following provides staff with guidelines to implement POL 02/2008.

PROCEDURE

1. Where work restrictions are identified, Operations staff will determine entitlement to compensation benefits.

2. In accordance with POL 02/2008, where a worker’s part-time employment or partial RTW program is interrupted by a layoff, strike or lockout, Operations staff will ensure that the worker continues to receive partial WCB benefits. However, Operations will neither increase those benefits nor place the worker on full benefits so long as the layoff, strike or lockout, rather than the work injury, is the reason the worker cannot continue in his/her employment or RTW plan.

3. Where a layoff, strike, or lockout is long-term, and no resolution appears imminent, the worker’s individual circumstances will be used to determine if obtaining alternative employment represents the most practical means of reducing or eliminating wage loss (e.g., years of seniority, job skill level, nature of employment, severity of injury and how long the work disruption is expected to last).

Act Sec # 26, 100
Effective Date 01 February 2008
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act 2013
Application All workers who are unable to participate in their return-to-work (RTW) programming, due to a layoff, strike or lockout.
Supersedes n/a
Complements POL 02/2008 Compensation – Layoff, Strike or Lockout
POL 08/96 Return-to-Work Plans
POL 01/2011 Vocational Rehabilitation – Programs and Services
6.8 Voluntary Relocation Outside Canada (PRO 07/2007)

Document Date 04 June 2007

Purpose To establish guidelines for managing claims where clients voluntarily relocate their residence outside Canada.

BACKGROUND

1. POL 07/2007, Voluntary Relocation Outside Canada has been approved regarding the management of claims where clients of the Workers’ Compensation Board (WCB) voluntarily relocate outside Canada.

2. The following provides WCB staff with guidelines to implement POL 07/2007.

PROCEDURE

1. The Case Manager is responsible for the initial communication to clients after acceptance of the claim in accordance with Point 1 of POL 07/2007.

2. In accordance with Point 2 of POL 07/2007, where a client resides outside Canada while in receipt of Long-Term Earnings Replacement, the Case Manager must complete a re-evaluation of the estimation of earning capacity on an annual basis and convert the estimated wage in the country of residence to Canadian funds. (This will not result in greater entitlement than the client would have received had he/she continued to reside in Canada.) This annual review will be conducted on the anniversary date of the claim.

3. The Case Manager will provide a form letter informing the client that he/she is required to provide copies of tax returns both for Canada and the current country of residence (where that jurisdiction requires a return to be filed) in order to verify the client’s earnings. In accordance with Point 3 of POL 07/2007, the form letter will also inform clients that where they do not file a tax return, they are still required to inform the WCB of this in writing and include confirmation of earnings.

4. Where a client moves while under active treatment, or is already residing outside Canada and suffers a recurrence requiring treatment:
   a. The Case Management Team will meet to define the medical treatment that would have been followed in Saskatchewan;
   b. The client is to be informed of this plan, and where it is interrupted or extended by the client’s choice to relocate, his/her benefits may be terminated or suspended;
   c. The Case Management Team will monitor the situation to determine whether the client should return to Saskatchewan (or another jurisdiction providing more...
convenient, but equivalent, service) for medical treatment or diagnostic examination. Where treatment or an examination is required, it will be at the expense of the WCB.

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<tr>
<th>Act Sec #</th>
<th>36, 58(1), 58(2), 101, 103(2)</th>
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<tr>
<td>Effective Date</td>
<td>01 June 2007.</td>
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<tr>
<td>Amended</td>
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<tr>
<td>Application</td>
<td>All clients residing outside Canada.</td>
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<tr>
<td>Supersedes</td>
<td>PRO 22/95 Voluntary Relocation Outside Canada</td>
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<tr>
<td>Complements</td>
<td>POL 07/2007 Voluntary Relocation Outside Canada</td>
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6.9 Verification of Earnings (PRO 12/2010)

Document Date 03 March 2010

Purpose To establish guidelines for the verification of earnings.

BACKGROUND

The Workers’ Compensation Board (WCB) has approved POL 12/2010, Verification of Earnings, which outlines the process for the verification of earnings that is required on all claims with long-term earnings replacement.

PROCEDURE

1. Long-term earnings replacement will not be paid without some form of earnings verification. WCB staff are responsible for determining what form of verification is required. Whenever possible, verification will occur through a request for tax information or a Notice of Assessment from the Canada Revenue Agency (CRA).

2. Where CRA tax information confirms that a client’s long-term earnings replacement was calculated using incorrect earnings information, WCB staff will recalculate and adjust long-term earnings replacement. The new rate will be adjusted retroactively to the date at which the incorrect information would have affected the long-term earnings replacement rate. Where the recalculation results in an overpayment, recovery of the overpayment will be pursued in accordance with POL 38/2010, Overpayment Recovery – Compensation.

3. Where CRA tax information is unavailable, verification may not be required if a worker is institutionalized, or is clearly unable to perform any gainful employment. WCB staff must review the client’s file in order to determine if there is any evidence of the client securing earnings from employment.

Act Sec # 20, 25, 44, 68, 81(6)
Effective Date 01 May 2010
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All long-term earnings replacement annual verifications after effective date
Supersedes PRO 19/98 Verification of Earnings
POL 12/2010 Verification of Earnings
POL 24/2013 Offset of Canada or Quebec Pension Plan Disability Benefits
POL 38/2010 Overpayment Recovery – Compensation

Complements
6.11 Attachment of Compensation (PRO 04/2010)

Document Date 02 March 2010
Purpose To establish guidelines for legal attachments on compensation.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved policy that establishes guidelines for legal attachments on compensation, such as where the WCB receives obligatory notices of garnishment from the Canada Revenue Agency (CRA), support orders filed under The Enforcement of Maintenance Orders Act, 1997, or Employment and Social Development Canada (ESDC).

2. The following procedure provides guidance for the implementation of POL 04/2010, Attachment of Compensation.

PROCEDURE

1. All notices of garnishment received from the CRA, the Saskatchewan Ministry of Justice and Attorney General’s Maintenance Enforcement Office (MEO), or ESDC will be the responsibility of Operations staff.

2. In cases of multiple notices of garnishment that are obligatory in nature, Operations staff will ensure that the garnishee pays the full amount required by the CRA before honouring legal attachments from the MEO or ESDC.

3. Where an obligatory notice of garnishment is received, wage loss benefits, permanent functional impairment or disfigurement awards will be subject to the terms of the notice or order.

4. Under The Enforcement of Maintenance Orders Act, 1997, the MEO has the ability to garnish annuity benefits at the time the worker reaches age 65, and prior to the worker reaching age 65 if certain criteria outlined in The Enforcement of Maintenance Orders Act, 1997 are met. Any garnishment of annuity benefits received from the MEO will be honoured by the WCB.

5. In the event that the CRA and or ESDC create legislation that allows garnishment from annuity benefits, these attachments will also be honoured by the WCB.

6. Where the WCB receives a notice of garnishment, Operations staff will redirect the requested amount from the worker’s eligible benefits to the CRA, the MEO, or ESDC. Operations staff will provide the worker with a written explanation for the deductions.
7. Where the WCB halts attachments on compensation, regardless of reason, Operations staff will provide all affected parties with written notification.

Maintenance Orders

8. Maintenance orders from other jurisdictions can be enforced by the Saskatchewan MEO under reciprocal enforcement legislation. Where an out-of-province order is received, Operations staff will advise the other jurisdiction that registration with the Saskatchewan MEO is required before any garnishment can be applied.

9. The MEO can serve a notice of continuing garnishment which requires ongoing, periodic attachment until the order has been terminated. Where the MEO serves this notice to the WCB directing the ongoing attachment of the worker’s benefits, an extra copy of the notice will be provided. Operations staff will forward the extra copy, with an attached explanation letter, to the worker without delay. Operations staff will forward a copy of the explanation letter to the MEO.

Other

10. Where the worker disputes the garnishment notice or notifies that the garnishment may cause financial hardship, Operations staff will refer the worker to the agency to which the benefits are being redirected.

11. In all cases, workers are encouraged to contact Operations staff with any questions they have about the effects the notice of garnishment may have on their benefits.

Act Sec # 166
The Enforcement of Maintenance Orders Act, 1997 sections 33, 40.5, 40.6, 40.7, 40.8, 40.9, 40.91
The Enforcement of Maintenance Orders Regulations, 2009 sections 8, 9, Form I, Form M

Effective Date 03 February 2012
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All obligatory notices for attachment of compensation benefits on and after the effective date
Supersedes PRO 09/2008 Attachment of Compensation
Complements POL 04/2010 Attachment of Compensation
6.12 Benefit of the Doubt (PRO 03/2012)

Document Date 17 January 2012

Purpose To establish the basis on which decisions will be made.

BACKGROUND

POL 03/2012, Benefit of the Doubt, identifies the standards for determining, documenting, and communicating decisions that are made pursuant to The Workers’ Compensation Act, 2013 (the “Act”).

PROCEDURE

1. All staff who:
   a. have contact with workers, employers, health care providers or their representatives, and
   b. make decisions affecting workers or employers;

   are to document their contacts and decisions. The documentation will provide a clear record of developments in worker and employer account files with respect to entitlements, adjustments, agreements, decisions, etc.

2. Detailed explanations will be required in communications regarding a decision that is:
   a. not in favour of the person making the request or claim
   b. in favour of the person making the request or claim, but based on benefit of the doubt, or
   c. in favour of the person making the request or claim, but where objections had been raised, or some development or other investigation had been required in order to resolve the issue.

3. Where it is relevant, communications requiring detailed explanations will contain the following elements:
   a. an outline of the issue under consideration.
   b. the decision made and its impact.
   c. the reason for the decision, including if it involved giving benefit of the doubt.
   d. the evidence that was considered on both sides of the issue.
   e. the weight given to the evidence, and the reasons, and
   f. reference to any WCB policies or sections of the Act applicable to the issue.
4. Operations staff decisions regarding the entitlement of a worker or dependent under the Act affect the cost experience of the worker’s employer. Therefore, decisions about entitlement will be communicated to the worker and the affected employer.

5. All written advice of decisions affecting workers and employers should encourage dialogue with the writer of the letter. This opportunity for discussion will ensure the decision is understood before a worker or employer considers the possible submission of an appeal.

**Act Sec #** 2(1)(ee), 20, 23, 48  
**Effective Date** 01 February 2012  
**Amended** References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013  
**Application** Staff who have contact with or make decisions regarding entitlement or the standing under the Act of workers, dependents, or employers.  
**Supersedes** PRO 04/99 Benefit of Doubt  
**Complements**  
- POL 03/2012 Benefit of the Doubt  
- POL 15/2013 Privacy of Information  
- PRO 17/2013 Authority for Disclosure  
- POL 23/2014 Reversing Decisions  
- PRO 23/2014 Reversing Decisions  
- POL 22/2013 Appeals – Board Appeal Tribunal  
- POL 21/2013 Appeals – Claims  
- PRO 21/2013 Appeals – Claims  
- POL 20/2013 Appeals – Employer Accounts  
- PRO 20/2013 Appeals – Employer Accounts
6.13 Pre-Existing Condition – Section 49 (PRO 01/2000)

Document Date 20 April 2000

Purpose To establish procedures for claims where pre-existing conditions exist.

BACKGROUND

1. The Board has approved policy guidelines regarding the adjudication of claims where there are pre-existing conditions.

2. The following procedures identify the business areas responsible for implementing the policy, along with their key responsibilities.

PROCEDURE

1. Operations staff are responsible for the application of Section 49 as soon as possible after learning that the worker had a pre-existing condition which may affect the course of recovery from the work injury.

2. Operations staff will investigate the pre-existing condition, gathering all the information that is available regarding the condition from the worker, his or her health care providers, and if necessary, from past and present employers and coworkers, as well as other insurers. As stated in the policy, particular attention should be paid to:
   a. any history of prior problems in the same or nearby areas as the work injury,
   b. the effect(s) of any pre-existing condition on the worker’s function leading up to the work injury (i.e., pre-injury status), and
   c. obtaining relevant medical reports regarding such problems.

3. Operations staff will access the workers’ health care providers and the board’s Medical Consultants for whatever assistance and advice may be needed to establish and document the following medical facts:
   a. the extent of the work injury (essentially a matter of diagnosis), whether or not the worker has recovered from the work injury, and
   b. whether and to what extent a pre-existing condition has been aggravated or accelerated by the work injury. If acceleration has occurred, there will almost always be some pathological evidence confirming the presence of permanent changes resulting from the work injury. In most cases, this information will be obtained during the course of utilizing the Early Intervention Program and by following case management principles and policy.
4. Operations staff is to consider the application of cost relief under the Second Injury and Re-employment Reserve policy.

5. Operations staff is to make document and communicate decisions pursuant to Section 49 in accordance with legislation and policy regarding decisions and the application of the benefit of doubt.
   a. To avoid misunderstanding, correspondence is to focus on the effects of the work injury. For example, when a worker has recovered from a work injury and is fit to return to work, the decision to terminate benefits should be communicated with that information. Unnecessary discussion of any ongoing effects of the pre-existing condition should be avoided.

6. A copy of a Fact Sheet regarding pre-existing conditions and the application of Section 49 is to be enclosed with Section 49 decision letters.

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<td>2(r), 20, 26, 31, 49, 103</td>
<td>01 May 2000</td>
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<td>All Claims Where There Is a Pre-Existing Condition</td>
<td>POL 17/94 Pre-Existing Conditions</td>
<td>POL 01/2000 Pre-Existing Conditions – Section 49</td>
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<td>POL 02/2006 Medical Boards – Repeal</td>
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<td>POL 03/2012 Benefit of the Doubt</td>
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<td>POL 21/2010 Second Injury and Re-Employment Reserve</td>
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<td>PROC 03/2013 Benefit of the Doubt</td>
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<td>POL 12/2013 Arising Out Of And In The Course Of Employment</td>
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<td>PROC 13/2007 Injuries – Occupational Disease</td>
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<td>PROC 11/2003 Injuries – Occupational Disease</td>
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<td>PROC 05/2013 Injuries – Heart Attack</td>
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<td>POL 06/2009 Benefits – Clients in Transition from WCB to SGI Benefits</td>
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<td>POL 06/2009 Benefits – Clients in Transition from WCB to SGI Benefits</td>
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6.14 Procurement Procedure (PRO 07/2012)

Document Date 28 June 2012

Purpose To define the process that governs the purchase of goods and services by Workers’ Compensation Board (WCB) staff.

DEFINITION

Best Value means the acquisition of goods and services through a competitive process which results in supply arrangements at the most effective life cycle cost (i.e., a combination of purchase prices, amortization, maintenance, repair, operating and disposal costs), in the correct quantities, at the right quality, and from the most qualified, responsive and responsible vendor or supplier.

Bid means an offer submitted in response to a tender to supply goods or services, or to purchase assets at a specific price or price formula, under stated terms and conditions.

Contract signatory means the WCB staff member with designated authority to purchase goods and services.

Expression of interest (EOI) means a list compiled of prospective vendors and suppliers who are interested in participating at a future date in a competitive bidding process for a particular good or service. The list of prospective vendors and suppliers will be viewed when WCB staff do not have a solid idea of the type of good or service required. Viewing this list is the starting point in the overall tendering process.

Purchase order means an authorized legal contract to acquire goods or services.

Purchase request means a request for the purchase of goods and services to be approved by the applicable purchasing authority.

Purchases for the internal administration of the WCB means all goods and services procured for internal day to day business (e.g., paper, printer cartridges, business cards).

Purchases on behalf of clients means goods and services required to facilitate return-to-work or vocational rehabilitation programs (e.g., equipment, tools, modifications to residence, vehicle or workplace).

Request for proposal (RFP) means an invitation to potential vendors and suppliers for bids where the requirements for goods and services may not be clearly defined and the expected price is likely to exceed $2,500. Vendors and suppliers will outline their methodology, approach in delivery, price and timelines.
Request for quotation (RFQ) means an invitation to vendors and suppliers to provide pricing and delivery information for clearly defined goods and services, generally of a low dollar value (e.g., $2,500). A request for quotation may be issued to multiple vendors or suppliers as an informal tender.

Standing offer means a contract for standardized goods and or services to be purchased and delivered on an as-required basis for specific periods of time at prearranged prices and delivery conditions (e.g., printer cartridges, paper products, business cards, ergonomic chairs).

Tender means the process in which qualified vendors and suppliers are invited to submit sealed bids for the supply of specific and clearly defined goods and services during a specified timeframe. The tendering process includes a request for quotation and request for proposal.

BACKGROUND

1. The WCB autonomy is acknowledged by the Saskatchewan Government with respect to the purchase of goods and services required to complete daily operations. While the WCB does not fall within the jurisdiction of The Purchasing Act, 2004, or the interprovincial Agreement on Internal Trade (1995), the WCB observes the guiding principles and best practices. WCB procurement practices also comply with the New West Partnership Trade Agreement (NWPTA) where applicable.

2. The following principles have been adopted to govern all purchase and procurement transactions of the WCB:
   a. To procure goods and services that support achievement of the WCB’s corporate objectives in a fiscally responsible and competitive manner;
   b. To ensure a fair, open and accountable process; and
   c. To ensure goods and services are purchased in accordance to best value.

3. The annual administration budget process or program budget process is the method by which the WCB approves the overall spending required for the operations of the WCB. Subsequent decisions to purchase budgeted goods and services are made throughout the year and must be approved in accordance with this procedure.

4. This procedure applies to goods and services purchased for the internal administration of the WCB and on behalf of WCB clients. This procedure also applies to the provision of health care services unless rates are set by the Saskatchewan Ministry of Health, or negotiated with health care professional associations.

5. For medical aid prescribed by a treating physician or health care provider (e.g., bandages, heating pads), or paid in accordance with established WCB policy (POL 19/2010, Allowance – Clothing, POL 17/2008, Expenses – Orthotics/Appliances –
Provision, Replacement and Repair, and POL 10/2011, Reimbursement for Medications), this procedure will not apply.

PROCEDURE

General

1. When purchasing goods and services for the internal administration of the WCB and on behalf of WCB clients, WCB staff will adhere to the principles of ADM 03/2006, Code of Conduct and Ethics:
   a. Confidential information will not be disclosed unless it is necessary in order to fulfill job responsibilities.
   b. Situations where there may be a conflict or a perceived conflict of interest will be avoided.

2. If an employee believes that they have information regarding a wrongdoing that has been committed or is about to be committed, or if they have been asked to commit a wrongdoing, the employee may make a disclosure to WCB’s Designated Officer in accordance with POL 05/2012, Public Interest Disclosure Act Procedure.

3. To maximize benefit and minimize the risk to the WCB, every effort must be made to acquire goods and services through a competitive purchasing process. Competitive procurement practices are accomplished by tendering for goods and services.

4. Whenever possible, standing offers will be initiated to ensure that long-term consistency of service, quality and performance requirements are met.

5. For unanticipated expenditures of goods and services (not included in the annual administrative or program budget) exceeding $2,500, a written business case must be documented and signed by the WCB staff member making the purchase. In addition, the WCB staff member must report to their direct supervisor the reasoning for the unanticipated expenditure.

6. Purchases by a department must be authorized by the department having the corporate mandate to manage the product or service.

Purchase Authorities and Spending Limits

7. WCB staff with the designated authority to purchase goods and services on behalf of clients can, without secondary approval, purchase goods and services where the amount is less than $2,500.

8. Managers responsible for each cost center may designate (in writing) a limit of two employees (e.g., Supervisor and Administrative Assistant) to purchase, without secondary approval, goods and services for the internal administration of the WCB where the amount is less than $2,500.
9. Where the purchase amount noted on the invoice is greater than or equal to:
   a. $2,500 but less than $20,000, secondary approval is required from a Manager or Team Leader.
   b. $20,000 but less than $50,000, secondary approval is required from a Director.
   c. $50,000 but less than $100,000, secondary approval is required from a Vice-President or designate.
   d. $100,000 or greater, secondary approval is required from the Chief Executive Officer or designate.

10. Managers, Team Leaders, Directors, Vice-Presidents (and designates) and the Chief Executive Officer (and designate) cannot authorize their own purchase requests unless the amount is less than $100.

Purchase Requests

11. Where the good or service cannot be filled from an existing contract, standing offer, stock or inventory and the price of the good or service is estimated to be less than $2,500, a WCB staff member with the designated authority to make purchases may select a vendor or supplier from a list established and maintained by the Purchasing Team.

12. Where the price of the good or service is estimated to be greater than $2,500, a tender, in accordance with Points 19 to 21, is required.

13. On occasion, there may be a situation that presents unique conditions that can only be met by one vendor or supplier. The following situations may require a single source purchase request:
   a. Maintenance by a specific company on equipment to ensure warranty conditions are met;
   b. Equipment has already been purchased that is only compatible with another specific product obtained from the same source;
   c. Continuity of service for a project where it would be detrimental to the WCB if the service provider was to be changed;
   d. Project or program commencement is imminent; or
   e. A client is in a location where there is only one vendor or supplier and it is cost effective to use that vendor or supplier.

14. Single source purchase requests for emergency purchases will only be acceptable where:
   a. There is an unforeseen interruption to the normal course of business (e.g., electrical services that shut down operations); or
b. Purchases need to be made after regular office hours and or within a short period of time (e.g., same or next day).

15. Receipts for incidental purchases, or minor expenses typically under $100 that are not budgeted for, but are essential to the business of the WCB, must be submitted for secondary approval before reimbursement from Financial Services can be received. In every case, reimbursement for incidental purchases requires secondary approval.

**Purchase Orders**

16. Purchase orders are required in order to obtain goods or services exceeding a cost of $500. Exceptions include, but are not limited to:

   a. Contracts for advertising;
   b. Contracts established by Legal Services on behalf of other departments or for its own purposes;
   c. Contracts established prior to the effective date of this procedure;
   d. Travel expense claims;
   e. Incidental expenses; and
   f. Purchases for telephone, postage, utilities, rent, membership fees, association fees, or registration fees.

17. Purchase orders are issued when the Purchasing Team selects a vendor or supplier, or when a vendor or supplier has been selected through a tender.

18. Where the WCB has a signed contract with a vendor or supplier, purchase orders are issued when goods and services are requested directly from that vendor or supplier.

**Tendering**

**Tendering Requirements by Procurement Value**

19. When the expected cost of the good or service over the life of the contract is greater than or equal to $2,500 but less than $10,000, a tender (which includes a request for quotation and request for proposal) may be conducted by telephone, facsimile, written proposal or in person.

20. For purchases that are expected to be greater than or equal to $10,000 over the life of the contract, it is mandatory to formally issue tender notices, either written or electronically, and obtain written bids or submissions. These must be documented through the purchasing system.

21. For purchases (other than for the provision of health care services) of:
a. goods at a cost greater than or equal to $10,000;
b. services at a cost greater than or equal to $75,000; or
c. construction at a cost greater than or equal to $100,000.

equal opportunity will be provided to vendors and suppliers from British Columbia, Alberta and Saskatchewan in accordance with the NWPTA. Tender notices will be issued on a central electronic tendering system (when available).

**Tendering Process**

22. An expression of interest may be used to compile a list of prospective vendors and suppliers that can be used at a future date when preparing a tender. However, the expression of interest must be prepared using the same process for a tender, ensuring criterion and evaluations are documented. This same process will be used for obtaining professional services.

23. A minimum of three vendors or suppliers (when available) will be contacted to quote on a contract.

24. The WCB will re-tender all business contracts (including standing offers) every five years unless the CEO provides written permission not to re-tender. Where tendering is bypassed, the WCB must re-tender the business contract after an additional five years.

25. WCB representatives for the Saskatchewan Government and General Employees’ Union (SGEU) will be notified of intentions to finalize new contracting out of work arrangements.

26. Where there is labour involved in the contract to be performed on WCB premises or the premises of a WCB client, a current WCB “Letter of Good Standing” must be supplied by the bidder before a decision can be made to award the contract.

27. Travel services are excluded from the tendering process and may be obtained in accordance with ADM 05/2009, Board Employee Travel and Other Reimbursable Expenses.

28. Motor vehicles permanently assigned to WCB staff will be leased. The lease is to be arranged and managed by the Purchasing Team. Other short-term rental vehicles will be arranged by the Purchasing Team or WCB employees (e.g., out-of-town rentals) in accordance with this procedure and ADM 05/2009.

**Awarding the Contract**

29. Evaluation criteria for the selection of the successful vendor or supplier must be clearly defined and documented within the tender.
30. The successful vendor or supplier will be chosen by the Purchasing Team, or where directly tendered, by a panel with a minimum of three members, including the contract signatory and a member of the Purchasing Team.

31. All contracts must be endorsed by Legal Services.

32. The WCB will award contracts based on the principles of best value.

Evaluations

33. The Purchasing Team or contract signatory is responsible for monitoring and managing vendor and supplier performance relative to the terms and conditions of the contract. Evaluations of business contracts (including standing offers) will be completed:
   a. When reviewing current performance (such evaluations may occur at any time during the contract);
   b. When determining if the contract should be renewed; or
   c. Upon completion of the contract.

Receipt of Goods

34. Goods must be inspected and reconciled with the packing slip and or the purchase order prior to distribution. The receipt of goods will be coordinated by the Purchasing Team.

35. Purchases of goods and services on behalf of clients require the WCB staff member who initiated the purchase and a member of the Purchasing Team to verify and document receipt of goods to the claim file, coordinate returns and determine how credit will be received.

Invoices

36. Invoices must have a valid purchase order or contract billing number (unless the purchase is exempt in accordance with Point 16 above).

37. Where there is labour involved in a contract for services performed on WCB premises or that of a WCB client, prior to making payment a clearance letter must be obtained to ensure the contractor’s account is current. Where an out-of-province contractor is awarded the contract, registration with the WCB is required in accordance with POL 07/2002, Coverage Within Saskatchewan – Out of Province Employers.

38. Where costs exceed the maximum contract value amount, the contract signatory must obtain appropriate secondary approval before payment of invoices can be made.
39. For internal purchases, Finance will annually reconcile all suppliers with aggregate payments exceeding $100,000 to the Corporate Solicitor’s active contract list. This also applies to purchases on behalf of clients, but will be reconciled by the responsible department. The lists will be forwarded to the CEO annually for review.

**ATTACHMENTS**

**Procurement Standards and Guidelines**

<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>18(1 – 4), 115, 131 and 132</th>
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<tr>
<td><em>The Freedom of Information and Protection of Privacy Act</em> (FOIPP)</td>
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<td><em>The Public Interest Disclosure Act</em> (PIDA)</td>
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**Effective Date**

01 July 2012

**Amended**

References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*

**Application**

All staff purchasing goods and services on behalf of the WCB

**Supersedes**

PRO 50/2007 Procurement Procedure

**Complements**

- POL 17/2008 Expenses – Orthotics/Appliances – Provision, Replacement and Repair
- POL 07/2002 Coverage Within Saskatchewan – Out of Province Employers
- POL 05/2004 Equipment and Tools – Vocational Rehabilitation
- POL 04/2015 Modifications – Home, Vehicle, and Work
- POL 19/2010 Allowance – Clothing
- POL 10/2011 Reimbursement for Medications
- PRO 11/2014 Vocational Rehabilitation – Self-Employment Plans
- PRO 101/2001 Disposal of Surplus Goods/Assets
- ADM 03/2006 Code of Conduct and Ethics
- ADM 02/2002 CEO Authority for Procurement
6.17 Interjurisdictional Agreement on Workers’ Compensation (IJA) (PRO 08/2013)

Document Date: 28 November 2013

Purpose: To establish an interjurisdictional agreement for workers’ compensation claims.

BACKGROUND

1. The Saskatchewan Workers’ Compensation Board (WCB) has approved POL 08/2013, Interjurisdictional Agreement on Workers’ Compensation.

2. The following procedure provides guidance for the implementation of POL 08/2013.

PROCEDURE

General

1. Clients entitled to file a claim in more than one jurisdiction must elect to file their claim in either their home province or territory, or the jurisdiction where the injury or fatality occurred.

2. Where the client elects to file a claim with the Saskatchewan WCB:
   a. The claim will be adjudicated in accordance with The Workers’ Compensation Act, 2013 (the “Act”) and approved policy directives.
   b. The client must also waive and forego any rights to compensation with any other jurisdiction for this claim.
   c. The client will not apply for nor accept any benefits from any other jurisdiction for this claim unless released to do so by the Saskatchewan WCB.

Saskatchewan Injury – Non-Resident

3. Where the Saskatchewan WCB receives Employer’s Report of Injury (E1) or Worker’s Report of Injury (W1) forms that indicate a work-related injury or fatality occurred in Saskatchewan, but the worker is a resident of another province or territory, the Interjurisdictional Agreement on Workers’ Compensation (IJA) Officer will advise the client that they may elect to file the claim in their home jurisdiction.

4. Claims Entitlement will proceed with adjudication unless the client elects to file the claim in their home jurisdiction.
Out of Province Injury – Saskatchewan Resident

5. Where the Saskatchewan WCB receives Employer’s Report of Injury (E1) or Worker’s Report of Injury (W1) forms that indicate a work-related injury or fatality occurred in another province or territory, but the client is a resident of Saskatchewan, Employer Services will determine if the employer is eligible for coverage under the Act.

6. If the worker or employer is not eligible for coverage, the IJA Officer will notify the client. The contents of the claim submitted to the Saskatchewan WCB will also be forwarded to the appropriate jurisdiction who will determine entitlement.

7. If the worker or employer is eligible for coverage, the IJA Officer will determine if the client can elect to file the claim in accordance with Section 35 of the Act and POL and PRO 08/1999, Coverage – Out of Province/Country.

8. If the client can elect to file the claim, the IJA Officer will notify the client. The client will be provided a Worker Election Form. This form allows the client to elect to file the claim with the Saskatchewan WCB.

9. The client will complete and submit the Worker Election Form to the IJA Officer within three months of the injury or fatality. Extensions to this time period will be authorized or recommended by the IJA Officer in certain situations.

10. If the client does not respond to the IJA Officer’s request to elect where to file the claim by filling out the Worker Election Form, the claim will not be adjudicated by the Saskatchewan WCB.

11. If the client elects to file the claim with the Saskatchewan WCB, the IJA Officer will refer the file to Claims Entitlement Services for adjudication.

12. If the client elects to file the claim with the other jurisdiction, the IJA Officer will forward the contents of the claim submitted to the Saskatchewan WCB to the other jurisdiction. The IJA Officer will advise all parties involved, in writing, that the claim will be adjudicated by the elected jurisdiction.

13. The IJA Officer will request the worker’s home jurisdiction to reimburse all claim costs when the total cost of the claim is over $1,000.

Cost Relief

14. The IJA Officer will consider cost relief on IJA claims where all of the following apply:
   a. Injury occurred in Saskatchewan.
   b. Worker elected to file the claim with another jurisdiction, and
   c. Other jurisdiction requested and received reimbursement from Saskatchewan.
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<th>Application</th>
<th>Supersedes</th>
<th>Complements</th>
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<td>33, 35, 39</td>
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<td>All interjurisdictional claims</td>
<td>n/a</td>
<td>POL 08/2013 Interjurisdictional Agreement on Workers’ Compensation</td>
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<td>POL 24/2014 Alternative Assessment Procedure for the Interjurisdictional Trucking Industry</td>
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<td>POL 01/2007 Experience Rating Program</td>
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<td>POL 05/2014 Occupational Disease Reserve</td>
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<td>POL 12/2014 Disaster Reserve</td>
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Disposal of Surplus Goods/Assets (PRO 101/2001)

Document Date 08 March 2001
Purpose To establish guidelines on the disposal of surplus goods and assets.

DEFINITION

In the procedure document, the term **Goods/Assets** is used to describe consumable and non-consumable goods, material, products or assets.

**Asset** means a non consumable product such as: furniture, computers, photocopiers, etc.

The terms **Goods** or **Material** describe consumables, such as office supplies and paper which are used and then discarded. Typically consumables are goods or materials that have a “shelf life” (e.g. batteries), or are supplies used to keep equipment functioning such as printer, copier or fax cartridges.

**Surplus** is a term used to describe goods/assets or materials that may or may not have functional use or application within a department or organization. For example, a fax machine may still work; however, the technology no longer meets the needs of the department. This equipment is considered **surplus to the department**. While the equipment may be surplus to the department, it may have an application in some other area because it is still functional.

When it is determined the goods/assets are no longer functional or have no further use or application anywhere in the organization, they are considered **surplus to the organization**.

BACKGROUND

1. The Executive requested that a procedure for the disposal of surplus assets be developed separate from the internal administrative Procurement Policy/Procedure.

2. A review of internal procedures and the current practice of using Sales and Salvage (S&S), a division of Saskatchewan Property Management Corporation (SPMC) for disposal of surplus assets was undertaken. The review provided an opportunity to develop guidelines on items such as: asset management, disposal authorization, and methods of disposal.

3. The Lotus Notes system will facilitate the procedure and will link inventory databases using electronic forms to ensure we have accurate records from date of purchase to date of disposal.
4. Purpose
   a. To establish procedures governing the disposal of goods/assets and define procedures for Managers/Directors who have responsibility for managing Board assets.
   b. To encourage responsible use of Board assets by reducing, reusing and recycling.
   c. To maximize the return value of surplus goods/assets.

PROCEDURE

Guiding Principles

1. The following principles will be considered when disposing of surplus goods/assets:
   a. Obtain maximum possible return value, especially for assets with a market value.
   b. Support employee computer literacy by allowing employees preferential access to computer hardware which is surplus to the organization.
   c. Provide the public fair access to surplus assets.
   d. Practice/promote environmental responsibility, especially in the disposal of consumables.
   e. Use existing infrastructures such as S&S, unless other options can be shown to significantly increase the return/value, or better achieve one of the other principles/objectives.
   f. Recognize the responsibilities of department Directors/Managers to manage assets required for operations within their operational budgeting and purchasing authorization.
   g. Recognize the role of service units such as Purchasing, Facilities, and Information Technology Services (ITS) in assisting the organization in its management of assets and costs, e.g. storage and transportation.

Procedure

2. Methods of Disposal (General)
   a. The S&S division of SPMC will be the primary outlet for disposal of surplus assets. Surplus goods/assets may be offered to employees on an "as is basis if the surplus goods/assets have no further use or application at the Workers' Compensation Board (WCB). Other methods of disposal, such as private auction services, may be utilized if they maximize the return value on the disposal of assets.
   b. If possible, trade in or buy back arrangements should be negotiated for surplus assets with a residual market value (e.g. major office refit). Purchasing is responsible for administering such arrangements.
3. Disposition of Surplus Goods/Assets (Excluding Computer Hardware & Software)
   a. The Director or designate of each department is responsible for determining which assets are no longer functional or surplus and give approval to Facilities for the goods/assets to be disposed of. Where maintenance or service contracts are in place, Purchasing will be notified to terminate the contract or if equipment is redeployed, transfer the charges to the appropriate department.
   b. Facilities is responsible for removing the goods/assets and logging pertinent information concerning the items (description, make, model, size, quantity, serial number and condition) on the Surplus Goods Log. The Director or designate must review and sign the log giving final approval for the disposal, redeployment or recycling of goods/assets.
   c. The Facilities Manager or designate is responsible for determining if the goods/assets should be held for use as spare/back up equipment, used for parts, redeployed to another WCB department, or stored for disposal at a future date. Facilities is responsible for storing the goods/assets in-house or acquiring off site storage if necessary.
   d. Where it is determined the goods/assets are destined for S&S, Facilities will complete the Miscellaneous Property Transfer Sheets stating the description and condition of the goods/assets and forward to Purchasing for processing. (Sample attached)

4. Disposal of Computer Hardware, Software, Printers and Accessories
   a. Computer hardware, software, printers and accessories authorized for disposal, may be redeployed to another department, offered to employees, or donated to community organizations.
   b. The following process applies when computer equipment is deemed surplus by the departments:
      i. ITS is responsible for assisting the departments in determining their computer hardware needs (Disposal of surplus software will be handled by ITS in accordance with the licence agreements associated with the software).
      ii. ITS is responsible for evaluating the equipment and implementing the following process:
         (a) Assess the equipment's suitability for use by another department. If suitable, it will be redeployed.
         (b) If not redeployed to another department, the equipment may be stripped for parts (e.g. hard drives, memory, etc.). Stripped units will be designated “inoperable”, and noted as such on the Surplus Goods Log and on the Miscellaneous Transfer Sheet documentation when preparing for disposal through S & S.
         (c) Components left intact and in good working order that have resale value, will first be offered to WCB employees. ITS is responsible for determining which units/accessories are for sale and for determining the price, terms
and conditions of the sale, ensuring all employees have equal access to the sale items; e.g. by random draw.

(d) Functional equipment not sold to employees, may be donated to community organizations such as Computers For Kids or the Department of Education, or to organizations/agencies funded by WCB (e.g. Safety Associations, Office of the Workers' Advocate).

i) The Director of Communications or designate is responsible for coordinating these donations.

ii) Pick up or shipping charges will be the responsibility of the organization receiving the surplus equipment.

(e) All remaining equipment will be disposed of through S&S.

iii. WCB is responsible for the retention, disposal and release of records. Therefore, when equipment is disposed of in any manner, the Director of ITS or designate shall ensure all information on the hard drive is eliminated, in accordance with The Archives Act, The Freedom of Information and Protection of Privacy Act and The Health Information Protection Act.

(a) Where ITS has determined the surplus computer equipment is suitable for sale or donation, a written declaration must be provided stating that the computer has been “sanitized”. (Sample attached)

(b) For every computer disposed of through S & S, ITS will state on the Miscellaneous Property Transfer sheet either “Hard Drive Sanitized” or “Hard Drive Removed”. (S&S requires this statement for every computer disposed of using their services, as the potential purchaser must be made aware of the condition of the computer.)

5. General Procedures

a. Purchasing, in consultation with Facilities and ITS, is responsible for coordinating the removal of surplus assets by arranging for suitable transportation and ensuring S&S is advised in advance of the shipment. Special shipping or handling instructions, if any, must be noted on the transfer documentation (chemicals, batteries, weight, environmental concerns). Transfer documentation must be reviewed and signed by WCB employees who have signing authority with SPMC.

b. ITS & Facilities are responsible for updating inventory/asset management databases.

| Act Sec #  | 18(1), 115 |
| Effective Date | 01 April 2001 |
| Amended      | References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013 |
| Application  | All WCB Departments |
| Supersedes   | n/a Complements PRO 07/2012 Procurement Procedure |
6.20 Overpayment Recovery – Compensation (PRO 38/2010)

Document Date 01 December 2010

Purpose To establish guidelines for the recovery of overpaid benefits.

DEFINITION

Demand letter means a formal letter sent by Administrative Services Collections to a debtor acceptable as establishing a creditor’s claim on the debtor by setting out particulars of the debt owed as follows:

- Amount of the debt (in this case, an overpayment of compensation or benefits);
- Circumstances/reason(s) that gave rise to the overpayment;
- Request for immediate repayment;
- Offer of acceptability of repayment by installments, if full payment is not possible;
- (Optional) methods/schedules of repayment to be suggested “without prejudice”;
- Deadline for response and/or commitment to repayment arrangements, normally one month from the date of the letter;
- Explanation that although it is the preference of the Workers’ Compensation Board (WCB) to come to agreement with the debtor regarding repayment arrangements, failure to cooperate on the part of the debtor may result in legal action; and,
- Any other details that may be relevant.

BACKGROUND

1. POL 38/2010, Overpayment Recovery – Compensation has been approved for the recovery, write-off and suspension of recovery of compensation benefits overpayments.

2. The following procedure outlines the administrative guidelines for staff to follow when compensation overpayments occur.

PROCEDURE

Overpayment Registration

1. The appropriate WCB staff member must identify that an overpayment has or may have occurred.

2. The overpayment will be calculated and documented, along with the circumstances that gave rise to the overpayment. The overpayment will include any applicable
interest, in accordance with POL 38/2010, Overpayment Recovery – Compensation. Staff will apply an annual interest rate 30 calendar days from the date of written advice.

3. The WCB staff member will determine whether the overpayment is subject to recovery as per POL 38/2010, Overpayment Recovery – Compensation.

4. Where the overpayment has resulted from a Board Tribunal appeal decision, Operations staff will complete the preliminary calculation of the overpayment, but will arrange for a review by Service Excellence prior to finalization and notification of the overpayment amount. Service Excellence will also review overpayment calculations where alleged fraud may be involved and prior to Legal Services initiating any legal recovery action.

Limitation Periods for Overpayment Recovery

5. Staff must be aware that the recovery of overpayments is governed by the applicable limitations of actions legislation in force when the overpayment occurred or was discovered. Legal Services will notify Operations of updates to the legislation and the Executive Director of Operations will be responsible for initiating procedural change.

6. Where the overpayment occurred and was discovered before May 1, 2005 the following will apply, except where the debtor knowingly provided incorrect or incomplete information:
   a. Legal Services has six years from the date of discovery to recover the overpayment or register a Board Order as a judgment of the Court. This period can be extended for an additional six years if there is acknowledgement of the debt and/or partial payment.
   b. Once the Board Order is registered, all actions to collect the overpayment must be concluded within 20 years from the date of registration.

7. Where the overpayment was discovered on or after May 1, 2005, regardless of when it occurred, the following will apply, except where the debtor knowingly provided incorrect or incomplete information:
   a. Legal Services has two years from the date of discovery to recover the overpayment or register a Board Order as a judgment of the Court. This period can be extended for an additional two years if there is acknowledgement of the debt and/or partial payment.
   b. Once a Board Order is registered as a judgment of the Court, all actions to collect the overpayment must be concluded within 10 years from the date of registration. This period can be renewed for subsequent 10 year periods; if not renewed, all actions to collect the overpayment will be discontinued.
8. When a Board Order is registered as a judgment of the Court, Operations staff will provide Board Members with documentation.

9. Where the overpayment is discovered more than three years after it occurred, the entire amount of the overpayment will not be subject to recovery unless the debtor knowingly provided incorrect or incomplete information, or took any action that was intended to prevent the WCB from discovering than an overpayment had occurred.

Overpayments Not Subject to Recovery

10. Operations staff must document the rationale for overpayments not pursued for recovery according to point 5 of POL 38/2010, Overpayment Recovery – Compensation.

11. When overpayments are not subject to recovery, write-offs may be approved directly by the appropriate authority level shown in point 26 below.

Overpayments Subject to Recovery

12. Subject to Points 3 and 4 of POL 38/2010, overpayments resulting from the client or other debtor failing to provide, or WCB staff failing to obtain relevant, accurate or complete information will be subject to recovery. Such circumstances include, but are not limited to:
   i. An advance of benefits in excess of actual entitlement;
   ii. Wage loss benefits paid beyond the date of return to work;
   iii. Retroactive suspension of benefits;
   iv. Clerical, documentation or calculation errors on receipts for goods and/or services submitted in connection with physical rehabilitation or return-to-work programming;
   v. Incomplete or incorrect wage or exemption information; or,
   vi. Actual, verified earnings exceed estimated earnings

13. Notification:
   a. Operations staff must attempt to give the debtor verbal notice (in person or by direct telephone conversation) of the overpayment amount and the reason(s) it has occurred. Written confirmation of the verbal advice will be sent immediately, providing as much detail about the overpayment available at that time. A detailed explanation including a calculation sheet will be sent to the debtor, with a copy for the employer, within a week of the overpayment calculation (the “date of initial written notice”).
   b. Where a clerical or calculation error affecting only one worker has resulted in an overpayment and where entitlement is ongoing, the amount will be reduced to the corrected level effective the date of notification. In cases where a sudden substantial decrease in entitlement would create a hardship, up to two months advance notice of overpayment recovery may be provided.
c. For overpayments under $100, if there is no settlement after three months, Operations staff will complete an Overpayment Referral Form and send it to the appropriate Team Leader with a request to suspend recovery. Upon recommendation for suspending recovery, the claim file is to remain flagged so that subsequent claims by the debtor can be used to recover the overpayment.

d. If there is no settlement after one month of the date of initial written notice, overpayments over $100 will be sent for collection to Administration Services Collections. The information given to Administration Services Collections must include the calculation of the overpayment, the reason it arose, a copy of the written explanation sent to the client and the telephone number where the client can be reached. For each overpayment, Administration Services Collections must send written notice to the debtor in the form of a demand letter defined above.

14. Follow Up/Referral to Legal Department:
   a. If no response has been received from the debtor, Administration Services Collections is expected to attempt telephone and written follow up at least once in the month following the initial written notice of an overpayment. After three months from the date of initial written notice where no recovery arrangements are in place, Administration Services Collections must:
      i. recommend suspension of recovery activity;
      ii. recommend write-off to a Team Leader in Operations (when less than $1000); or
      iii. refer the file to the Legal Department (when more than $1000).

15. Agreements/Recoveries:
   a. Operations staff and/or Administration Services Collections will document and place on the claim file all agreements or amended agreements reached with the debtor regarding repayment methods and/or schedules.
   b. If agreement has not been possible, Operations staff and/or Administration Services Collections will document and place on the claims file the efforts made to reach agreement and the repayment methods and/or schedule(s) to be imposed on the debtor.
   c. When recovery occurs from ongoing entitlement, the recovered amount and balance owing will appear on the debtor’s benefit/expense payment statement that will be received by clients.
   d. Receipts will only be issued for cash repayments.

Collection Methods

16. Administration Services Collections may pursue the recovery of overpayments by every cost effective, legal means available (e.g., garnishees, liens and seizure).
However, allowances and reimbursements provided by the WCB to the worker for travel, sustenance and medications will not be pursued.

17. To avoid undue hardship on clients, the guidelines for recovery from ongoing entitlement are as follows:
   a. Recovery will not exceed more than 25 percent of wage loss benefits. Overpayments in the case of fraud may be collected at 100 percent.
   b. Recovery may begin as early as the first payment period after the initial verbal notice to the debtor of the overpayment.
   c. Operations staff will send written confirmation of the rate of recovery for each overpayment immediately following the calculation of the overpayment.

18. When recovery of an overpayment is sought in situations where the employer is continuing to pay the worker’s salary, arrangements will be made between WCB and the employer so that the latter suspends salary continuance while WCB pursues overpayment recovery. Monies owing to the worker can then be diverted for overpayment recovery.

19. Direct payment by client:
   a. May be made either in full or in installments;
   b. May be accepted at any time before the full amount of the overpayment is repaid by other means;
   c. May be made by normally accepted WCB payment methods.

20. Recovery from annuity entitlement:
   a. Will be arranged only when the annuity becomes payable (when the worker reaches age 65 or at the time of death if the worker dies prior to age 65), unless ordered otherwise by the Board.
   b. The debtor must be given written notice, in advance, of the financial implications.
   c. Where the overpayment remains outstanding, further written notice and the possibility of collection from annuity must be included in the annual annuity communication letter provided to clients by Finance each February.
   d. Where the overpayment of wage loss benefits results in annuity benefits accruing on the worker’s behalf, Operations staff will reduce the annuity by the amount of annuity benefits paid in respect of the overpayment along with accrued interest on that amount.

21. Recovery from former Act pensions:
   a. Will be arranged if there is insufficient or no ongoing entitlement to allow for full recovery of the overpayment within a reasonable time frame.
b. Recovery from former Act pensions will be governed by the applicable limitation of actions legislation.

c. The debtor must be given written notice, in advance, of the financial implications including compensation and interest.

22. Where an overpayment is being pursued for recovery and remains outstanding one year after the date of initial written notice, an annual letter will be sent to the debtor noting the remaining amount of any overpayment.

23. Where the collection methods above are not available to Operations staff, the claim is to be closed after consideration of suspension or write-off, in accordance with the authorization levels referenced in point 26 below.

Where no internal collection possible

24. Outstanding overpayment of less than $1,000:

a. After 3 months, where none of the above methods have led to full recovery of an outstanding overpayment and no repayment terms have been extended beyond that time frame, Collections may recommend suspending recovery or write-off, to be approved according to the authorization levels described in point 26. The decision will also be documented on the claim file.

b. Upon recommendation for suspending recovery, the claim file is to remain flagged so that subsequent claims by the debtor can be used to recover the overpayment.

25. Outstanding overpayments exceeding $1,000:

a. After 3 months, where none of the above methods have led to an arrangement for full recovery of an overpayment and the outstanding amount exceeds $1,000, Collections shall refer the file to Legal Services, including documentation of all collection activity to date, the amount of the outstanding overpayment, how the overpayment occurred, the debtor’s last known address and phone number, and current employer (if known). Confirmation of this referral must be documented on the claim file.

b. Legal Services will initiate whatever legal action is necessary and cost effective to collect the overpayment, including referral to external legal representatives for assistance, giving due consideration, except where fraud may have been involved, to avoiding the creation of undue financial hardship for the debtor.

c. Any external legal representative will be bound by the same obligations as Legal Services.

d. In the event that legal remedies do not lead to full recovery of the overpayment, Legal Services will make recommendations regarding suspending recovery or writing-off of an outstanding overpayment in excess of $1,000, to the authorization level described in point 26 below.
e. Upon recommendation for suspending recovery, the overpayment amount will be suspended and flagged for recovery on a debtor’s subsequent claim(s).

Authority Level for Write-Off or Suspending Recovery of Overpayments

26. Below are the signing authorities for suspending recovery or writing-off of non-collectible overpayments:
   a. Less than $10,000 Team leader, Operations;
   b. $10,000 - $49,999 Director Case Management (North/South);
   c. $50,000 - $99,999 Vice-President Operations;
   d. $100,000 or greater Chief Executive Officer.

Implementation: Suspending Recovery and Write-off

27. A decision to suspend recovery activity or to write off overpayments according to the authority level indicated in point 26 above will be implemented by the appropriate Team Leader in Operations.

Employer Cost Experience

28. The WCB will remove the overpayment from the employer’s cost experience record, provided the employer did not contribute to the overpayment by providing incorrect information.
6.21 Safety Association Funding (PRO 11/2008)

Document Date 05 August 2008

Purpose To outline the responsibilities for administering safety association funding.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved policy to provide funding for Safety Associations.

2. The following procedure outlines the responsibilities of WCB staff for administering Safety Association funding

PROCEDURE

1. New funding requests will be forwarded to the Board members for approval. Renewal applications may be approved by the VP, Prevention and Employer Services.

2. The VP, Prevention and Employer Services or designate will be responsible for the administration of Safety Association programs approved for funding and shall in accordance with POL 20/2010:
   a. Conduct quarterly meetings with delegates from each Association;
   b. Ensure that all quarterly and annual reporting requirements are met; and,
   c. Ensure Safety Association Funding Agreements are monitored for currency.

3. An annual report of the Safety Associations’ financial and program activities will be submitted to the Board members.

4. Employer Services will ensure that assessments are levied against the employers in the industry class participating in the Safety Association in order that budget requirements are met.

Act Sec # 146
Effective Date 01 September 2008
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All applicants for safety association funding.
Supersedes PRO 06/2002 Safety Association Funding
Complements POL 20/2010 Safety Association Funding
6.22 Extrication Services (PRO 16/2014)

Document Date 16 October 2014

Purpose To provide payment for extrication services.

BACKGROUND

The Workers’ Compensation Board (WCB) has approved POL 16/2014, Extrication Services.

PROCEDURE

1. Operations staff will review billings for extrication. Billings that meet the requirements of POL 16/2014 will be approved.

2. Payments will be charged to expense code M37.

Act Sec # 115(j)
Effective Date 01 December 2014.
Application All claims where the WCB is billed for extrication services.
Supersedes PRO 08/2008 Extrication Services
Complements POL 16/2014 Extrication Services
6.24 Translation Services (PRO 04/2012)

Document Date 18 January 2012

Purpose To remove communication barriers with non-English speaking workers and employers.

DEFINITION

Translation is defined as accurate written, oral or visual rendition in one language of what is expressed in another language.

BACKGROUND

1. In February 2008, the Association of Workers' Compensation Boards of Canada (AWCBC) National Compensation and Benefits Committee proposed a number of principles for each Canadian jurisdiction to follow when addressing how to provide workers’ compensation to migrant workers. These principles were endorsed by the AWCBC Executive Committee.

2. The following procedure will adhere to the AWCBC principle of allowing all injured workers access to translation services. With this procedure, the Workers’ Compensation Board (WCB) will work to remove communication barriers with all non-English speaking workers and employers (clients).

3. The WCB may enter into an agreement with an external translation service provider. The terms and conditions of the agreement should take precedence over the translation services guidelines noted below.

PROCEDURE

1. All workers as defined by Section 2(1)(ii) and employers as defined by Section 2(1)(l) of The Workers’ Compensation Act, 2013 (the “Act”) are entitled to and will be provided free translation services where a communication barrier exists between the client and the WCB. The exception being where the worker voluntarily relocates out of Canada, the cost of translation services necessary for the management of the claim, regardless of whether the WCB makes arrangements, will be the responsibility of the worker (POL 07/2007, Voluntary Relocation Outside Canada).

2. Translation services required by clients may be provided by internal WCB staff fluent in the client’s language. Where WCB staff are unable to provide appropriate translation services, the WCB will arrange for external translation services. The type of services arranged by the WCB will be dependent on the requirements of the client (e.g., written, oral or visual translation).
3. Where required, WCB staff may arrange for a client to be accompanied by a translator when attending an appointment at a medical treatment facility or with a health care provider.

4. Where the client prefers to provide their own translator (e.g., family member), and the translator has a salary loss due to attendance, the translator may be reimbursed on the basis of actual salary loss at a rate not to exceed the maximum wage rate (as defined by Section 37 of the Act).

5. Travel and sustenance expenses that result from the translator’s attendance will be reimbursed in accordance with PRO 54/2015, Expenses – Travel and Sustenance – PSC Rates. No additional recognition for translation services will be provided.

6. Since translators will participate in the exchange of personal information, translators (other than internal WCB staff) may be asked to sign a confidentiality agreement where necessary.

Act Sec # 2(1)(ii), 2(1)(l), 37
Effective Date 01 February 2012
Amended References updated 01 January 2014 in accordance with The Worker’s Compensation Act, 2013
Application Injured workers, employers and WCB staff
Supersedes PRO 08/2009 Translation Services
Complements PRO 54/2015 Expenses – Travel and Sustenance – PSC Rates
POL 05/2010 Coverage – Migrant Workers
PRO 05/2010 Coverage – Migrant Workers
POL 07/2007 Voluntary Relocation Outside Canada
PRO 07/2007 Voluntary Relocation Outside Canada
6.25 Serious and Wilful Misconduct (PRO 13/2011)

Document Date 26 October 2011

Purpose To provide clarity on what constitutes as “serious and wilful misconduct.”

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 13/2011, which applies to Section 30 of The Worker’s Compensation Act, 2013 (the “Act”), Wilful misconduct of the worker.

2. The following procedure provides guidance for the implementation of POL 13/2011.

PROCEDURE

1. Claims Entitlement Services will gather information related to the time, place and activity of an injury, in order to determine if an injury arose out of and in the course of employment. Where a worksite visit is required, Claims Entitlement Services can obtain assistance from a Claims Representative to supplement information to adjudicate a claim. Where the worker intentionally injures himself/herself, this will not qualify as an “injury” under Section 2(1)(r) of the Act, and the claim will be denied.

2. The Claims Entitlement Services/Claims Representative investigation will determine if the injury occurred:

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

   b. At a location that is consistent with the place of employment or the employers premises; and

   c. At a time and location where an activity takes place to benefit the employer’s business or is related to that business.

3. Claims Entitlement Services will investigate and determine if an injury is the result of serious and wilful misconduct. Where an injury arises out of and in the course of employment, Claims Entitlement Services may determine serious and wilful misconduct was the sole cause of the injury when:

   a. A worker deliberately violates a rule or law;

   b. The actions taken by the worker at the time of the injury are deliberate and intentional with a complete disregard for probable consequences;

   c. The employer has expressly indicated the type of activity or behaviour that is not permitted at the workplace;
d. The employer consistently enforced the rule or law and there were significant consequences for infractions;
e. Impairment was caused by alcohol or illicit use of drugs.

The list above is a reference guide and is not intended to be all-inclusive.

4. Where serious and wilful misconduct is alleged, Claims Entitlement Services will carry out an investigation in order to evaluate the extent of misconduct and the degree of responsibility the misconduct had in the cause of the injury. Where information gathered indicates that an injury is the sole result of serious and wilful misconduct, the claim for compensation may be denied, unless the injury results in serious functional impairment or death.

5. Where serious and wilful misconduct results in death or serious functional impairment, Section 30 of the Act does not bar the right to compensation.

6. Claims Entitlement Services will initially base a decision on whether Section 30 of the Act bars a right to compensation, an estimate of the anticipated Permanent Functional Impairment (PFI), or the period of disability.

7. Where coverage is originally denied, but subsequent information demonstrates that the injury did result in serious functional impairment (i.e., PFI in excess of 10 percent, or time loss in excess of three months), the decision to bar compensation will be reviewed.

8. Where coverage is originally provided because of an estimation that the injury would result in serious functional impairment, but subsequent information demonstrates that the injury did not result in serious functional impairment, the decision to provide compensation will not be reviewed.

Act Sec # 2(1)(r), 20, 26, 27, 29, 30, 66
Effective Date 01 December 2011
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013.
Application All work injury claims on and after the effective date.
Supersedes n/a
Complements POL 13/2011 Serious and Wilful Misconduct
POL 12/2013 Arising Out of and In the Course of Employment
7.0 HEALTH CARE SERVICES & MEDICAL CARE

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7.1 Medical – General
7.1.1 Health Care Services (PRO 05/96)

Document Date 25 March 1996

Purpose To establish guidelines for payment methods and authorization required of health care services paid for, or reimbursed by the Workers’ Compensation Board (WCB).

BACKGROUND

Policy POL 05/96 downgraded policies on medical fees to procedures. The policy provides three schedules listing the medical services and procedures paid for by the WCB.

PROCEDURE

The following are guidelines for the payment methods and authorization required of health care services paid for, or reimbursed by the WCB based on Schedules 1, 2, and 3 in policy POL 05/96.

1. For all services, continue to pay or reimburse as the case may be consistent with existing policy, except:
   a. Both worker and service provider will be informed that service will be discontinued when measurable and visible improvement ceases.
   b. Where the Case Manager (CM) is unable to determine whether measurable improvement is occurring, the client will be referred to an assessment team for further treatment recommendations.

2. Services listed in Schedule 1 will be paid by the Board in accordance with current practice.

3. For those services in Schedule 2, the WCB will pay direct subject to the following conditions:
   a. That the provider is on the WCB approved provider list, which along with the practice standards developed jointly by the WCB and the providers professional association, requires that the provider be registered with an appropriate, recognized national or provincial body.
   b. That the provider obtained CM approval before providing the subject treatment.

4. That the attending physician has referred the worker to seek such treatment or has approved it.
5. That the CM must ensure that it is demonstrated that such treatment will either facilitate or accelerate a return to work, or will permit the worker to continue to work where he could not do so without the treatment.

6. Both worker and service provider will be informed that service will be discontinued when measurable and visible improvement ceases.

7. Where the CM is unable to determine whether measurable improvement is occurring, the client will be referred to an assessment team for further treatment recommendations.

8. Reimbursement requests received for services not approved in Schedules 1, 2, or 3 must be specifically authorized by management.

9. In all cases, CMs will undertake continuous monitoring and assessment of results, with quarterly managerial review.

10. The initial mailing to injured workers will be revised to reflect the services covered for payment and reimbursement under Schedule 1 only.

Act Sec # 103
Effective Date 01 April 1996
(PRO 60/2000 - 10 November 2000)
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All Claims
Supersedes n/a
Complements POL 05/96 Health Care Services
7.1.3 Medical Aid Billings – Payment (PRO 53/2006)

Document Date 30 October 2006

Purpose To outline the procedure for the payment of late billings from health care providers.

DEFINITION

Medical aid is defined in Section 2(1)(v) of The Workers’ Compensation Act, 2013 (the “Act”) as the provision of medical and surgical aid, of hospital and professional nursing services, of chiropractic and other treatment and of prosthetics or apparatus.

BACKGROUND

1. Section 103 of the Act states that a worker who is entitled to compensation is entitled to receive medical and surgical aid that shall be furnished or arranged for by the Workers’ Compensation Board (WCB) in any manner that it may approve.

2. Section 104(1) of the Act states that the fees for medical aid furnished by any health care professional are those that are determined by WCB.

3. Section 110 of the Act states that, subject to the approval of the Lieutenant Governor in Council, the WCB may make regulations governing the payment of medical accounts and the assessment of penalties for the late filing of those accounts.

4. This procedure sets out the period for which bills should be submitted for reimbursement for health care services.

PROCEDURE

1. WCB will not pay any account rendered by a physician, surgeon, hospital or other health care professional or institution for medical aid services if application for payment is received by Operations or Medical Accounts after a twelve-month period from the time the medical aid is administered to an injured worker. However, this does not apply to the reimbursement of a medical invoice that has been paid by an injured worker.

2. Health care providers entitled to be paid by WCB for any services performed or for any medication or material supplied, shall bill WCB directly. Injured workers shall not be charged with these costs.

3. WCB will authorize payments in the case of medical aid billings received by Operations or Medical Accounts after the twelve-month period only when acceptable reasons for the late submission of billings are provided, specifically where:
a. A claim was originally denied by WCB but is accepted on appeal; or
b. The delay in payment to the health care provider is the result of an administrative oversight or delay on the part of WCB.

4. All other medical aid billings received after the twelve-month period for reasons other than those provided for in Point 3(a) or (b) above, will not be considered for reimbursement.

Act Sec # 2(v), 103,104, and 110
Effective Date 01 December 2006
Amended References updated 01 January 2014 in accordance with *The Workers’ Compensation Act, 2013*
Application All claims involving medical aid billings.
Supersedes Board Directive 17/50 Medical Aid – Late Discount
Complements POL 04/2011 Injuries – Travelling for or Attending Medical Aid or Return-to-Work Programming
POL 02/97 Health Care Services Fees
POL 10/2011 Reimbursement for Medications
POL 57/80 Medical Fees – Extra Billing
7.2 Health Care Services
7.2.2 Medical Fees – Dental Services (PRO 56/2011)

Document Date 18 August 2011

Purpose To establish the billing requirements for dental services provided to Workers’ Compensation Board (WCB) clients.

BACKGROUND

1. Section 103(1) of The Workers’ Compensation Act, 2013 (the “Act”) states “every worker who is entitled to compensation or who is disabled only on the day of the injury is entitled without charge to:
   a. any medical aid that may be necessary as a result of the injury;
   b. any other treatment by a health care professional;
   c. any prosthetics or apparatus that may be necessary as a result of the injury, and to have any prosthetic limbs and eyes and any surgical appliances such as belts, braces, supports and orthopaedic shoes repaired, maintained and renewed when necessary by reason of accident or ordinary wear and tear; and
   d. any transportation or sustenance occasioned by the medical aid.”

2. Section 104(1) of the Act states “the fees for medical aid furnished by any health care professional are those that are determined by the board.”

3. Section 115(c) of the Act states that the board may expend moneys from the fund for any expenses incurred in the administration of the Act and, without restricting the generality of the foregoing, the board may expend money for “any medical aid provided pursuant to this Act to injured workers and any specialized treatment or other medical aid that the board considers necessary and that is not provided for in this Act.”

4. Annually, the College of Dental Surgeons of Saskatchewan issues a suggested fee schedule to its members.

PROCEDURE

General

1. Dentists and dental surgeons will direct bill the WCB for all services provided to WCB clients and will charge according to the College of Dental Surgeons of Saskatchewan Fee Schedule. Payment for all dental services will comply with this fee schedule.

2. All dental services, except emergency treatment, must be pre-authorized by the WCB.
Non-Emergency Treatment

3. The dentist or dental surgeon will submit a Dentist’s Initial Report (M7) to the WCB indicating the type of service required, and a cost estimate based on the fee schedule.

4. Operations staff will review the report to ensure that the recommended service is related to the work injury, and the estimated costs are in accordance with the fee schedule. Assistance may be obtained from the WCB Dental Consultant.

5. Where the recommended service is not noted in the fee schedule, the WCB Dental Consultant may provide advice regarding a reasonable fee that should be paid.

6. Following this review, Operations staff will authorize the dentist or dental surgeon, in writing, to proceed with the service. The authorization will request the dentist or dental surgeon to direct bill the WCB for the service and amount authorized. A copy of the authorization will be sent to the client.

7. Operations staff will provide a detailed explanation, in writing, in all instances where the amount authorized is less than the cost estimate provided by the dentist or dental surgeon.

Emergency Treatment

8. Where the client obtains emergency treatment, the dentist or dental surgeon will submit a Dentist’s Initial Report (M7) to the WCB. Following review of the report by Operations staff, and by the WCB Dental Consultant where required, the WCB will process payment (if authorized) to the dentist or dental surgeon.

9. Where the client paid the fees for the emergency treatment, the client should submit to the WCB the original receipts and the form completed by the dentist or dental surgeon detailing the work completed. Where the fee is in excess of that determined by the WCB, the WCB will contact the dentist or dental surgeon and request a refund for the client. Where a refund is not provided, the WCB will reimburse the client and the extra billing will be recovered from WCB payments to the dental service provider.

Act Sec # 103(1), 104(1), 115(c)
Effective Date 01 October 2011
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All claims on and after the effective date
Supersedes PRO 03/91 Medical Fees – Dental Consultant
Complements POL 17/2008 Expenses – Orthotics/Appliances – Provision, Replacement and Repair
7.2.3 Medical Fees – Hospitals & Other Treating Centres (PRO 55/2010)

Document Date 21 October 2010
Purpose To establish hospital per diem out-patient/in-patient rates and high cost procedures billing.

DEFINITIONS

High Cost Procedures means medical aid provided in a hospital or treatment facility involving highly trained physicians and advanced technology (e.g., organ transplants).

BACKGROUND

POL 02/97, Health Care Service Fees, authorizes the Chief Executive Officer to negotiate and administer fees for medical aid furnished by any health care professional.

PROCEDURE

1. The Workers’ Compensation Board (WCB) will reimburse any hospital or treatment facility for out-patient and in-patient services, as well as high cost procedures, in accordance with the annual rates set by Saskatchewan Ministry of Health’s Medical Services Branch (MSB), except where an alternate contract exists.

2. Services not established under the MSB rates will be paid according to the WCB rates negotiated for their discipline.

3. The WCB Finance Department will be responsible for ensuring that the most current rates set by the MSB are used. Rate adjustments will be applied retroactively to the effective date set by the MSB.

4. Only hospital services and procedures that are directly necessary in the treatment of a worker’s compensable injury will be paid for by the WCB.

Act Sec # 103, 104, 109(b)
Effective Date 01 November 2010
Application All claims requiring out-patient/in-patient services and high cost procedures.

Supersedes PRO 03/98 Repeal of Medical Fees – Wascana Outpatient Medical Fees – Hospital Out-Patient & High Cost Procedures Billing Rates PRO 65/1999 Medical Fees – Hospital Per-Diem In-Patient

Complements POL 02/97 Health Care Services Fees
7.2.4 Medical Fees – Optometry (PRO 61/2011)

Document Date 21 October 2011

Purpose To establish billing requirements for optometry services provided to Workers’ Compensation Board (WCB) clients.

BACKGROUND

1. Section 103(1) of The Workers’ Compensation Act, 2013 (the “Act”) states “every worker who is entitled to compensation or who is disabled only on the day of the injury is entitled without charge to:
   a. any medical aid that may be necessary as a result of the injury;
   b. any other treatment by a health care professional;
   c. any prosthetics or apparatus that may be necessary as a result of the injury, and to have any prosthetic limbs and eyes and any surgical appliances such as belts, braces, supports and orthopaedic shoes repaired, maintained and renewed when necessary by reason of accident or ordinary wear and tear; and
   d. any transportation or sustenance occasioned by the medical aid.”

2. Section 104(1) of the Act states “the fees for medical aid furnished by any health care professional are those that are determined by the board.”

3. Section 115(c) of the Act states that the WCB may expend moneys from the fund for any expenses incurred in the administration of this Act and, without restricting the generality of the foregoing, the board may expend moneys for “any medical aid provided pursuant to this Act to injured workers and any specialized treatment or other medical aid that the board considers necessary and that is not provided for in this Act.”

4. The Saskatchewan Association of Optometrists (SAO) sets the standards of practice for optometry services. SAO is responsible for licensing and regulating the practice of optometry in accordance with The Optometry Act, 1985.

PROCEDURE

1. The WCB will cover the costs of optometry services, including the provision of eyewear, where it is required due to an injury arising out of and in the course of employment. Entitlement for corrective or replacement eyewear will be determined in accordance with POL 17/2008, Expenses – Orthotics/Appliances – Provision, Replacement, and Repair.

2. Optometrists will direct bill the WCB for all services provided to WCB clients and will charge according to the most current rates set by the Saskatchewan Ministry of
Health ([www.health.gov.sk.ca/optometrist-information](http://www.health.gov.sk.ca/optometrist-information)). Payment for all optometry services will comply with these rates.

3. Where the optometrist direct bills the WCB for reporting fees, the amount invoiced will be in accordance with PRO 55/2015, Medical Fees – Physicians.

4. All optometry services, except emergency treatment, must be pre-authorized by the WCB.

Non-Emergency Treatment

5. Optometrists will submit a report to the WCB indicating the type of service required, and a cost estimate based on the Saskatchewan Ministry of Health’s rates.

6. Operations staff will review the report to ensure that the recommended service is related to the work injury, and the estimated costs are in accordance with the Saskatchewan Ministry of Health’s rates. Assistance may be obtained from the Manager of Health Care Services or the WCB Medical Officer.

7. Where the recommended service is not noted in the Saskatchewan Ministry of Health’s rates, Medical and Health Care Services may provide advice regarding a reasonable fee that should be paid.

8. Following this review, Operations staff will authorize the optometrist, in writing, to proceed with the service. The authorization will request the optometrist to direct bill the WCB for the service and amount authorized. A copy of the authorization will be sent to the client.

9. Operations staff will provide a detailed explanation, in writing, in all instances where the amount authorized is less than the cost estimate provided by the optometrist.

Emergency Treatment

10. Where the client obtains emergency treatment, the optometrist will submit a report to the WCB indicating the type and cost of service provided. Following review of the report by Operations staff, and by Medical and Health Care Services where required, the WCB will process payment (if authorized) to the optometrist.

11. Where the client paid the fees for the emergency treatment, the client should submit to the WCB the original receipts and the form completed by the optometrist detailing the work completed. Where the fee is in excess of that determined by the WCB, the WCB will contact the optometrist and request a refund for the client. Where a refund is not provided, the WCB will reimburse the client and the extra billing will be recovered from WCB payments to the optometrist.
Act Sec # 103(1), 104(1), 109(a), 115(c); The Optometry Act, 1985
Effective Date 01 November 2011.
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All clients requiring optometry services on and after the effective date.
Supersedes PRO 22/92 Medical Fees – Optometry
Complements POL 17/2008 Expenses – Orthotics/Appliances – Provision, Replacement and Repair
PRO 55/2015 Medical Fees – Physicians
POL 05/96 Health Care Services
7.2.5 Medical Fees – Physical Therapy Services (PRO 52/2014)

Document Date 03 March 2014

Purpose To establish fees and guidelines for physical therapists treating workers.

BACKGROUND

1. Section 103 of The Workers’ Compensation Act, 2013 (the “Act”) states that upon approval by the Workers’ Compensation Board (WCB), a worker entitled to benefits is also entitled to:
   a. Any medical aid that may be necessary because of the work-related injury.
   b. Any other treatment by a health care provider.
   c. Any orthotic appliance or apparatus that may be necessary as a result of the injury, and
   d. Any travel and sustenance costs associated with receiving medical treatment as a result of the injury.

2. Section 104(1) of the Act directs that the Workers’ Compensation Board (WCB) shall determine health care services fees.

PROCEDURE

General

1. To provide services to injured workers, physical therapists (PTs) must be:
   a. Members in good standing of the Saskatchewan College of Physical Therapists (SCPT), and
   b. Accredited by the WCB.

2. All PTs must comply with:
   a. The Accreditation Standards and Service Provider Guidelines for Physical Therapists Providing Out-Patient and Private Clinic Services to WCB Clients (“Service Guidelines”).
   c. The Service Fees and Fee Codes for Physical Therapists Providing Out-Patient and Private Clinic Services to WCB Clients (“Fee Schedule”).
   d. The ethical requirements of:
i. The SCPT.
ii. The Saskatchewan Physiotherapy Association (SPA), and
iii. The Canadian Physiotherapy Association (CPA).

e. Current and future WCB policies that pertain to physical therapy, and
f. The Act.

Service Guidelines

3. The Service Guidelines (Schedule A) provide the accreditation standards and the service provider guidelines for PTs treating injured workers.

4. The PT will send an initial report (PTI) to the WCB within three business days of the initial assessment.

5. PTs can provide up to 10 treatments after the initial assessment unless the WCB says otherwise. This includes education, return-to-work efforts and exercise therapy.

6. If the worker needs more treatment after the initial 10 treatments, the PT will send a progress report (PTP) to the WCB. The report must include:
   a. All information regarding the client’s physical findings and functional outcome scores, and
   b. The efforts made by the PT to establish transitional and or full return-to-work.

   After submitting the report, the PT can provide up to 10 more treatments unless the WCB says otherwise.

7. If the worker needs more treatment after the first extension, the PT will send another progress report (PTP) to the WCB. After sending the report, the PT can provide up to 10 more treatments, unless the WCB says otherwise. At this time, and for every progress report (PTP) sent thereafter, the WCB file manager will request the WCB Physical Therapy Consultant review the worker’s progress.

8. The PT will send the discharge report (PTP) to the WCB within three business days of the discharge.

9. Health Care Services (HCS) will contact (by phone and in writing) PTs that continually send initial reports (PTI) or progress/discharge reports (PTP) late to the WCB. HCS will issue a final warning if the late reporting continues. Thereafter, the WCB will not pay for services that the PTs provide after the reports are due.

10. If the WCB denies a physical therapy claim for coverage (following the initial assessment or request for further treatments), the WCB will pay for services up to the date of notification. The WCB will charge the costs of these claims to the administrative fund.
11. If a worker wants more treatment, but has not had treatment for more than 30 days, the WCB will pay for another initial assessment and report (PTI). PTs can continue treating (up to 10 treatments) unless the WCB says otherwise.

12. PTs will use Functional Outcome Measures to:
   a. Plan treatment programs, and
   b. Alert the WCB when workers need assessment team reviews.

**Soft Tissue Injuries**

13. The Soft Tissue Treatment Guidelines (Schedule B) stress the importance of:
   a. An early return-to-work.
   b. Appropriate hands-on treatment and exercise therapy, and
   c. Educating the WCB client on the injury and recovery process.

14. Subject to Points 6 and 7, if a WCB client exhibits a soft tissue injury and is involved and progressing in a return-to-work program, the PT can provide a maximum of:
   a. 10 interventions within the first four weeks post-injury.
   b. 23 interventions between five and eight weeks post-injury, and
   c. 16 interventions between nine and 12 weeks post-injury.

15. The WCB will only reimburse functional conditioning treatment for clients after they have been unable to return to regular or modified work duties for at least four consecutive weeks. If the worker needs functional conditioning before then, the PT will contact the WCB. The WCB Physical Therapy Consultant will review the worker’s progress before making a decision.

16. The Case Manager (CM) will review the client’s file at seven weeks post-injury to:
   a. Evaluate the risk of prolonged recovery.
   b. Determine if the worker needs an assessment team review.
   c. Ensure vocational (return-to-work) interventions are occurring, and
   d. Ensure that the PT is using the WCB’s standards of care and treatment protocols.

17. The PT will tell the CM if the worker is not improving between nine and 12 weeks post-injury. The worker may need an assessment team review.

**Assessment/Extension Review**

18. Claims Entitlement Specialists (CES) are responsible for reviewing initial reports (PTI) and progress/discharge reports (PTP) that the WCB gets within the first four
weeks post-injury. CMs (or the WCB Physical Therapy Consultant) will review reports that the WCB gets after four weeks unless Claims Entitlement retains the file.

19. If the CES, CM or WCB Physical Therapy Consultant finds that the WCB should deny coverage, the file manager will advise the PT.

20. The WCB Physical Therapy Consultant will review files that have two or more progress reports (PTP). However, CESs and CMs can request the assistance of the WCB Physical Therapy Consultant at any time during the review of claims.

Evaluations

21. The WCB will measure performance and quality of care using:
   a. The primary care provider review process, and
   b. A clinical survey process.

22. HCS will issue letters to PTs that are non-compliant with Service Guidelines or the Soft Tissue Treatment Guidelines. These letters will outline appropriate corrective actions. Failure to comply may result in the loss of WCB accreditation.

Complaints and Dispute Resolution

23. Workers can report complaints of any nature to the WCB. The WCB employee receiving the complaint may refer the complaint for resolution to other WCB staff, including the Manager of HCS. If the complaint alleges professional incompetence or misconduct by a care provider, the Manager of HCS will direct the complainant to the SCPT.

24. HCS will note all complaints and resolutions on the service provider’s accreditation file.

25. Workers that want to see a different provider may:
   a. If self-referred, contact one directly, or
   b. See the primary care provider who made the initial referral.

Fees

26. The fee schedule (Schedule C) is effective April 1, 2014. The fee schedule will remain in effect until the WCB and the SPA reach a new agreement.

27. To prevent financial hardship to the injured worker, PTs will:
   a. Ensure their billing is directed to the WCB, not the worker, and
   b. Avoid extra billing by adhering to the approved fee schedule.
28. WCB funding for primary level physical therapy care may stop when:
   a. The client is not making any physical or functional gains.
   b. There are indications that the WCB client has recovered from the effects of the work-related injury, or
   c. The WCB client is moving into a secondary or tertiary treatment program.

ATTACHMENTS

Schedule A – Accreditation Standards and Service Provider Guidelines for Physical Therapists Providing Out-Patient and Private Clinic Services to WCB Clients

Schedule B – Primary Physical Therapy Soft Tissue Treatment Guidelines

Schedule C – Service Fees and Fee Codes for Physical Therapists Providing Out-Patient and Private Clinic Services to WCB Clients


Schedule E – WCB Billing Process – Example – Adjustments to Previous Billing Periods – Physical Therapy

Act Sec # 55, 103(1), 104, 115(c)
Effective Date 01 April 2014
Application All claims where workers require physical therapy.
Supersedes PRO 52/2013 Medical Fees – Physical Therapy Services
Complements POL 05/96 Health Care Services
            POL 05/96 Health Care Services
            POL 02/97 Health Care Services Fees
Schedule A
Accreditation Standards and Service Provider Guidelines for Physical Therapists
Providing Out-Patient and Private Clinic Services to WCB Clients

1. **Intent**
This document sets out physical therapy:
- Accreditation standards, and
- Service provider guidelines.

2. **Introduction**
All physiotherapists providing services to WCB clients will be members in good standing of the Saskatchewan College of Physical Therapists. Physiotherapists will comply with:
- Accreditation Standards and Service Provider Guidelines for Physical Therapists Providing Out-Patient and Private Clinic Services to WCB Clients (Schedule A).
- The Primary Physical Therapy Soft Tissue Treatment Guidelines (Schedule B).
- The Service Fees and Fee Codes for Physical Therapists Providing Out-Patient and Private Clinic Services to WCB Clients (Schedule C).
- The ethical requirements of the Saskatchewan College of Physical Therapists, the Saskatchewan Physiotherapy Association, and the Canadian Physiotherapy Association.
- Current and future WCB policies that pertain to physical therapy. The WCB will notify, via the Saskatchewan Physiotherapy Association, of specific changes that will affect the provider, and

By providing care to WCB clients, physiotherapists implicitly indicate their:
- Understanding of this agreement, and
- Willingness to comply with this agreement.

3. **Professional Affiliation and WCB Accreditation Requirements**
All physical therapy treatment shall be provided by, or under the supervision of, physiotherapists accredited by the WCB.

Physiotherapists that want to provide care to WCB clients must apply for WCB accreditation.

WCB accreditation ensures that WCB clients receive care from qualified physiotherapists that are independent of adjudication decisions and employer influence. Physiotherapists make decisions regarding continued treatment, return-to-work, and the need for assessment team review, based on objective and
documented medical findings. Physiotherapists must be independent and objective, and therefore must refuse to advocate on behalf of employers or workers regarding causation or ongoing benefits. When requested, physiotherapists will remind employers or workers of the WCB appeals processes and the Fair Practices Office, both of whom have access to medical expertise to address any concerns raised. Physiotherapists will not advertise their affiliation with the WCB.

4. Practice Guidelines

Intake and Assessment Guidelines

The physiotherapist will send the initial assessment report (PTI) to the WCB within three business days after the WCB client’s initial assessment. Physiotherapists are allowed to treat WCB clients for up to 10 visits after the initial assessment unless they receive notification from the WCB to the contrary.

Education, return-to-work efforts and exercise therapy may also be provided. Once the initial 10 visits are complete and further treatment is required, a physical therapy progress report (PTP) must be submitted to the WCB. The report must include:

- All information regarding the client’s physical findings and functional outcome scores, and
- The efforts made by the physiotherapist to establish transitional and or full return-to-work.
- Only after submitting this report, the physiotherapist may continue treating the WCB client for another 10 visits.

When further treatment is required after the first extension of treatment, a physical therapy progress report (PTP) must be submitted to the WCB. Only after submitting this report, the physiotherapist may continue treating the WCB client for another 10 visits. At this time, and for every physical therapy progress report (PTP) submitted thereafter, the WCB file manager will request the WCB Physical Therapy Consultant review the WCB client’s progress.

When a physical therapy claim for coverage is denied (following the initial assessment or request for further treatments), the WCB will pay for services up to the date when the therapist was notified that it was denied. When a WCB client requests further treatment, but has not attended treatment for more than 30 days, the WCB will fund another initial assessment and initial assessment report (PTI). Physiotherapists are allowed to continue treating (up to 10 visits as noted earlier) unless notified by the WCB.

The WCB, physiotherapists, employers, and workers will ensure services are provided, distributed, and funded without any conflict of interest. If the WCB, physiotherapist, employer or worker recognizes or perceives a conflict of interest, all parties are to be provided written notice of the conflict. The following are considered to be conflicts of interest:
• Referring workers to physical therapy clinics where the referrer has some aspect of control (e.g., the referrer is an owner, director, officer or stakeholder of the clinic).

• Providing services to workers for work-related injuries without advising the WCB.

• Any officer, director, employee or agent of the physiotherapist approaching WCB personnel to promote the business of the physiotherapist.

• Physiotherapists that enter into agreements with employers for the treatment of workers for work-related injuries.

Management Guidelines

WCB clients will receive care equivalent with the:

• Type and severity of the injury.

• Stages of tissue healing, and

• Availability of the worksite to provide therapeutic progressions.

If the WCB client is diagnosed to have a soft tissue injury, the physiotherapist will use the Primary Chiropractic and Physical Therapy Soft Tissue Treatment Guidelines (Schedule B). The Primary Chiropractic and Physical Therapy Soft Tissue Guidelines will be reviewed during the term of agreement. Once the parties have agreed upon the amendments, the amended version will be available to physiotherapists to view via the WCB website.

Soft tissue treatment will not exceed two hours per day.

Physiotherapists will book a maximum of three clients in an hour. This will ensure:

• Adequate time for physical care.

• Education.

• Reassurance, and

• Return-to-work discussion.

This ratio does not apply to back classes, education classes, conditioning programs, inter-professional conferencing or work hardening programs.

In programs involving strength training, the staff/client ratio will not exceed one to six. In non-strength training programs (i.e., aerobic exercise), the staff/client ratio will not exceed one to 12.

If the physiotherapist suggests that the services of an exercise therapist that is not part of the credentialed team or a massage therapist are required, the physiotherapist will provide a written referral to the exercise or massage therapist. The exercise or massage therapist will then request authorization to treat the client from the WCB. If the exercise therapist is included as a member of the credentialed team, a written referral is required, but an authorization request is not required.
Discharge Guidelines

WCB clients are discharged from treatment when they:

- Are not making any physical or functional gains, or
- Move into secondary or tertiary treatment programs.

Physiotherapists will send discharge reports (PTP) to the WCB within three business days of the clients’ discharge.

The WCB Physical Therapy Consultant will review files to assist in determining the worker’s entitlement to benefits. The WCB discourages maintenance care that is perceived to be preventative in nature but does not result in functional improvement. In certain exceptions, the WCB Physical Therapy Consultant shall be contacted by the treating physiotherapist.

Identifying the Need for Re-Assessment

Physiotherapists will tell the WCB if an assessment team review is required to determine if secondary or tertiary level care is more appropriate if the client:

- Needs more comprehensive care.
- Is not progressing satisfactorily.
- Is not recovering from the work injury, or
- Requires psychology and or pain management services.

The physiotherapist will continue with normal treatment prior to the assessment team review only if the client will physically or functionally benefit from the treatment. Otherwise, the physiotherapist may continue treatment at a decreased frequency in order to ensure that a regression of the injury does not occur.

Physiotherapists can contact the WCB Physical Therapy Consultant at:

- 306-787-4370, or
- 1-800-667-7590.

If a worker, as a result of an assessment team review or physical/functional capacity evaluation, requires secondary or tertiary level care, the WCB Health Care Services Coordinator will refer the worker to a care centre if the primary care provider has not indicated a preference. To the extent possible, the Health Care Services Coordinator will make the referral to the centre that currently provided the primary level care, while ensuring there is equal distribution of clients among secondary and tertiary providers.

5. Facility

To fulfill the needs of WCB clients, physical therapy treatment centres must have:

- Adequate space.
- Facilities, and
- Equipment.
In the absence of standards from the Saskatchewan College of Physical Therapists, Saskatchewan Physiotherapy Association, or the Canadian Physiotherapy Association, adequacy will be determined by the clinic survey tool.

6. **Continuing Education**

Physical therapy treatment centres will provide an orientation program to all new staff, including training in emergency procedures, and processes established within the centre to provide care and return-to-work planning to WCB clients. All physiotherapists will be encouraged to participate in continuing education programs and will have knowledge of current physical therapy practice and treatment protocols. All physiotherapists will comply with continuing education or competency programs developed by the Saskatchewan College of Physical Therapists.

7. **Storage of Health Information and Charting**

There will be a written or electronic report for each client within the treatment facility. These reports will include the:

- Findings of initial assessment.
- Goals of treatment.
- Treatment provided.
- Findings of periodic reviews.
- Details of the worker’s job duties.
- Efforts made toward establishment of transitional and then full return-to-work, and
- Discharge summary.

Charting and storage of health information will meet all requirements of:

- The Saskatchewan College of Physical Therapists.
- *The Health Information Protection Act* (HIPA).
- *The Workers’ Compensation Act, 2013*, and any future revisions, and
- Any other applicable legislation.

If the worker requests a copy of the client chart, the information, excluding information received from the WCB, will be provided in the manner directed by the Saskatchewan College of Physical Therapists. Physiotherapists will tell clients that they can only get WCB documents from the WCB.

8. **Duty to Report Work Injury**

Section 55 of the Act states:
“Any health care professional who attends to or is consulted with respect to an injury to a worker shall:

(a) furnish the board with any reports with respect to the examination or treatment of the worker that are relevant to the injury for which compensation is claimed;

(b) give all reasonable and necessary information, advice and assistance to the injured worker or the worker’s dependants in making an application for compensation; and

(c) furnish any certificates and proofs that the board may require.”

Physiotherapists will report work-related injuries to the WCB by sending initial assessment reports (PTI) to the WCB.

Physiotherapists will tell workers to report injuries to the WCB by:

- Calling 1-800-787-9288, or
- Completing a worker’s report of injury form (W1). Physiotherapists may attach worker’s report of injury forms (W1) to initial assessment reports (PTI).

9. **WCB Reporting Forms**

WCB reporting forms and frequency of reporting are subject to periodic revision, with input from the Saskatchewan Physiotherapy Association and the WCB Physical Therapy Consultant. The WCB will provide sufficient time to physical therapy treatment centres to implement the use of the revised templates.

Physiotherapists will send initial assessment reports (PTI) to the WCB within three business days of initial assessments.

To request extensions, physiotherapists will send progress reports (PTP) to the WCB every 10 visits.

Physiotherapists will send discharge reports (PTP) to the WCB within three business days of the clients’ discharge.

Physiotherapists will send return-to-work schedules to the WCB before they begin. If the schedules need changes, physiotherapists will tell the WCB. The WCB will provide a financial incentive to physiotherapists that report online.

10. **Confidentiality Requirements**

Physiotherapists will treat all health-related and personal information in a confidential manner. No information will be revealed to any person or party other than those persons to whom reports are to be made or to such other persons as may, from time to time, be designated by the WCB. Information pertaining to functional ability may be provided to the employer for the purposes of establishing a return-to-work arrangement.

All public relations work, interviews, public appearances and press releases related to services being provided to WCB clients will require WCB approval.
Physiotherapists will not, without prior written approval of the WCB, publish or allow to be published any work that relies upon or uses information obtained by the physiotherapist, the Saskatchewan Physiotherapy Association or its members in carrying out the terms of this agreement, except for retroactive research where the workers treated are not identifiable.

11. Quality Assurance and Performance Evaluation Measures

There must be a sufficient number of physiotherapists on staff to provide efficient and effective services. Physiotherapists will make reasonable efforts to provide evidence-based care. The ratio of non-professional to professional staff in a physical therapy centre must meet the standards of the Saskatchewan College of Physical Therapists.

Each physical therapy centre will evaluate the quality and quantity of care provided. The evaluation will include an evaluation of outcomes by using Functional Outcome Measures. Centres must be able to provide verification upon WCB request that physiotherapists have not provided care to more than three clients in the hour that care was provided to a WCB client subject to the “Management Guidelines” under Section 4, “Practice Guidelines”.

Compliance to these standards will be evaluated through quality assurance processes that utilize a clinic survey process.

Performance and quality care will be measured by the primary care provider review process.

12. Fees for Service

Section 103(1) of the Act states:
“Every worker who is entitled to compensation or who is disabled only on the day of the injury is entitled without charge to:
(a) any medical aid that may be necessary as a result of the injury;
(b) any other treatment by a health care professional.”

Physiotherapists will ensure that WCB clients never pay for their services and that billing is always directed to the WCB. Physiotherapists will adhere to the Service Fees and Fee Codes for Physical Therapists Providing Out-Patient and Private Clinic Services to WCB Clients (Schedule C) and will not extra bill WCB clients.

Where the worker has sustained a soft tissue injury, the Primary Chiropractic and Physical Therapy Soft Tissue Treatment Guidelines (Schedule B) will be adopted and billed accordingly unless the WCB Physical Therapy Consultant has been contacted regarding an amended protocol and has recorded the need for additional funding on the file.

Prorated service fees, billed as 20 minute units of care, will be rounded up to the next full 20 minute unit of care, with ethical scheduling guiding the practitioner.
Modalities are discouraged, but where necessary will not be billed independent of other therapeutic interventions and will be suitable to the stage of tissue healing specific to the worker. Theraband also must not be extra billed to the worker and or the WCB and is considered a component of the already funded physical therapy. Theraballs and other equipment are billable to the WCB only with prior approval of the Case Manager, who may consult with the WCB Physical Therapy Consultant regarding appropriateness of the prescription. The Case Manager must be contacted by the physiotherapist in writing and WCB payment refused prior to any equipment recommended by the physiotherapist being billed to the worker. To reduce the perception of prescriber/provider bias, the WCB will pay the manufacturer’s fee plus a 10 percent handling fee.

13. **Return-to-Work**

Section 53 of the Act states:

“An employer shall co-operate with the board and the worker to achieve the early and safe return of an injured worker to his or her employment.”

Within the first week of treatment, the physiotherapist will contact the employer to determine the availability of transitional return-to-work. If transitional return-to-work is available and appropriate, the physiotherapist will coordinate a transitional return-to-work plan with the:

- Primary care provider.
- Worker.
- Employer, and
- WCB.

The duration and start date of the transitional return-to-work plan will be based on clinical judgment regarding type and severity of injury, the stages of tissue healing, the physical requirements of the pre-injury job, and the availability of transitional return-to-work. Where any return-to-work partner is not cooperative with return-to-work planning, the physiotherapist will advise the WCB that a barrier to recovery has occurred, asking the WCB to make contact with the individual. The resultant transitional return-to-work plan will be forwarded to the WCB using the practitioner return-to-work (PRTW) form and will be resubmitted should revisions to the original plan occur.

The same process will occur for coordination of graduated return-to-work plans.

14. **Term of Agreement**

These service provider guidelines and service fees shall come into effect 30 calendar days after the date of WCB endorsement of the Accreditation Standards and Service Provider Guidelines for Physical Therapists Providing Out-Patient and Private Clinic Services to WCB Clients and the associated fee schedule, with the new fee schedule implemented on April 1, 2014.
The agreement and appended schedules shall continue in full force and effect until the 31st day of December, 2015, unless earlier termination occurs in accordance with Clauses 7 or 8 of this agreement.

Notwithstanding the foregoing, from time to time the schedules to this agreement may be updated in accordance with this agreement, without affecting the terms hereof. Should the fee schedule not be implemented on April 1, 2014, this agreement will be null and void, and a new agreement shall be negotiated between the WCB and the Saskatchewan Physiotherapy Association.

15. Ongoing Relationship

Ongoing input from physiotherapists will be obtained from the WCB Physical Therapy Consultants, those individuals who respond to an expression of interest advertised by the WCB, and or by requesting input or information from the Saskatchewan Physiotherapy Association and the Saskatchewan College of Physical Therapy. If physiotherapists would like to provide input about the care of WCB clients that is not file specific, they should contact the President of Saskatchewan Physiotherapy Association or their third party payers committee who will then request to meet with the Manager of Health Care Services.
1. **Preface**

The WCB Health/Medical Services Unit developed these guidelines for soft tissue injuries, with input from biomechanical health care consultants, the Chiropractors' Association and the Saskatchewan Physiotherapy Association.

These guidelines have been developed to address typical soft tissue injuries; however, the time frames identified here do not apply to post-surgical injuries or fractures. In some instances, more intensive treatment will be required at a primary level.

When enhanced services are required, the WCB physical therapy and chiropractic consultants should be contacted to help decide if enhanced services should occur at the primary level or if an assessment team review is required.

2. **Definitions**

**Soft Tissue**

Soft tissue includes muscle, tendons, fascia and ligaments.

**Soft Tissue Injury**

Soft tissue injury is an injury to one or more soft tissue structures including muscle, tendons, fascia and ligaments that connect the skeletal structure.

Soft tissue injuries generally include strains, sprains and contusions. Soft tissues also can be injured as a result of:

i. Direct trauma;
ii. Over-use;
iii. Over stretching;
iv. Whiplash-type injuries (i.e., caused by a motor vehicle accident).

Soft tissue injuries do not include:

v. Direct or indirect trauma to bones (i.e., fractures);
vi. Nerves (i.e., carpal tunnel syndrome or neuropraxia);

vii. Vascular (i.e., complex regional pain syndrome);

viii. Post-surgical soft tissue recovery.

3. **Basic Soft Tissue Injury Treatment Program**

a. **Zero to Four Weeks Post-Injury**

i. Interventions
After conducting an initial assessment of the injured worker, chiropractors and physical therapists may provide a maximum of 10 interventions within the first four weeks that could include:
(a) Biomechanical treatment (Code 400 and 401 DC or Code 2000 and subsequent 2001);
(b) Regional conditioning instruction (Code 410 – Individual Conditioning Instruction DC) and (Code 2008 – Individual Regional/Global Conditioning PT).

In most cases, it is recommended that regional conditioning should be done at home during this period. If, as a health care practitioner, you feel an injured worker requires in-clinic regional conditioning, you should deliver the intervention using one-on-one individualized exercise instruction for a typical intervention period (i.e., 20 minutes).

At least one “one-on-one” educational session with the injured worker, lasting at least 20 minutes (Code 414 DC-Education and Code 2011 PT – Education).

During an educational session, you should explain:
(a) The stages of tissue healing;
(b) Self-management including self-directed reactivation strategies;
(c) The recovery process and return-to-work (return-to-work during the early stages of recovery is safe when clinically appropriate);
(d) Pain management, where indicated.

Current literature supports maintenance of normal activity such as walking, swimming, and suitable employment for injured workers.

At your discretion, you may use multiple interventions in a day; however, each intervention will be counted as part of the 10 interventions allotted during this stage of tissue healing.

When an injured worker enters primary treatment later than the first week post-injury, the number of interventions should be prorated to the four-week mark. For example, where treatment commences at three weeks post-injury, five interventions can be provided.

*NOTE: An intervention is defined as a biomechanical treatment or one of the prorated interventions identified on the WCB fee schedule.

ii. Return-to-Work
Chiropractors and physical therapists should make at least one return-to-work planning contact with the employer (Code 407 DC RTW Plan and Development and Code 2002 RTW Planning and Monitoring).

The contact should be a telephone conversation; a letter mailed to the employer will not fulfill this requirement.

When an employer can accommodate the injured worker’s current functional abilities and restrictions, return-to-work planning and reporting should proceed, with the agreement of the primary care provider (if not you). The return-to-work schedules should be communicated to all parties using WCB’s Practitioner Return-to-Work form.
Return-to-work planning sessions with an injured worker are not counted as part of the 10 interventions during this treatment period.

iii. Billing
During the first four weeks post-injury, the WCB will not fund group supervised, global and functional conditioning and functional testing.

The WCB will fund, but does not count the following items as interventions:
(a) Initial assessment;
(b) Return-to-work planning;
(c) Telephone calls or consultations (Code 405C and Code 2015).

b. Five to Eight Weeks Post-Injury
i. Interventions
Chiropractors and physical therapists may provide a maximum of 23 interventions between five and eight weeks that could include:
(a) Biomechanical treatment (Code 401 DC and Code 2001 PT);
(b) Regional conditioning instruction (Code 410 – Individual Conditioning Instruction DC and Code 2008 – Individual Regional/Global Conditioning PT);
(c) Patient education session (Code 414 DC and Code 2011 PT);
(d) Global conditioning (Code 411 DC and Code 2007 PT). See below for situations that warrant global conditioning;
(e) Functional conditioning (Code 408 DC and Code 2004 PT) See below for situations that warrant functional conditioning;

ii. Global and Functional Conditioning
Functional and global conditioning sessions are used only in situations where the client is not progressing in treatment or on a return-to-work plan where conditioning allows for tolerance development that cannot be safely introduced in the workplace.

Before you begin functional conditioning, you need to conduct a functional assessment (Code 415 DC and Code 2012 PT). Only one functional test is allowed during this period.

However, you may not need to conduct functional testing if your return-to-work discussions with the injured worker indicate he/she feels capable of performing his/her critical job demands. Return-to-work capacities can be determined from daily functional conditioning records and observations and does not always require an additional assessment.

iii. File Review
Following WCB guidelines, WCB Case Management staff will review the injured worker’s file at seven weeks post-injury to evaluate the risk of prolonged recovery and determine if an assessment team review is needed.

This review may involve the WCB asking you as the injured worker’s practitioner or therapist regarding:
(a) The injured worker’s timeframe for recovery;
(b) The injured worker’s timeframe for return-to-work, if a return-to-work plan has not been communicated to the WCB, employer, injured worker and primary care provider (if other than yourself). As a practitioner or therapist, you should be prepared to discuss progress in recovery and return-to-work to help the WCB determine if either:

♦ reasonable progression is occurring; or
♦ you feel a multidisciplinary assessment is required.

The WCB may ask the injured worker be sent to an assessment team review at this time if:

(c) Progress is not being attained;
(d) There are yellow or red flags present with little progress in recovery;
(e) A return-to-work plan is not in progress.

NOTE: Return-to-work planning/telephone calls would not be counted as part of the interventions delivered during this treatment period.

c. Nine to 12 Weeks Post-Injury

i. Interventions

Chiropractors and physical therapists can continue with a maximum of 16 interventions during this period as long as the worker is involved with a return-to-work program that is progressing.

Return-to-work planning/telephone calls would not be counted as part of the interventions delivered during this treatment period.

Where the injured worker is participating in a return-to-work plan and non-endurance progressions are required, you can use functional conditioning if the injured worker’s material handling tasks are greater than what has been measured during the rehabilitation program. For example, you can use functional conditioning if the injured worker requires lifting to heavy industrial, as per the Dictionary of Occupational Titles, and the worker is presenting with substantially reduced lifting levels.

ii. Assessment Team Review

If, as the practitioner/therapist, you do not see any objective improvement, you should request an assessment team review.

In situations where no functional improvement has occurred and or the injured worker is not in the workplace and awaiting assessment team review, the recommended treatment frequency is one to two times a week with biomechanical and regional conditioning.

NOTE: Usually WCB’s Case Management staff and a Chiropractic or Physical Therapy Consultant will have reviewed the injured worker’s file before nine weeks as part of their efforts to identify injured workers who would benefit from assessment team review. As part of this review, team members will ensure vocational (return-to-work) interventions have been occurring and that WCB’s standards of care and treatment protocols have been implemented.

4. Enhanced Soft Tissue Injury Program
If, as a chiropractor or physical therapist, you feel that the injured worker’s condition warrants more than the maximum number of interventions in any of the time frames discussed in this document, please phone the Chiropractic/Physical Therapy Consultant at the WCB offices.

During the call, you and the consultant will discuss your client’s needs, clinical findings, and your evidence-based rationale to request an enhanced treatment program. The goal of this discussion ensures that:
(a) Injured workers receive the right treatment at the right time;
(b) Injured workers at risk of prolonged recovery are routed to an assessment team review promptly to reduce the risks of chronic disability.

5. **Soft Tissue Injury Care Model**

**WCB SOFT TISSUE INJURY GUIDELINES**

6. **Literature Review and Resource List**

The literature review was undertaken in an effort to answer the following questions:

a. Does the literature support the theory/hypothesis that typical soft tissue injuries resolve within six to eight weeks without intervention or with minimal intervention?

b. Does it support treatment during this time frame?

c. Does it not support treatment during this time frame?

d. Is there evidence that supports a style of treatment during this time frame?

e. Key search terms used during this literature review:
   i. Ligament injury;
   ii. Soft tissue;
iii. Soft tissue rehabilitation;
iv. Insurance rehabilitation;
v. WCB;
vi. Workers;
vii. Work hardening;
viii. Functional restoration;
ix. WCB Rehabilitation;
x. Rehabilitation soft tissue injury;
xi. Treatment guidelines WCB;
xii. Treatment guidelines soft tissue;
xiii. Treatment guidelines soft tissue injuries;
xiv. Soft tissue injuries evidence-based guidelines;
xv. Evidence-based treatment soft tissue injuries;
xvi. Excessive treatment soft tissue injuries;
xvii. Cost effective treatment WCB soft tissue injuries;
xviii. Cost effective treatment soft tissue injuries;
xix. Cost effective treatment work injuries;
xx. Soft tissue work injury management;
xxi. Soft tissue rehabilitation best practice;
xxii. Physiotherapy intervention work injury;
xxiii. Physiotherapy intervention soft tissue injury;
xxiv. Physiotherapy best practice work injury.

f. The literature review found 42 articles. The resource list that was used as a reference appears below. Articles were excluded if they did not meet the time frames of treatment identified in the soft tissue injury care model.

Resource List


Karjalainen, K; Malmivaara, A; van Tulder, M; Roine, R; Jauhiainen, M; Hurri, H; Koes, B. 2000. Multidisciplinary biopsychosocial rehabilitation for sub acute low-back


Stenstra, Ivan; Anema, Johannes; van Tulder, Maurits; Bongers, Paulien; de Vet, Henrica; van Mechelen, Willem. 2006. Economic Evaluation of a Multi-Stage Return to work Program for Workers on Sick-Leave Due to Low Back Pain. Journal of Occupational Rehabilitation. 16(4):557-78.


Schedule C  
Service Fees and Fee Codes for Physical Therapists Providing Out-Patient and Private Clinic Services to WCB Clients

The following WCB fee codes and fees are to be used to bill for services provided to WCB clients by physical therapists accredited to provide primary level services to WCB clients. Prorated service fees, billed as 20 minute units of care, will be rounded up to the next full 20 minute unit of care. The rounding privilege will be utilized in an ethical manner. Double billing of any portion of a unit of care will not occur.

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</tr>
<tr>
<td>Service</td>
<td>Fee Code</td>
<td>Effective January 1, 2013</td>
<td>Effective April 1, 2014</td>
<td>Effective January 1, 2015</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>---------------------------</td>
<td>-------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Initial Assessment Form (PTI) with Functional Outcome Measures</td>
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<td>Physical Therapy Progress/Discharge Report (PTP) with Functional Outcome Measures</td>
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<td>$34.86</td>
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<tr>
<td>PTP without Functional Outcome Measures</td>
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<td>$23.00</td>
<td>$23.81</td>
<td>$24.52</td>
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<tr>
<td>On-line Submission of any WCB Report</td>
<td>2100</td>
<td>$10.00</td>
<td>$10.35</td>
<td>$10.66</td>
</tr>
<tr>
<td>Theraball and other equipment/appliances (requires WCB pre-authorization)</td>
<td>34</td>
<td>Manufacturer’s price + 10%</td>
<td>Manufacturer’s price + 10%</td>
<td>Manufacturer’s price + 10%</td>
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<tr>
<td>Response to WCB request for PFI rating info2</td>
<td>2097</td>
<td>$180</td>
<td>$186.32</td>
<td>$191.91</td>
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</table>

1. Individual Conditioning will be billed only where the WCB client requires instruction on the safe use of equipment or therapeutic exercise, has new exercises introduced to their regimen or is cognitively impaired, or the Manager of WCB Health Care Services or the WCB Physical Therapy Consultant has determined that the group billing is in appropriate. Individual Conditioning should not be billed because a clinic does not have sufficient workers to make up a group and so is treating a single individual.

2. Fee Code 2097 should be billed along with fee code 2000 and fee code 2018.

3. Fees for Theraband will be included in the treatment fee.

Contact numbers:
Medical Accounts Inquiry Line at (306)787-4412 for all billing inquiries.
Manager of Health Care Services, at (306)787-7760 for inquiries concerning:
- Fee and or service agreement
- Procedure regarding Saskatchewan Physiotherapy
**TREATMENT BILLING SUMMARY**

<table>
<thead>
<tr>
<th>Fee Descriptor</th>
<th>Level: P, S, T</th>
<th>Fee Code</th>
<th># of Treatments or Units</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Biomechanical Assessment</td>
<td>P</td>
<td>2000</td>
<td>1</td>
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<tr>
<td>Functional Ability Evaluation</td>
<td>P</td>
<td>2012</td>
<td>2</td>
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</tr>
<tr>
<td>Subsequent Visit</td>
<td>P</td>
<td>2001</td>
<td>3</td>
<td>$130.68</td>
</tr>
<tr>
<td><strong>Total of all services for billing period</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$307.29</strong></td>
</tr>
</tbody>
</table>

Billing period is June 1 to June 30, 2014. Treatment start date is June 12, 2014.

Service provided was one initial biomechanical assessment, 30 minutes of functional ability evaluation, and three subsequent treatments.

The fee schedule directs that for prorated service fees, one treatment or unit of care will be considered as 20 minutes of care, and be rounded up to the next full 20 minute unit of care. Therefore, the fee for 30 minutes of functional ability evaluation will be rounded up to two units of care (40 minutes) at a cost of $87.12.
### TREATMENT BILLING SUMMARY

**DEFINITION:**
THER

**FOR**
MONTHLY/BIMONTHLY BILLINGS

**SERVICE PROVIDER:** ABC Clinic
999 - 1st St.
Saskatoon, SK  S4X 7S9

**BILLING PERIOD:** 01/06/14 - 30/06/14

**Phone:** 777-9999  **Fax:** 777-8888  **Caregiver Billing Number:** MAS079990

**CLAIMANT'S NAME:** Sally Smith  **Claim Number:** 100079786
111 Albert St.
Saskatoon, SK  S7K 9C4

**Primary start date:** 12/06/14  **Secondary start date:**  **Tertiary start date:**

<table>
<thead>
<tr>
<th>Fee Descriptor</th>
<th>Level: P, S, T</th>
<th>Fee Code</th>
<th># of Treatments or Units</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent Visit</td>
<td>P</td>
<td>2001</td>
<td>(3)</td>
<td>($130.68)</td>
</tr>
<tr>
<td>Subsequent Visit</td>
<td>P</td>
<td>2001</td>
<td>2</td>
<td>$87.12</td>
</tr>
<tr>
<td><strong>Total of all services for billing period</strong></td>
<td></td>
<td></td>
<td></td>
<td>$87.12</td>
</tr>
</tbody>
</table>

In billing period June 1 to June 30, 2014 three subsequent visits were billed in error. Only two subsequent visits were provided.
7.2.6 Medical Fees – Chiropractors (PRO 56/2013)

Document Date 12 December 2013

Purpose To establish fees and guidelines for chiropractors treating workers.

BACKGROUND

1. Upon Workers’ Compensation Board (WCB) approval, a worker entitled to benefits under The Workers’ Compensation Act, 2013 (the “Act”) is also entitled to (Section 103):
   a. Any medical aid that may be necessary because of the work-related injury.
   b. Any other treatment by a health care provider.
   c. Any orthotic appliance or apparatus that may be necessary as a result of the injury, and
   d. Any travel and sustenance costs associated with receiving medical treatment as a result of the injury.

2. The WCB is authorized to determine health care services fees (Section 104(1)).

PROCEDURE

General

1. To provide services to injured workers, chiropractors must be members in good standing of the Chiropractors’ Association of Saskatchewan (CAS).

2. Chiropractors must comply with:
   a. Accreditation Standards and Service Provider Guidelines for Chiropractors Providing Services to Saskatchewan Workers’ Compensation Board Clients (Schedule A).
   b. Primary Chiropractic and Physical Therapy Soft Tissue Treatment Guidelines (Schedule B).
   c. Service Fees and Fee Codes for Saskatchewan Workers’ Compensation Board Primary Chiropractic Service Providers (Schedule C).
   d. The ethical requirements of the CAS.
   e. The Workers’ Compensation Act, 2013.
   f. The Chiropractic Act, 1994, and
   g. CAS Bylaws.
3. All members of the CAS get:
   a. Accreditation from the WCB, and
   b. A billing number from the Ministry of Health.

Service Guidelines

4. Schedule A provides the accreditation standards and service provider guidelines for chiropractors treating injured workers.

5. The chiropractor will send an initial report (CHI) to the WCB within three business days of the initial assessment.

6. Chiropractors can provide up to six treatments (after sending the CHI form) unless the WCB says otherwise. The WCB will pay for the:
   a. Intake assessment.
   b. Initial report, and
   c. Subsequent treatment.

7. The WCB will pay for one treatment per visit day (unless otherwise noted in Schedule C). Treatment may include a number of interventions in a single visit (e.g., exercise, education, RTW planning, etc.). Treatment cannot exceed two hours per day.

8. Chiropractors will communicate the worker’s current restrictions and abilities within the first two visits to the:
   a. Worker.
   b. Employer.
   c. WCB, and
   d. Primary care provider (if not the chiropractor).

9. If the worker needs more treatment after the initial six treatments, the chiropractor will send a progress report (CHP) to the WCB. The report must include:
   a. All information about the worker’s physical findings and Functional Outcome Measure scores.
   b. The efforts made by the chiropractor to establish transitional and or full return-to-work, and
   c. Referral to an assessment team if appropriate.

   After submitting the report, the chiropractor can provide up to six more treatments unless the WCB says otherwise.
10. If the worker needs more treatment after the first extension, the chiropractor will send another progress report (CHP) to the WCB. After sending the report, the chiropractor can provide up to six more treatments unless the WCB says otherwise. At this time, and for every progress report (CHP) sent thereafter, the WCB file manager will request the WCB Chiropractic Consultant to review the worker’s progress.

11. If the worker wants more treatment, but has not had treatment for more than 30 days, the WCB will pay for another initial assessment and initial report (CHI). Chiropractors can continue treating (up to six treatments) unless the WCB says otherwise.

12. If the WCB denies a chiropractic claim for coverage (following the initial assessment or request for further treatments), the WCB will pay for services up to the date of notification. The WCB will charge the costs of these claims to the administrative fund.

13. MHCS will contact chiropractors (by phone and in writing) that continually send initial reports (CHI) or progress/discharge reports (CHP) late to the WCB. MHCS will issue a final warning if the late reporting continues. Thereafter, the WCB will not pay for services that chiropractors provide after reports are due.

14. If the worker does not recover after four weeks from the date of injury, the chiropractor may introduce:
   a. Aerobic conditioning
   b. Global conditioning, or
   c. Functional conditioning.

15. Chiropractors will reassess:
   a. New conditions after four to six weeks of treatment, and
   b. Chronic conditions after six to eight weeks of concentrated treatment.

16. Chiropractors will use Functional Outcome Measures to:
   a. Plan treatment programs, and
   b. Alert the WCB when workers need assessment team reviews.

17. Chiropractors will ensure return-to-work planning occurs:
   a. The chiropractor may contact the primary care provider to arrange to manage the return-to-work process.
   b. If the chiropractor is the primary care provider, the chiropractor must either:
      i. Manage the return-to-work process, or
ii. Inform the physical therapist or physician who is co-treating the worker to manage the return-to-work process.

18. The chiropractor will send a discharge report (CHP) to the WCB within seven calendar days of discharge.

**Soft Tissue Injuries**

19. Schedule B stresses the importance of:
   a. An early return-to-work.
   b. Appropriate treatment and exercise therapy, and
   c. Educating workers on their injury and the recovery process.

20. The WCB will only reimburse functional conditioning treatment for clients after they have been unable to return to regular or modified work duties for at least four consecutive weeks. If the worker needs functional conditioning before then, the chiropractor will contact the WCB. The WCB Chiropractic Consultant will review the worker’s progress before making a decision.

21. The Case Manager (CM) will review the worker’s file at seven weeks post-injury to:
   a. Evaluate the risk of prolonged recovery.
   b. Determine if the worker needs an assessment team review.
   c. Ensure vocational (return-to-work) interventions are occurring, and
   d. Ensure that the chiropractor is using the WCB’s standards of care and treatment protocols.

22. The chiropractor will tell the CM if the worker is not improving between nine and 12 weeks post-injury or earlier. The worker may need an assessment team review.

**Assessment/Extension Review**

23. Claims Entitlement Specialists (CES) will review initial reports (CHI) and progress/discharge reports (CHP) that the WCB gets within the first four weeks post-injury. CMs will review reports that the WCB gets after four weeks unless Claims Entitlement retains the file.

24. The WCB Chiropractic Consultant will review files that have two or more progress reports (CHP) if the worker is not discharged or sent for an assessment team review. However, CESs and CMs can request the assistance of the WCB Chiropractic Consultant at any time during the review of claims.

25. If the CES, CM or WCB Chiropractic Consultant finds that the WCB should deny coverage, the file manager will tell the chiropractor.
Evaluations

26. The WCB measures performance and quality of care by using the Primary Care Provider Review Process (Schedule F).

27. MHCS will send letters to chiropractors that do not comply with:
   a. Schedule A (accreditation standards and provider guidelines), or
   b. Schedule B (soft tissue guidelines).

   Letters will outline appropriate corrective actions. Chiropractors that do not comply may lose their WCB accreditation.

28. The WCB will notify the CAS within 30 days if the WCB revokes a chiropractor’s accreditation.

29. The CAS will notify the WCB within seven days if the CAS:
   a. Terminates a chiropractor’s licence
   b. Suspends a chiropractor’s licence, or
   c. Places conditions on a chiropractor’s licence.

Complaints and Dispute Resolution

30. Workers can report complaints of any nature to the WCB. The WCB employee receiving the complaint may refer the complaint for resolution to other WCB staff including the Manager of Health Care Services. If the complaint alleges professional incompetence or misconduct by a care provider, the Manager of Health Care Services will direct the complainant to the CAS.

31. MHCS will note all complaints and resolutions on the service provider’s accreditation file.

32. Workers that want to see a different provider can either contact one directly, or see the primary care provider who made the initial referral.

Fees

33. Schedule B provides increases to chiropractic service fees on:
   a. January 1, 2014, and
   b. June 1, 2015.

   These fees will remain in effect until the WCB and CAS reach a new agreement.

34. Workers will never pay for chiropractic services. Chiropractors will always direct bill the WCB. Chiropractors will adhere to Schedule B and will not extra bill workers.
35. The WCB will stop paying for chiropractic care when the worker is:
   a. Not making any functional gains (unless awaiting further treatment), or
   b. Recovered from the effects of the work-related injury.

ATTACHMENTS

Schedule A – Accreditation Standards and Service Provider Guidelines for Chiropractors Providing Services to Saskatchewan Workers’ Compensation Board Clients

Schedule B – Primary Chiropractic and Physical Therapy Soft Tissue Treatment Guidelines

Schedule C – Service Fees and Fee Codes For Saskatchewan Workers’ Compensation Board Primary Chiropractic Service Providers

Schedule D – Primary Care Provider Review Process

Schedule E - WCB Billing Process – Example Billing Summary - Chiropractors

Schedule F - WCB Billing Process – Example – Adjustments to Previous Billing Summary - Chiropractors

Act Sec # 55, 103(1), 104, 115(c)
Effective Date 01 January 2014
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All claims where workers require chiropractic services.
Supersedes PRO 50/2011 Medical Fees - Chiropractors
Complements n/a
Schedule A
Accreditation Standards and Service Provider Guidelines
For Chiropractors Providing Services To
Saskatchewan Workers’ Compensation Board Clients

1. Intent
This document sets out the:

- Accreditation standards, and
- Service provider guidelines

for chiropractors providing services to WCB clients.

2. Introduction
The Chiropractors’ Association of Saskatchewan (CAS) and the Workers’ Compensation Board (WCB) developed and agreed to this document. The CAS or WCB can dissolve this agreement with appropriate notice.

3. Professional Affiliation Requirements and WCB Accreditation
All chiropractors providing services to WCB clients will be members in good standing of the CAS. Chiropractors will comply with:

- Accreditation Standards and Service Provider Guidelines for Chiropractors Providing Services to Saskatchewan Workers Compensation Board Clients (Schedule A).
- Primary Chiropractic and Physical Therapy Soft Tissue Treatment Guidelines (Schedule B).
- Service Fees and Fee Codes for Saskatchewan Workers’ Compensation Board Primary Chiropractic Service Providers (Schedule C).
- The ethical requirements of the CAS.
- The Chiropractic Act, 1994, and
- CAS Bylaws.

All members of the CAS are accredited by the WCB and will get a billing number from the Ministry of Health.

By providing care to WCB clients, chiropractors intuitively indicate their:
- Understanding of this agreement.
- Willingness to comply with this agreement, and
- Intent to maintain WCB accreditation.
The WCB will revoke a chiropractor’s accreditation and delete their billing number if the chiropractor:

- Does not want to provide services to WCB clients (these chiropractors should tell the WCB immediately).
- Does not comply with Schedule A and or the Primary Chiropractic and Physical Therapy Soft Tissue Treatment Guidelines.

If the WCB revokes a chiropractor’s accreditation, the WCB will give the chiropractor and the CAS notice within 30 days.

CAS members that are not accredited by the WCB (by choice or WCB decision) will redirect WCB clients to accredited providers.

If a chiropractor is non-compliant with these standards and guidelines, or is providing care that is not helpful in returning a WCB client to work, Medical and Health Care Services may:

- Make the chiropractor aware of the issues.
- Identify how those issues will be resolved and measured, and
- Set a timeline for a resolution.

Chiropractors not willing to address issues identified by the Chiropractic Consultant may have their WCB accreditation discontinued on a temporary or permanent basis.

To maintain independence and objectivity, chiropractors must not lobby on behalf of any worker or employer for other WCB benefits (e.g., earnings loss, vocational rehabilitation).

Chiropractors that contravene this agreement may be subject to disciplinary actions initiated by the:

- CAS, or
- WCB.

Disciplinary actions related to maintaining a CAS member’s WCB accreditation for:

- Abnormal billing, or
- Quality assurance reviews

will be at the discretion of the WCB.

If the CAS terminates or suspends a member’s licence, or if a member’s licence becomes conditional due to professional misconduct or incompetence, the CAS must tell the WCB within seven days.
4. **Practice Standards**

**Assessment Guidelines**

Chiropractic assessments of injured workers should include:

- Thorough reviews of case history.
- Reviews of past medical history specific to the area of injury.
- Physical examinations.
- Diagnoses.
- Appropriate investigations.
- Detailed management and treatment of the injury.
- Identification of risk factors for chronic disability.

Chiropractors will provide enough time to ensure work-related injuries are efficiently and effectively managed in accordance with the Primary Chiropractic and Physical Therapy Soft Tissue Treatment Guidelines.

**Management Guidelines**

Visit service means all examinations and treatments provided for the injured worker during each calendar day. Unless specifically identified as an additional service with an additional payment in the fee schedule, the WCB will pay for one treatment visit per day.

a. **Initial Visit:**

   The following usually constitutes an initial visit:

   - A detailed client history including documenting past medical history to the area or region of injury.
   - Physical examination.
   - Ordering and recommending appropriate radiological and laboratory tests to confirm diagnosis.
   - Diagnosis.
   - Developing and implementing a management and treatment plan.
   - Prognosis and timeline for treatment.
   - Identifying potential risks for chronic disability.
   - Complete record of the visit, including any reasons for deviation from this standard.

   The WCB encourages the use of Functional Outcome Measures by:
• Including a field for Functional Outcome Measure scores on WCB reporting forms, and
• Paying higher fees for reports that include this information.

b. Subsequent Visit:

A chiropractic visit will include necessary injury management and advice to facilitate a timely recovery and return-to-work. Management, advice and treatment will promote the normal progression of the stages of soft tissue healing. This may include:

- Advising the injured worker on early activity and an active lifestyle.
- Home and work injury management advice.
- Home rehabilitative exercises and activities, and
- A progressive transitional return-to-work plan
during the recovery period.

Four weeks post injury, the chiropractor may add clinic supervised:

- Aerobic conditioning
- Global conditioning, or
- Functional conditioning

if transitional return-to-work is not expected to help the worker progress to full work duties. Treatment will not exceed two hours per day. The WCB will only fund one treatment per visit day. Other interventions after the initial four weeks (e.g., supervised conditioning (code 410), education (code 414), etc.) can be billed appropriately as deemed necessary.

If the worker sustained a soft tissue injury, the chiropractor will adhere to the Primary Chiropractic and Physical Therapy Soft Tissue Treatment Guidelines.

Adjunctive physical procedures include the following and are included in the office visit fee:

- Therapeutic ultrasound.
- Muscle stimulation.
- Interferential current therapy.
- Short wave diathermy.
- Transcutaneous electrical nerve stimulation (TENS).
- Microelectrical neuromuscular stimulation (MENS).
- Exercise and nutritional advice.
- Support procedures (i.e., orthotics).
• First aid advice and emergency procedures.
• Consultation and indicated referral, and
• Complete record of visit.
• Acupuncture, where the Chiropractor meets the minimum requirements of the CAS to administer this procedure.

A treatment consists of the application of one or more of the techniques and procedures listed above. A treatment may be a separate entity or may be included in the consultative process. When a treatment is a separate entity, as in a subsequent visit, it must also include a:

• Review of subjective symptoms.
• Re-evaluation of objective signs, and
• Recording of the client’s assessment and progress.

c. Minimum Requirements for Charts and Record Keeping in Saskatchewan:

Chiropractors will make a record of each visit. The record will include:

• Date.
• Subjective symptoms.
• Objective findings, both positive and negative.
• Areas to be (or not to be) treated or manipulated.
• Recommendations for future care (management plan).
• Missed or cancelled appointments.
• Telephone calls, and
• Copies of all letters, x-ray and diagnostic reports.

d. Identifying the Need for Re-assessment:

Chiropractors will reassess:

• New conditions after four to six weeks of treatment, and
• Chronic conditions after six to eight weeks of concentrated treatment.

The WCB may revise the assessment/treatment and reporting forms protocol during the term of this contract. If this happens, the WCB will notify the CAS.

Chiropractors will ask for a WCB multidisciplinary assessment team review if recovery becomes prolonged.

Facility

The chiropractic treatment centre must abide by the CAS clinical office space standards and have:
• Adequate space.
• Facilities, and
• Equipment
to fulfill the needs required to manage WCB clients.

Continuing Education
All chiropractors must obtain the recommended continuing education hours for licensure by the CAS. Chiropractors will also be encouraged to participate in continuing education programs sponsored by:

• The CAS, and
• The WCB.

Recordkeeping and Reporting
In-Clinic Chart:
Each clinic will keep written records for each client. Written records will include the:

• Date.
• Subjective symptoms.
• Objective findings, both positive and negative.
• Areas to be (or not to be) treated or manipulated.
• Recommendations for future care (management plan).
• Missed or cancelled appointments.
• Telephone calls, and
• Copies of all letters, x-ray and diagnostic reports.

Duty to Report a Work Injury
The Workers’ Compensation Act, 2013 (Section 55) states:
Any health care professional who attends to or is consulted with respect to an injury to a worker shall:

a. furnish the board with any reports with respect to the examination or treatment of the worker that are relevant to the injury for which compensation is claimed;

b. give all reasonable and necessary information, advice and assistance to the worker or the worker’s dependants in making an application for compensation; and

c. furnish any certificates and proofs that the board may require.

Chiropractors will report injuries by sending Chiropractor's Initial Report (CHI) forms to the WCB. Chiropractors will tell WCB clients to report their injuries:
• By telefile (1-800-787-9288)
• Online at www.wcbsask.com, or
• By completing a Workers’ Report of Injury form (this form can be attached to the chiropractor’s reports).

### WCB Reporting Forms

#### a. Chiropractor’s Initial Report (CHI) form:

Chiropractors will send CHI forms to the WCB within three days of the initial assessment. The WCB will pay for the:

- Intake assessment.
- Initial report, and
- Subsequent treatment

to the date of the WCB letter advising of non-coverage to a maximum of six treatments.

Until the WCB advises of non-coverage, other insurers, and/or the worker will not be billed for any treatment or portion of treatment.

#### b. Chiropractor’s Progress/Discharge Report (CHP) form:

Chiropractors will send the CHP forms to the WCB:

- After the first six treatments, and
- Prior to each subsequent block of six subsequent visits.

CHP forms will include:

- Present complaints related to the work injury where a worker has not received treatment from the provider for more than 30 days (the chiropractor should re-submit the above forms to confirm funding).

- Impact of pre-existing and non-compensable factors delaying recovery, including areas of treatment.

- Subjective and objective physical findings (especially positive neurological finding that confirm the chiropractor’s diagnosis).

- Diagnostic reports and findings.

- Management program.

- Duration and timeline for further treatment.

- Transitional work.

- Factors that may delay recovery.

- Functional Outcome Scores.
• Suggestion regarding referral to assessment team (i.e., secondary, tertiary) where appropriate, and
• Comments.

In all cases, the chiropractor will provide full and accurate information regarding the client’s progress towards recovery and the impact of non-compensable factors.

The chiropractor must submit another CHP form if continued care is required after the first six treatments. The chiropractor can continue care, unless otherwise directed by the WCB. The WCB may refuse to fund the additional treatments if the subsequent CHP form is not sent to the WCB.

Chiropractors can report online or fax CHP forms to:

• (306)787-4311, or
• 1-800-844-7773.

c. Discharge Report (CHP) form:

Chiropractors will send discharge summaries within seven days of discharge.

The CAS will support electronic communication initiatives for reporting and invoicing as these are developed. The WCB will allow the CAS adequate consultation, input, and lead time for implementation of changes.

Confidentiality Requirements

All health-related and personal information received during the course of treatment of a WCB client will be treated in a confidential manner, and no information will be revealed to any person or party other than those persons to whom reports are to be made or to such other persons as may, from time to time, be designated by the WCB. Information pertaining to functional ability may be provided to the employer for the purposes of establishing a return-to-work arrangement.

PCP – A Review Process of Chiropractors

The WCB will analyze care provider profiles to identify those chiropractors whose composite index score differs significantly from that of their peers. The WCB will utilize the Primary Care Provider Protocol, where necessary, to provide an outreach service to assist the provider in managing the recovery and return-to-work of future WCB clients (see Primary Care Provider Review Process).

Fees for Service

The Workers’ Compensation Act, 2013 (Section 103) states:

Every worker who is entitled to compensation or who is disabled only on the day of the injury is entitled without charge to:

i. any medical aid that may be necessary as a result of the injury;
ii. any other treatment by a health care professional.
Chiropractors will direct bill the WCB for services unless the WCB provides written notification that funding will not be provided.

If Functional Outcome Measures are not included in the PCP report, the WCB will pay a lesser fee. During the course of this agreement, the WCB and CAS can agree to update:

- The authorization process, and
- Reporting forms.

**Return-to-Work**

The main goal of the WCB is to return workers to appropriate work and health. The WCB believes, and professional literature supports, that many workers benefit from an early return-to-work. A worker may be ready for some other form of work before they are ready for a return-to-work at the pre-injury job. This alternate work is referred to as “transitional work,” and the return to these alternate duties is called "transitional return-to-work." With recent legislation requiring the accommodation of workers with disabilities and injuries, the emphasis on transitional and alternate duties has accelerated. Many workplaces now have personnel who work specifically with workers needing to return-to-work in a gradual fashion. The WCB wishes to utilize these resources to support and encourage the recovery of workers.

Although several care providers may be treating the worker, the chiropractor will ensure that return-to-work planning occurs. If the chiropractor is not the primary care provider, the chiropractor may contact the primary care provider and arrange to manage the return-to-work process.

If the chiropractor is the primary care provider, the chiropractor must either manage the return-to-work process or delegate that responsibility to either a physical therapist or a physician who is co-treating the worker. To assist with the return-to-work process, chiropractors must provide comments on the worker’s functional ability in the initial and progress reports.

Following the initial examination, chiropractors will advise the employer within one or two treatments of the worker’s current restrictions and abilities. Chiropractors will also provide this information to the WCB case manager. This allows the WCB and the primary practitioner time to develop a transitional return-to-work plan. The chiropractor will notify:

- The worker.
- Employer, and
- The WCB

of the worker’s ongoing restrictions and abilities until full return-to-work is achieved.

If the worker is not making appropriate progress toward returning to work, the chiropractor or the WCB care manager will ask the WCB to arrange an assessment team review.
5. **Term of Agreement**

These service provider guidelines and service fees are in effect until May 31, 2016 and will remain in effect until a new agreement is reached.
Schedule B
Primary Chiropractic and Physical Therapy
Soft Tissue Treatment Guidelines

1. Preface

The WCB Health/Medical Services Unit developed these guidelines for soft tissue injuries, with input from biomechanical health care consultants, the Chiropractors’ Association and the SPA.

These guidelines have been developed to address typical soft tissue injuries; however, the time frames identified here do not apply to post-surgical injuries or fractures. In some instances, more intensive treatment will be required at a primary level.

When enhanced services are required, the WCB physical therapy and chiropractic consultants should be contacted to help decide if enhanced services should occur at the primary level or if an assessment team review is required.

2. Definitions

**Soft Tissue**

Soft tissue includes muscle, tendons, fascia and ligaments.

**Soft Tissue Injury**

Soft tissue injury is an injury to one or more soft tissue structures including muscle, tendons, fascia and ligaments that connect the skeletal structure.

Soft tissue injuries generally include strains, sprains and contusions. Soft tissues also can be injured as a result of:

i. Direct trauma;
ii. Over-use;
iii. Over stretching;
iv. Whiplash-type injuries (i.e., caused by a motor vehicle accident).

Soft tissue injuries do not include:

i. Direct or indirect trauma to bones (i.e., fractures);
ii. Nerves (i.e., carpal tunnel syndrome or neuropraxia);
iii. Vascular (i.e., complex regional pain syndrome);
iv. Post-surgical soft tissue recovery.

3. Basic Soft Tissue Injury Treatment Program

a. Zero to Four Weeks Post-Injury

i. Interventions
After conducting an initial assessment of the injured worker, chiropractors and physical therapists may provide a maximum of 10 interventions within the first four weeks that could include:

(a) Biomechanical treatment (Code 400 and 401 DC or Code 2000 and subsequent 2001);

(b) Regional conditioning instruction (Code 410 – Individual Conditioning Instruction DC) and (Code 2008 – Individual Regional/Global Conditioning PT).

In most cases, it is recommended that regional conditioning should be done at home during this period. If, as a health care practitioner, you feel an injured worker requires in-clinic regional conditioning, you should deliver the intervention using one-on-one individualized exercise instruction for a typical intervention period (i.e., 20 minutes).

At least one “one-on-one” educational session with the injured worker, lasting at least 20 minutes (Code 414 DC-Education and Code 2011 PT – Education).

During an educational session, you should explain:

(c) The stages of tissue healing;

(d) Self-management including self-directed reactivation strategies;

(e) The recovery process and return-to-work (return-to-work during the early stages of recovery is safe when clinically appropriate);

(f) Pain management, where indicated.

Current literature supports maintenance of normal activity such as walking, swimming, and suitable employment for injured workers.

At your discretion, you may use multiple interventions in a day; however, each intervention will be counted as part of the 10 interventions allotted during this stage of tissue healing.

When an injured worker enters primary treatment later than the first week post-injury, the number of interventions should be prorated to the four-week mark. For example, where treatment commences at three weeks post-injury, five interventions can be provided.

*NOTE: An intervention is defined as a biomechanical treatment or one of the prorated interventions identified on the WCB fee schedule.

ii. Return-to-Work

Chiropractors and physical therapists should make at least one return-to-work planning contact with the employer (Code 407 DC RTW Plan and Development and Code 2002 RTW Planning and Monitoring).
The contact should be a telephone conversation; a letter mailed to the employer will not fulfill this requirement.

When an employer can accommodate the injured worker’s current functional abilities and restrictions, return-to-work planning and reporting should proceed, with the agreement of the primary care provider (if not you). The return-to-work schedules should be communicated to all parties using WCB’s Practitioner Return-to-Work form.

Return-to-work planning sessions with an injured worker are not counted as part of the 10 interventions during this treatment period.

iii. Billing

During the first four weeks post-injury, the WCB will not fund group supervised, global and functional conditioning and functional testing.

The WCB will fund, but does not count the following items as interventions:
(a) Initial assessment;
(b) Return-to-work planning;
(c) Telephone calls or consultations (Code 405C and Code 2015).

b. Five to Eight Weeks Post-Injury

i. Interventions

Chiropractors and physical therapists may provide a maximum of 23 interventions between five and eight weeks that could include:
(a) Biomechanical treatment (Code 401 DC and Code 2001 PT);
(b) Regional conditioning instruction (Code 410 – Individual Conditioning Instruction DC and Code 2008 – Individual Regional/Global Conditioning PT);
(c) Patient education session (Code 414 DC and Code 2011 PT);
(d) Global conditioning (Code 411 DC and Code 2007 PT). See below for situations that warrant global conditioning;
(e) Functional conditioning (Code 408 DC and Code 2004 PT) See below for situations that warrant functional conditioning;

ii. Global and Functional Conditioning

Functional and global conditioning sessions are used only in situations where the client is not progressing in treatment or on a return-to-work plan where conditioning allows for tolerance development that cannot be safely introduced in the workplace.
Before you begin functional conditioning, you need to conduct a functional assessment (Code 415 DC and Code 2012 PT). Only one functional test is allowed during this period.

However, you may not need to conduct functional testing if your return-to-work discussions with the injured worker indicate he/she feels capable of performing his/her critical job demands. Return-to-work capacities can be determined from daily functional conditioning records and observations and does not always require an additional assessment.

iii. File Review

Following WCB guidelines, WCB Case Management staff will review the injured worker’s file at seven weeks post-injury to evaluate the risk of prolonged recovery and determine if an assessment team review is needed.

This review may involve the WCB asking you as the injured worker’s practitioner or therapist regarding:
(a) The injured worker’s timeframe for recovery;
(b) The injured worker’s timeframe for return-to-work, if a return-to-work plan has not been communicated to the WCB, employer, injured worker and primary care provider (if other than yourself). As a practitioner or therapist, you should be prepared to discuss progress in recovery and return-to-work to help the WCB determine if either:
♦ reasonable progression is occurring; or
♦ you feel a multidisciplinary assessment is required.

The WCB may ask the injured worker be sent to an assessment team review at this time if:
(c) Progress is not being attained;
(d) There are yellow or red flags present with little progress in recovery;
(e) A return-to-work plan is not in progress.

NOTE: Return-to-work planning/telephone calls would not be counted as part of the interventions delivered during this treatment period.

c. Nine to 12 Weeks Post-Injury
   i. Interventions

Chiropractors and physical therapists can continue with a maximum of 16 interventions during this period as long as the worker is involved with a return-to-work program that is progressing.

Return-to-work planning/telephone calls would not be counted as part of the interventions delivered during this treatment period.
Where the injured worker is participating in a return-to-work plan and non-endurance progressions are required, you can use functional conditioning if the injured worker’s material handling tasks are greater than what has been measured during the rehabilitation program. For example, you can use functional conditioning if the injured worker requires lifting to heavy industrial, as per the Dictionary of Occupational Titles, and the worker is presenting with substantially reduced lifting levels.

ii. Assessment Team Review

If, as the practitioner/therapist, you do not see any objective improvement, you should request an assessment team review.

In situations where no functional improvement has occurred and or the injured worker is not in the workplace and awaiting assessment team review, the recommended treatment frequency is one to two times a week with biomechanical and regional conditioning.

NOTE: Usually WCB’s Case Management staff and a Chiropractic or Physical Therapy Consultant will have reviewed the injured worker’s file before nine weeks as part of their efforts to identify injured workers who would benefit from assessment team review. As part of this review, team members will ensure vocational (return-to-work) interventions have been occurring and that WCB’s standards of care and treatment protocols have been implemented.

4. Enhanced Soft Tissue Injury Program

If, as a chiropractor or physical therapist, you feel that the injured worker’s condition warrants more than the maximum number of interventions in any of the time frames discussed in this document, please phone the Chiropractic/Physical Therapy Consultant at the WCB offices.

During the call, you and the consultant will discuss your client’s needs, clinical findings, and your evidence-based rationale to request an enhanced treatment program. The goal of this discussion ensures that:

(a) Injured workers receive the right treatment at the right time;
(b) Injured workers at risk of prolonged recovery are routed to an assessment team review promptly to reduce the risks of chronic disability.

5. Soft Tissue Injury Care Model
6. Literature Review and Resource List

   The literature review was undertaken in an effort to answer the following questions:

   a. Does the literature support the theory/hypothesis that typical soft tissue injuries resolve within six to eight weeks without intervention or with minimal intervention?

   b. Does it support treatment during this time frame?

   c. Does it not support treatment during this time frame?

   d. Is there evidence that supports a style of treatment during this time frame?

   e. Key search terms used during this literature review:

      i. Ligament injury;
      ii. Soft tissue;
      iii. Soft tissue rehabilitation;
      iv. Insurance rehabilitation;
      v. WCB;
      vi. Workers;
      vii. Work hardening;
      viii. Functional restoration;
      ix. WCB Rehabilitation;
      x. Rehabilitation soft tissue injury;
      xi. Treatment guidelines WCB;
      xii. Treatment guidelines soft tissue;
      xiii. Treatment guidelines soft tissue injuries;
      xiv. Soft tissue injuries evidence based guidelines;
      xv. Evidence based treatment soft tissue injuries;
xvi. Excessive treatment soft tissue injuries;
xvii. Cost effective treatment WCB soft tissue injuries;
xviii. Cost effective treatment soft tissue injuries;
xix. Cost effective treatment work injuries;
x. Soft tissue work injury management;
xx. Soft tissue rehabilitation best practice;
xxi. Physiotherapy intervention work injury;
xxii. Physiotherapy intervention soft tissue injury;
xxiii. Physiotherapy best practice work injury.

f. The literature review found 42 articles. The resource list that was used as a reference appears below. Articles were excluded if they did not meet the time frames of treatment identified in the soft tissue injury care model.

Resource List


Stenstra, Ivan; Anema, Johannes; van Tulder, Maurits; Bongers, Paulien; de Vet, Henrica; van Mechelen, Willem. 2006. Economic Evaluation of a Multi-Stage Return to work Program for Workers on Sick-Leave Due to Low Back Pain. *Journal of Occupational Rehabilitation*. 16(4):557-78.


Schedule C
Service Fee and Fee Codes
For Saskatchewan Workers’ Compensation Board Primary Chiropractic Service Providers

An intervention is an appropriate WCB coded service provided to the injured worker by the treating practitioner during the acute, sub-acute or chronic phase of the injury. This intervention or service can include the following:

- Initial visit.
- Subsequent visit (biomechanical treatment, movement patterns, myofascial therapy, electrotherapy, advice and reassurance).
- Initial conditioning assessment.
- Individual conditioning instruction.
- Group supervised exercise therapy.
- Functional conditioning.

Interventions are limited to the phases of soft tissue healing (acute, sub-acute and chronic)

Following are the fees payable by the WCB. These fees are payable where the negative response process utilizing the initial report (CHI) and progress/discharge report (CHP) has been followed as per Schedule A.

Where a flat rate fee is indicated, the fee is intended to represent the average time required to treat a WCB client. Where a prorated fee is indicated, the provider will bill to the next higher quarter (1/4) hour. To prepare for electronic invoicing, chiropractors are asked to bill these prorated fees using “units of care” rather than number of treatments or visits. A unit of care = the unit by which the fee is listed below (e.g., a 15 minute fee code (1/4 hour) = 0.25 unit -- Fee Code 407; $74.26/hr/0.25 = $18.57).

The WCB retains the right to audit the records and invoices of care providers who have provided services to a WCB client.

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<tr>
<th>Service</th>
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<th>June 1, 2015</th>
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<tr>
<td>Subsequent Visit</td>
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<td>$37.13</td>
<td>$38.24</td>
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<tr>
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<td>$64.79</td>
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<td>$61.75</td>
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<tr>
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<td>$50.82</td>
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<td>$37.23</td>
<td>$38.35</td>
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<tr>
<td>Service</td>
<td>Fee Code</td>
<td>January 1, 2014</td>
<td>June 1, 2015</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------</td>
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<td>$28.30</td>
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<tr>
<td>Research Fee</td>
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<td>$31.61/10 min</td>
<td>$32.56/10 min</td>
</tr>
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<tr>
<td>Functional Conditioning **</td>
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<td>$76.49/hr</td>
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<td>Group Supervised Exercise Therapy</td>
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<td>$81.96/hr</td>
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<td>Job Site Evaluation</td>
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<td>$79.57/hr</td>
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<td>WCB RHCS4 form</td>
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<td>WCB RHCS4 form :Returned within 5 days of WCB request date</td>
<td>426</td>
<td>$26.52</td>
<td>$27.31</td>
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</table>

Note:
* Includes initial assessment plus first treatment.
** Partial units of time should be rounded up to the next ¼ hour.
X-rays will be billable using MSP (Medical Service Plan) fee codes and fees.
Only 1 Chiropractic subsequent visit service per day will be funded by WCB.
Subsequent visits are inclusive of modalities.

Contact numbers:
Medical Accounts Inquiry Line at (306)787-4412 for all billing inquiries.
Manager of Health Care Services, at (306)787-7760 for inquiries concerning:
- Fee and/or service agreement
- Procedure
Schedule D

Primary Care Provider Review Process

**The Primary Care Provider Review Process will be reviewed during the term of this agreement. This version will remain in force until a revised process has been developed by the parties and the revised edition posted on the WCB website.**

1. Step One:
   Annually, the WCB will produce a four-part composite index (CI) score for each care provider or clinic, identifying those providers whose CI score does not meet the predetermined benchmark. WCB has established a benchmark specific to each profession with the benchmark and CI scores based on Workers with soft tissue injury diagnoses.

2. Step Two:
   Where a care provider or clinic has not achieved the required benchmark, the WCB Chiropractic Consultant will review files used to generate the CI score for that clinic or provider. The attached **PRIMARY CARE PROVIDER FILE REVIEW TOOL** will be used to generate an acceptable or not acceptable score.

3. Step Three:
   Where the care provider or clinic receives a Not Acceptable score, the WCB Chiropractic Consultant will contact the care provider to discuss the results of the review.

   Components of the review will include:
   a. Purpose and components of the composite index
   b. The score achieved by the care provider in question
   c. Recommendations geared to helping the care provider improve their CI score
      - Frequency of treatment
      - Communication with Case Manager
      - Appropriate referral secondary or tertiary assessment
      - Appropriate referral to other health care providers

4. Step Four:
   After allowing the care provider or clinic six months to improve their CI score, the WCB Chiropractic Consultant will review files of their recently treated WCB clients, contacting the care provider to acknowledge improvements and further discuss practice patterns that are not conducive to high quality care or safe appropriate return to work. The WCB Chiropractic Consultant will again go over specific improvements to case management and treatment that the care provider should initiate in their practice to improve CI score.
5. **Step Five:**

At the one-year mark, WCB will be producing the next CI report. Where a care provider under review again fails to achieve the required benchmark, WCB has the option of escalating the review process to a Peer Review Committee or review committee. The committee would be composed of the following:

- A WCB representative
- WCB Chiropractic Consultant
- 2 Peers - WCB will advertise or approach members of the Chiropractors’ Association of Saskatchewan for members who would be interested in sitting as Peer Review Members. A list of five members will be chosen by WCB to form a pool. Where less than five members agree to form the pool, a smaller pool may be used. The care provider under review will then select 2 members from this pool to form a Peer Review Committee. Where two members of the CAS are not available to sit on a Peer Review Committee, WCB may appoint a review committee using WCB staff rather than Chiropractors.
- Those members of the Chiropractors’ Association of Saskatchewan sitting on the Peer Review Committee will be paid by WCB.

The Peer Review Committee or review committee will review the care providers practise utilizing WCB files, clinic files, the composite index, the file review tool, if appropriate, and may interview the care provider, with a view to recommending appropriate action to the WCB.

6. **Step Six:**

At the request and recommendation of committee members, WCB will be the determiner of final actions, which may include:

- Mandated continuing medical education
- Ongoing review and education with WCB Consultant
- Suspension of billing privileges with possible re-instatement
- Ongoing reviews at the discretion of the WCB
- One or more of the above
Performance Measures

1. Purpose:
   The primary objective of this memo is to outline the recommended performance measures that are to act as components in a composite index that can be used to provide relevant and accurate statistical data for the review of primary care providers. This composite index will be used to identify outliers that will require a further more detailed qualitative review.

2. Methodology:
   There is substantial incentive to adopt a method of evaluation that is similar to the one developed for assessing secondary and tertiary care providers. As this is a well-researched methodology that has been thoroughly tested and already implemented, we can avoid “re-inventing the wheel” and the large costs associated with that kind of redundant endeavour.

   Through a careful analysis of sample sizes, it is recommended that this quantitative analysis be conducted on a yearly basis. This presupposes a sample size of approximately 15 for physicians, chiropractors and physiotherapists. For individuals that have been previously identified as outliers, it is possible to summarize data on a quarterly or semi-annual basis, but this should not be the only criterion for any kind of punitive measure. A qualitative review will always be necessary to provide a final assessment.

   The secondary and tertiary provider analysis incorporated the use of 4 key measures with their weighting in brackets: success (40%), program costs (30%), treatment duration (15%) and graduated return to work duration (15%).

   Success (40%) - % of claims closed (based on WCB status codes) within a determined appropriate time period.

   Costs (30%) – Total medical costs attributable to the primary care provider.

   Duration (15%) (calendar days) – Total number of compensation days paid out on the claim.

   Time Loss Rate (15%) – the % of claims that are time loss among all accepted claims for the primary care provider.

3. Allocation of Scores in the Composite Index:
   In order to determine the standards/benchmarks for assigning scores for each measure, WCB will consider data from claims with an injury date between January 1st, 2000 and December 31st, 2002. Although the numeric value for the scores of each caregiver type may vary considerably (as they will be constructed only from data obtained on that specific type), the methodology used to determine that value are the same for each. A rigorous explanation of each measure is as follows:
Success – The success score will merely be the % of claims closed over a specified time period divided by the total number of claims multiplied by 40. Examining historical closure rates and establishing a benchmark equal to the 85th percentile of the length of time (in calendar days) to closure will determine the “specified time period”. Although the selection of the 85th percentile is somewhat arbitrary it will insure success rates that are consistent with those used in the secondary/tertiary review.

Time Loss Rate – Merely multiply 1 - the % of time loss claims over all claims by 15.

For the remaining two measures, we will use the following methodology based on a comparison of distance from the mean score:

Notation:

\[ M = \text{the mean or average} \]

\[ \text{s.d.} = \text{the standard deviation} \]

<table>
<thead>
<tr>
<th>Costs</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; M – 3 * s.d.</td>
<td>30</td>
</tr>
<tr>
<td>M – 3<em>s.d. to M – 2</em>s.d.</td>
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</tr>
<tr>
<td>M – 2<em>s.d. to M – 1</em>s.d.</td>
<td>20</td>
</tr>
<tr>
<td>M – 1<em>s.d. to M + 1</em>s.d.</td>
<td>15</td>
</tr>
<tr>
<td>M + 1<em>s.d. to M + 2</em>s.d.</td>
<td>10</td>
</tr>
<tr>
<td>M + 2<em>s.d. to M + 3</em>s.d.</td>
<td>5</td>
</tr>
<tr>
<td>&gt; M + 3*s.d.</td>
<td>0</td>
</tr>
</tbody>
</table>

* For each caregiver type, there will be different value ranges for the assignment of each of these measures, but the formula for calculating the values is the same.

Assuming that the 4 measures identified are used, the average score per primary care provider will be approximately 64 (34 for success, 15 for costs, 7.5 for duration, 7.5 for TL). Individuals of potential concern will have a score less than 50, while definite outliers will have scores less than approximately equal to 40 or less. Note: this varies from the secondary and tertiary passing grade of 65, which represents the 25th percentile. Preliminary analysis suggests that using this methodology will yield approximately 5-8% of care providers less than 50 and approximately 1% less than 40, i.e., it is designed to identify extreme outliers.
PRIMARY CARE PROVIDER FILE REVIEW TOOL

Name of Care Provider:
Date of Review:

FILE SUMMARY:
Name:
Claim Number:
Date of Injury:
Area of Injury:
Synopsis of Case:
Outcome:

Reporting:

<table>
<thead>
<tr>
<th>Check Y or N for each item below</th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please comment on all (N) responses</td>
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</tr>
</tbody>
</table>

**Initial Report (PPI)**
1. History reasonably documented
2. Physical findings reasonably documented
3. Diagnosis documented
4. Management plan (problem analysis and follow-through)
5. Timelines clear
6. Return to Work
7. Timely filing of PPI (within 5 working days)

**Progress Reports (PPP)**
1. PPP’s on file
2. PPP’s filed on a regular basis at 3 week intervals
3. Adequate progress notes
4. Objective findings documented
5. Management plan consistent with initial assessment (PPI)
6. Management plan was appropriate for the condition
7. Interventions were appropriate

**Occupation**
1. Indication of type of occupation
2. Job tasks listed on file

**Diagnostics & Consultations**
1. Appropriate and timely consultations
2. Referral for diagnostics
### Check Y or N for each item below

<table>
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<tr>
<th>Please comment on all (N) responses</th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Each diagnostic investigation was logical and contributory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Appropriate and timely reporting of the results of investigations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Referral for concurrent treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of provider:</td>
<td></td>
<td></td>
<td>Date of Referral:</td>
</tr>
</tbody>
</table>

### Multidisciplinary Assessment (EIP)

| 1. Referral to Assessment Team                                          |   |   |          |
| 2. Appropriate and timely referral to Assessment Team                  |   |   |          |
| 3. Implementation of Assessment Team recommendations                   |   |   |          |

### Overall File Review

| 1. Legible                                                             |   |   |          |
| 2. Timely reporting and communications                                |   |   |          |
| 3. An active approach to recovery encouraged with the Worker          |   |   |          |

Were there any unusual or extenuating circumstances (i.e. type of injury, psychosocial issues, or other complicating factors) that appeared to affect the management of this file? If so, please describe:

( ) In the opinion of this reviewer, this file was managed in an acceptable manner.

### Strengths:

( ) In the opinion of this reviewer, file management of this case was not acceptable.

### Significant concerns:

______________________________

Reviewer Name (please print)                  Reviewer Signature and Date
Schedule E
WCB Billing Process
Example – Billing Summary
Chiropractors

TREATMENT BILLING SUMMARY
FOR
MONTHLY/BI-MONTHLY BILLINGS

<table>
<thead>
<tr>
<th>Profession</th>
<th>Chiropractor</th>
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</thead>
<tbody>
<tr>
<td>Worker's Last Name, First Name &amp; Initial</td>
<td>Sally Smith</td>
</tr>
<tr>
<td>Clinic Name, Address &amp; Postal Code</td>
<td>ABC Clinic 999 – 1st St. Saskatoon, SK S4X 7S9</td>
</tr>
<tr>
<td>Address</td>
<td>111 Albert St. Saskatoon, SK</td>
</tr>
<tr>
<td>Clinic Billing #</td>
<td>CHI012345</td>
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<tr>
<td>Billing period</td>
<td>Billing period is June 1 to June 30, 2015.</td>
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<tr>
<td>Service provided</td>
<td>Service provided was an initial visit and three subsequent treatments.</td>
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<table>
<thead>
<tr>
<th>Treatment Date</th>
<th>Fee Descriptor</th>
<th>Fee Code</th>
<th>Number of Units</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 1, 2015</td>
<td>Initial Visit</td>
<td>400</td>
<td>1</td>
<td>$63.65</td>
</tr>
<tr>
<td>June 6, 2015</td>
<td>Subsequent Visit</td>
<td>401</td>
<td>3</td>
<td>$114.72</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$178.37</strong></td>
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</tbody>
</table>
TREATMENT BILLING SUMMARY
FOR MONTHLY/BI-MONTHLY BILLINGS

Profession
Chiropractor

Clinic Name, Address & Postal Code
ABC Clinic
999 – 1st St.
Saskatoon, SK  S4X 7S9

Clinic Billing # CHI012345

Provider's Name, Address & Postal Code
ABC Clinic
999 – 1st St.
Saskatoon, SK  S4X 7S9

Provider’s Professional Designation
Chiropractor

Worker’s Last Name, First Name & Initial (Please Print)
Sally Smith

Address
111 Albert St.
Saskatoon, SK

Postal Code
S7K 9C4

Patient’s Phone #
555-1234

WCB Claim #
1234-5678

Date of Birth (dd/mm/yy)
28/01/86

Personal Health #
123456789

Date of Injury (dd/mm/yy)
01/01/10

Area of Injury
shoulder

Employer Name
X Company

Employer Address
123 Hoffer Place, Saskatoon, SK  S7K 2X1

<table>
<thead>
<tr>
<th>Treatment Date</th>
<th>Fee Descriptor</th>
<th>Fee Code</th>
<th>Number of Units</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 6, 2015</td>
<td>Subsequent Visit</td>
<td>401</td>
<td>(3)</td>
<td>($114.72)</td>
</tr>
<tr>
<td>June 6, 2015</td>
<td>Subsequent Visit</td>
<td>401</td>
<td>2</td>
<td>$76.48</td>
</tr>
</tbody>
</table>

Total of all services for billing period $76.48

In billing period June 1 to June 30, 2015 three subsequent visits were billed in error. Only two subsequent visits were provided.
7.2.8 Medical Fees – Podiatry (PRO 55/2011)

Document Date 18 August 2011

Purpose To establish billing requirements for podiatry services provided to Workers’ Compensation Board (WCB) clients

DEFINITION

Podiatry, also referred to as chiropody, means the health science pertaining to the medical care of the human foot as performed by a podiatrist.

Podiatrist, also referred to as chiropodist, means a member of the Saskatchewan College of Podiatrists who has received the education recognized by the council of the Saskatchewan College of Podiatrists, to engage in the practice of podiatry.

BACKGROUND

1. Section 103(1) of The Workers’ Compensation Act, 2013 (the “Act”) states “every worker who is entitled to compensation or who is disabled only on the day of the injury is entitled without charge to:
   a. any medical aid that may be necessary as a result of the injury;
   b. any other treatment by a health care professional;
   c. any prosthetics or apparatus that may be necessary as a result of the injury, and to have any prosthetic limbs and eyes and any surgical appliances such as belts, braces, supports and orthopaedic shoes repaired, maintained and renewed when necessary by reason of accident or ordinary wear and tear; and
   d. any transportation or sustenance occasioned by the medical aid.”

2. Section 104(1) of the Act states “the fees for medical aid furnished by any health care professional are those that are determined by the board.”

3. Section 115(c) of the Act states that the board may expend moneys from the fund for any expenses incurred in the administration of this Act and, without restricting the generality of the foregoing, the board may expend moneys for “any medical aid provided pursuant to this Act to injured workers and any specialized treatment or other medical aid that the board considers necessary and that is not provided for in this Act.”

4. The Saskatchewan College of Podiatrists sets the standards of practice and conduct for podiatry. The Saskatchewan College of Podiatrists is responsible for regulating the practice of the profession of podiatry and governing its members in accordance with The Podiatry Act, 2003.
5. Section 21(1) of *The Podiatry Act, 2003* states “subject to subsection (2), no person other than a member shall use the title “Podiatrist” or “Chiropodist” or any word, title or designation, abbreviated or otherwise, to imply that that person is a member” of the Saskatchewan College of Podiatrists. Therefore, all podiatrists who work in Saskatchewan are required to be licenced by the Saskatchewan College of Podiatrists, and are responsible for meeting Saskatchewan College of Podiatrists’ standards.

6. Each year the Saskatchewan College of Podiatrists issues a suggested fee schedule to its members. Medical and Health Care Services will request copies of updated fee schedules on behalf of the WCB.

**PROCEDURE**

**General**

1. Podiatrists will direct bill the WCB for all services provided to WCB clients and will charge according to the Saskatchewan College of Podiatrists Fee Schedule. Payment for all podiatry services will comply with this fee schedule. Where the podiatrist direct bills the WCB for reporting fees, the amount invoiced will be in accordance with PRO 55/2015, Medical Fees – Physicians.

2. All podiatry services, except emergency treatment, must be pre-authorized by the WCB.

**Non-Emergency Treatment**

3. Podiatrists will submit a report to the WCB indicating the type of service required, and a cost estimate based on the fee schedule.

4. Operations staff will review the report to ensure that the recommended service is related to the work injury, and the estimated costs are in accordance with the fee schedule. Assistance may be obtained from Medical and Health Care Services.

5. Where the recommended service is not noted in the fee schedule, Medical and Health Care Services may provide advice regarding a reasonable fee that should be paid.

6. Following this review, Operations staff will authorize the podiatrist, in writing, to proceed with the service. The authorization will request the podiatrist to direct bill the WCB for the service and amount authorized. A copy of the authorization will be sent to the client.

7. Operations staff will provide a detailed explanation, in writing, in all instances where the amount authorized is less than the cost estimate provided by the podiatrist.
Emergency Treatment

8. Where the client obtains emergency treatment, the podiatrist will submit a report to the WCB indicating the type and cost of the service provided. Following review of the report by Operations staff, and by Medical and Health Care Services where required, the WCB will process payment (if authorized) to the podiatrist.

9. Where the client paid the fees for the emergency treatment, the client should submit to the WCB the original receipts and the form completed by the podiatrist detailing the treatment provided. Where the fee is in excess of that determined by the WCB, the WCB will contact the podiatrist and request a refund for the client. Where a refund is not provided, the WCB will reimburse the client and the extra billing will be recovered from WCB payments to the podiatrist.

Act Sec # 103(1), 104(1), 115(c); The Podiatry Act, 2003
Effective Date 01 October 2011
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All clients requiring podiatry services on and after the effective date
Supersedes PRO 19/94 Medical Fees – Chiropody
Complements PRO 55/2015 Medical Fees – Physicians
POL 17/2008 Expenses, Orthotics/Appliances – Provision, Replacement and Repair
7.2.11 Medical Fees – Occupational Therapy (PRO 50/2014)

Document Date 11 February 2014

Purpose To establish fees and guidelines for occupational therapists (OT) treating workers.

BACKGROUND

1. Upon WCB approval, a worker entitled to benefits under *The Workers’ Compensation Act, 2013* (the “Act”) is also entitled to (Section 103):
   a. Any medical aid that may be necessary because of the work-related injury.
   b. Any other treatment by a health care provider.
   c. Any orthotic appliance or apparatus that may be necessary as a result of the injury, and
   d. Any travel and sustenance costs associated with receiving medical treatment as a result of the injury.

2. The WCB is authorized to determine health care services fees (Section 104(1)).

3. The WCB can spend money for any specialized treatment or medical aid that it considers necessary (Section 115).

PROCEDURE

General

1. To provide services to injured workers, OTs must be:
   a. Accredited by the WCB, and
   b. Fully licenced members in good standing of the Saskatchewan Society of Occupational Therapists (SSOT).

2. OTs must comply with:
   a. Accreditation Standards and Service Provider Guidelines for Saskatchewan Workers’ Compensation Board Primary Occupational Therapy Service Providers (Schedule A).
   b. Service Fees and Fee Codes for Saskatchewan Workers’ Compensation Board Primary Occupational Therapy Service Providers (Schedule B).
   c. The practice standards and ethical requirements of the SSOT, and
Service Guidelines

3. Schedule A provides the accreditation standards and service provider guidelines for OTs treating workers.

4. If a worker needs occupational therapy, the Vocational Rehabilitation Specialist or attending care giver will tell Medical and Health Care Services (MHCS) to arrange care.

5. Before treating a worker, the OT must send a Primary Level Authorization to Treat – Occupational Therapy form to the WCB. OTs can only begin treatment once they hear from the WCB. The WCB will not pay for treatment that begins before approval. However, if the OT feels that the referral is urgent (i.e., fresh post-operative hand therapy client), the OT can begin treatment before hearing from the WCB.

6. The OT will send an initial report (TXI) to the WCB within three business days of the initial assessment.

7. OTs can see workers for up to 10 visits (after they send the TXI form) unless the WCB says otherwise.

8. Treatment cannot exceed two hours per day.

9. Within the first week of treatment, the OT will contact the employer to see if they can accommodate the worker’s return-to-work. If accommodated work is available, the OT will develop a return-to-work plan with the help of the:
   a. Worker.
   b. Employer.
   c. Primary care provider, and
   d. WCB.

   Before the plan starts, the OT will send a Practitioner’s Return-to-Work Report (PRTW) to the WCB.

10. If the worker needs more treatment after the initial 10 visits, the OT will send a progress report (TXP) to the WCB. If the WCB approves, the OT can see the worker for up to 10 more visits.

11. If the worker needs more treatment after the first extension, the OT will send another progress report (TXP) to the WCB. If the WCB approves, the OT can see the worker for up to 10 more visits. At this time, and for every progress report (TXP) sent thereafter, the WCB file manager will request the WCB Physical Therapy Consultant to review the worker’s progress.
12. If the worker wants more treatment, but has not had treatment for more than 30 days, the OT must send another Primary Level Authorization to Treat – Occupational Therapy form. OTs can only resume treatment once they hear from the WCB. The WCB will not pay for treatment that begins before approval.

13. If the WCB denies an occupational therapy claim for coverage (following the initial assessment or request for further treatments), the WCB will pay for services up to the date of notification. The WCB will charge the costs of these claims to the administrative fund.

14. MHCS will contact OTs (by phone and in writing) that continually send initial reports (TXI), progress reports (TXP) or discharge reports (TXD) late to the WCB. MHCS will issue a final warning if the late reporting continues. Thereafter, the WCB will not pay for services that OTs provide after reports are due.

15. If the worker needs more comprehensive care, the OT will tell the WCB that an assessment team review is required (e.g., the worker’s recovery is not progressing, psychological or pain management services are required). The assessment team will determine if secondary or tertiary treatment is more appropriate. If the worker will benefit from further treatment, the OT can continue treatment while waiting for the assessment team review.

16. OTs will list all options and solutions if the WCB asks them to evaluate the worker’s needs for equipment in their:
   a. Home
   b. Vehicle, or
   c. Workplace.

   If possible, OTs will provide estimates from three suppliers.

17. The OT will send a discharge report (TXD) to the WCB within three business days of discharge.

Assessment/Extension Review

18. Claims Entitlement Specialists (CES) will review Primary Level Authorization to Treat – Occupational Therapy forms, initial reports (TXI), progress reports (TXP) and discharge reports (TXD) that the WCB gets within the first four weeks post-injury. Case Managers (CM) or the WCB Physical Therapy Consultant will review reports that the WCB gets after four weeks unless Claims Entitlement retains the file.

19. The WCB Physical Therapy Consultant will review files that have two or more progress reports (TXP) if the worker is not discharged or sent for an assessment team review. However, CESs and CMs can request the assistance of the WCB Physical Therapy Consultant at any time during the review of claims.
20. If the CES, CM or WCB Physical Therapy Consultant finds that the WCB should deny coverage, the file manager will tell the OT.

Evaluations

21. MHCS will send letters to OTs that do not comply with Schedule A. Letters will outline appropriate corrective actions. OTs that do not comply may lose their WCB accreditation.

Complaints and Dispute Resolution

22. Workers can report complaints of any nature to the WCB. The WCB employee receiving the complaint may refer the complaint for resolution to other WCB staff including the Manager of Health Care Services. If the complaint alleges professional incompetence or misconduct by a care provider, the Manager of Health Care Services will direct the complainant to the SSOT.

23. MHCS will note all complaints and resolutions on the service provider’s accreditation file.

24. Workers that want to see a different provider can either contact one directly, or see the primary care provider who made the initial referral.

Fees

25. Schedule B provides increases to occupational therapy service fees on:
   b. April 1, 2014, and
   c. April 1, 2015.
   These fees will remain in effect until the WCB and SSOT reach a new agreement.

26. Workers will never pay for occupational therapy services. OTs will always direct bill the WCB. OTs will adhere to Schedule B and will not extra bill workers.

27. OTs do not need WCB approval to purchase therapy equipment and supplies if:
   a. Waiting for approval will delay the worker’s recovery, and
   b. They cost less than $250.

28. Hourly fees are equal to one unit of care. OTs will bill by 15 minute blocks or 0.25 units. OTs will round fees up to the next 15 minute block or 0.25 unit.

29. The WCB will stop paying for occupational therapy when the worker is:
   a. Not making any functional gains (unless awaiting further treatment).
b. Recovered from the effects of the work injury.

c. Moving into a secondary or tertiary treatment program.

ATTACHMENTS

Schedule A – Accreditation Standards and Service Provider Guidelines for Saskatchewan Workers’ Compensation Board Primary Occupational Therapy Service Providers

Schedule B – Service Fees and Fee Codes for Saskatchewan Workers’ Compensation Board Primary Occupational Therapy Service Providers


Schedule D – WCB Billing Process – Example – Adjustments to Previous Billing Periods – Occupational Therapy

Act Sec # 55, 103(1), 104, 115(c)
Effective Date 01 March 2014
Application All claims on and after the effective date
Supersedes PRO 57/2011 Medical Fees – Occupational Therapy Services
Complements PRO 57/2013 Medical Fees – Secondary and Tertiary Treatment
PRO 53/2014 Medical Fees – Assessment Teams
POL 02/97 Health Care Services Fees
Schedule A
Accreditation Standards and Service Provider Guidelines
for Saskatchewan Workers’ Compensation Board
Primary Occupational Therapy Service Providers

1. **Intent**

   This document sets out the:
   
   - Accreditation standards, and
   - Service provider guidelines

   for occupational therapists providing services to WCB clients.

2. **Introduction**

   All occupational therapists providing services to WCB clients will comply with:
   
   - Accreditation Standards and Service Provider Guidelines for Saskatchewan
     Workers’ Compensation Board Primary Occupational Therapy Service Providers
     (Schedule A).
   - Service Fees and Fee Codes for Saskatchewan Workers’ Compensation Board
     Primary Occupational Therapy Service Providers (Schedule B).
   - The practice standards and ethical requirements of the Saskatchewan Society of
     Occupational Therapists.
   - Current and future WCB policy, where the policy does not contravene the
     practice standards and ethical requirements of the Saskatchewan Society of
     Occupational Therapists, and
   - All sections of *The Workers’ Compensation Act, 2013* (the “Act”).

   WCB accredited occupational therapists that do not want to provide services to WCB
   clients should immediately notify Medical and Health Care Services. The WCB will
   revoke their accreditation.

   By providing care to WCB clients, occupational therapists automatically indicate
   their:
   
   - Understanding of this agreement.
   - Willingness to comply with this agreement, and
   - Intent to maintain WCB accreditation.

3. **Professional Affiliation and WCB Accreditation Requirements**

   The WCB requires all occupational therapists providing services to WCB clients to
   be:
• Members in good standing with the Saskatchewan Society of Occupational Therapists, and
• Accredited as a WCB service provider.

Occupational therapists seeking accreditation will provide the WCB:
• Proof of their Occupational Therapy degree.
• Their current license to practice, and
• Proof of malpractice insurance (i.e., individual coverage or a letter from the occupational therapist’s employer confirming coverage).

The application and process for accreditation can be found on www.wcbsask.com. Occupational therapists will provide all treatment.

Occupational therapists that want to provide care to WCB clients will apply for WCB accreditation.

WCB accreditation ensures WCB clients receive care from qualified occupational therapists that are independent of:
• Adjudication and insurance decisions, and
• Employer influence.

Based on objective and documented medical findings, accredited occupational therapists will make decisions regarding:
• Continued treatment.
• Return-to-work, and
• The need for assessment team review,

Occupational therapists must function as:
• Independent providers, and
• Objective providers.

Occupational therapists must refuse to advocate on behalf of employers or workers regarding the cause of injuries or ongoing benefits. When requested, occupational therapists will remind the client of the WCB:
• Appeals processes, and
• Fair Practices Office,
both of whom have access to medical expertise to address any concerns raised.

Occupational therapists will not note in any:
• Advertising, or
• Promotional material information
Procedure Manual

4. **Practice Guidelines**

   **Intake and Assessment Guidelines**

   After receiving referral from a care provider or worker contacting the occupational therapist directly, the occupational therapist will send a Primary Level Authorization to Treat – Occupational Therapy form (available at [www.wcbsask.com](http://www.wcbsask.com)) to the WCB file manager. When the occupational therapist receives the signed authorization form, they will provide an intake appointment as soon as possible. However, where the referral is of an urgent nature, the therapist will commence treatment (i.e. fresh post operative hand therapy clients), the therapist will commence treatment and, if not eventually WCB approved, will redirect the invoices.

   The occupation therapist will complete an intake assessment to determine the health care needs of the injured worker. To help create a return-to-work plan, the occupational therapist will contact the employer to determine the type of work and demands required of the injured worker. This contact will involve transitional Return to Work as well as final RTW efforts.

   **Management Guidelines**

   WCB clients will receive care equivalent to the:

   - Type and severity of injury.
   - Stages of tissue healing, and
   - Availability of the worksite to provide therapeutic progressions.

   Primary level treatment will not exceed two hours per day.

   Occupational therapists will ensure adequate time for:

   - Occupational therapy care.
   - Education.
   - Reassurance, and
   - Return-to-work discussion

   by booking a maximum of three clients in that hour. This ratio does not apply for:

   - Back classes
   - Education classes
   - Conditioning programs, or
   - Work hardening programs.

   In programs involving strength training, the staff/client ratio will not exceed one to six. In non-strength training programs, the staff/client ratio will not exceed one to 12. Clients, regardless of the type of health care delivered or received, will be
supervised individually or in a group setting, always with an occupational therapist in the room.

Discharge Guidelines

WCB clients are discharged from treatment when:

- There are no occupational or functional gains being made, or
- The injured worker moves into a secondary or tertiary program.

The WCB recognizes that some WCB clients with permanent functional impairment may require additional care to manage the flare-ups.

Operational therapists do not need to send new Primary Level Authorization to Treat forms if the injured worker requests further treatment within 30 days of being discharged. If the request is made after 30 days, the occupational therapist must send a new form and confirm funding before continuing treatment.

Identifying the Need for Re-Assessment

Where more comprehensive care is needed because:

- The worker is not progressing and is not recovering from the work injury, or
- Psychology and or pain management services are required

the occupational therapist will notify the WCB that an assessment team review is required. The assessment team review will determine if secondary or tertiary level care is more appropriate. The occupational therapist will continue treatment prior to the assessment team review only where the injured worker will benefit from continued treatment.

Where a worker, as a result of an assessment team review or physical/functional capacity evaluation, requires secondary or tertiary level care, the WCB Health Care Services Coordinator will refer the primary care provider to a care centre if they do not have a preferred treatment centre. The Health Care Services Coordinator will make referrals to centres that:

- Currently provide primary level care, and
- Ensure there is equal distribution of clients among secondary and tertiary providers.

Evaluation of personal care or workplace needs

Where an Occupational Therapist is asked to evaluate the worker’s needs for equipment at home, in a vehicle or in a work place, the therapist shall list all the possible options and solutions and will avoid advocating for a particular solution. Where the therapist is providing estimates to the WCB, a minimum of three suppliers and cost estimates will be provided, notifying the WCB where this is not practicable.

5. Facility
The occupational therapy treatment centre must have:

- Adequate space.
- Facilities, and
- Equipment

to fulfill services required by WCB clients. In the absence of standards from the Saskatchewan Society of Occupational Therapists, adequacy will be determined by the occupational therapy treatment centre survey process.

6. **Continuing Education**

Occupational therapy treatment centres will provide:

- An orientation program to all new staff (including training in emergency procedures), and
- Processes established within the centre to provide care and return-to-work planning to WCB clients (including review of this document).

All occupational therapists will:

- Be encouraged to participate in continuing education programs, and
- Have knowledge of current occupational therapy practice and treatment protocols.

All therapists will comply with:

- Continuing education, or
- Competency programs
developed by the Saskatchewan Society of Occupational Therapists.

7. **Storage of Health Information and Charting**

There will be a written report for each client within the treatment facility, which includes:

- Notation of the findings of the initial assessment.
- Goals of treatment.
- Treatment provided.
- Findings of periodic reviews.
- Details of the worker's job duties.
- Efforts made toward the establishment of transitional and full return-to-work, and
- A discharge summary.

Charting and storage of health information will meet all requirements of:
- The Saskatchewan Society of Occupational Therapists.
- *The Health Information Privacy Act.*
- The Act, and
- Any other applicable legislation.

If the worker requests a copy of the client chart, the information, excluding information received from the WCB, will be provided in the manner directed by the Saskatchewan Society of Occupational Therapists. The worker will be advised that WCB documents should be requested from WCB personnel. The provision of these documents is subject to WCB policy.

8. **Duty to Report Work Injury**

*The Workers’ Compensation Act, 2013* (Section 55) states:

Any health care professional who attends to or is consulted with respect to an injury to a worker shall:

a. furnish the board with any reports with respect to the examination or treatment of the worker that are relevant to the injury for which compensation is claimed;

b. give all reasonable and necessary information, advice and assistance to the worker or the worker’s dependants in making an application for compensation; and

c. furnish any certificates and proofs that the board may require.

Occupational therapists will report injuries by sending Primary Level Authorization to Treat – Occupational Therapy forms to the WCB. Occupational therapists will tell WCB clients to report their injuries by:

- Telefile (1-800-787-9288)
- Online at [www.wcbsask.com](http://www.wcbsask.com), or
- Completing a Worker's Report of Injury form (this form can be attached to the occupational therapist's reports).

Reporting injuries ensures:

- All WCB clients receive the benefits to which they are entitled, and
- Accurate information is used when employer rates are set.

Employers also have a legislated duty to report work-related:

- Injuries, or
- Illnesses

... to the WCB. Occupational therapists will ensure they are not party to claim suppression by reporting the treatment of WCB clients to the WCB.
9. **WCB Reporting Forms**

WCB reporting forms and frequency of reporting are subject to periodic revision, with the input from the Saskatchewan Society of Occupational Therapists. The WCB and the Saskatchewan Society of Occupational Therapists may revise this agreement prior to expiration. The WCB will provide sufficient time to occupational therapy treatment centres to implement revised standards.

Assessment findings must be sent to the WCB within three business days of the initial assessment (TXI).

Progress reports (TXP) will be sent to the WCB every 10 visits.

Discharge summaries (TXD) will be sent to the WCB within three business days of discharge.

Where occupational therapists are monitoring return-to-work arrangements, return-to-work schedules and particulars will be sent to the WCB prior to commencement, using the Practitioner’s Return to Work Report (PRTW). If revisions are necessary, the occupational therapist will notify the WCB.

10. **Confidentiality Requirements**

All health related and personal information received during the course of treatment of an injured worker will be treated in a confidential manner, and no information will be revealed to any person or party other than those persons to whom reports are to be made or to such other persons as may, from time to time, be designated by the WCB. Information pertaining to functional ability may be provided to the employer for the purposes of establishing a return-to-work arrangement.

All public relations work, interviews, public appearances and press releases related to services being provided to WCB clients will require WCB approval. Approval will not be unreasonably withheld. The occupational therapist will not, without prior written approval of the WCB, publish or allow to be published any work that relies upon or uses information obtained by the occupational therapist, the Saskatchewan Society of Occupational Therapists or its members in carrying out the terms of this agreement, except for retroactive research where the WCB clients treated are not identifiable as a group.

11. **Quality Assurance and Performance Evaluation Measures**

There must be a sufficient number of occupational therapists on staff to provide efficient and effective services. Occupational therapists will provide care that encourages the injured worker’s active involvement wherever appropriate. Occupational therapists will provide evidence-based care.

The ratio of non-professional to professional staff in the occupational therapy treatment centre must not be greater than two occupational therapy assistants to one active full-time occupational therapist. Information will be available within the clinic to indicate the total number of:
Procedure Manual

- Professional staff’s working hours per month and
- Non-professional staff’s working hours per month (excluding reception and office staff)

This information may be recorded as full-time equivalents of 40 hours per week.

In rare instances, occupational therapy assistants may be used for in clinic treatment to:
- Provide auxiliary services, and
- Monitor equipment.

In all cases, the occupational therapist will, at a minimum, provide indirect supervision (i.e., the occupational therapist will be present within the clinic). The occupational therapist will direct care and progressions of care. Only licensed or registered providers will be used to supervise functional conditioning, and provide functional testing.

Compliance to these standards will be evaluated through quality assurance processes that utilize a clinic survey process. This process is to be developed jointly by the WCB and occupational therapy professional representatives.

12. Fees for Service

The Workers’ Compensation Act, 2013 (Section 103) states:

Every worker who is entitled to compensation or who is disabled only on the day of the injury is entitled without charge to:

i. any medical aid that may be necessary as a result of the injury;

ii. any other treatment by a health care professional.

The occupational therapist will direct bill the WCB for services unless the WCB provides written notification that funding will not be provided.

The services payable by the WCB are listed in the Service Fees and Fee Codes for Saskatchewan Workers’ Compensation Board Primary Occupational Therapy Service Providers (Schedule B). A maximum of two hours of treatment services per day five days per week, as appropriate for the treatment of the work injury may be billed. Occupational therapists will not extra bill WCB clients for other services. Occupational therapists will bill by 15 minute blocks or 0.25 units, and will round up to the next 15 minute block or 0.25 unit.

Where necessary, modalities will not be billed independent of other therapeutic interventions and will be suitable to the stage of tissue healing specific to the worker. Theraband must also not be extra billed to the worker and or the WCB and is considered a component of the already funded occupational therapy. Theraballs and other consumable therapeutic supplies and equipment are billable to the WCB only with prior approval of the Case Manager. To reduce the perception of prescriber/provider bias, the manufacturer’s fee and an additional handling fee only
will be paid by WCB (see Schedule B). Where possible, direct billing and delivery of the supply to the WCB for items greater than $500 will be arranged.

The WCB recognizes that the wait for pre-approval of therapeutic equipment and supplies may, at times, delay recovery. In cases where recovery will be delayed, by waiting for pre-approval, the WCB will waive the pre-approval requirement and fund the therapeutic equipment and supplies to a maximum of $250. These include post-surgical clients or clients with acute symptoms who require same day issuance of specific therapeutic equipment and supplies in an outpatient clinic.

The occupational therapist will invoice the WCB in units of care rather than number of visits, allowing the therapist to personalize the care delivered to the needs of the injured worker. Occupational therapists will be allowed input into billing processes that may be developed by the WCB from time to time.

13. Return-to-Work

Within the first week of treatment, the occupational therapist will contact the employer of any worker not at full work to determine the availability of transitional return-to-work (work suitable to the worker’s occupational findings as he transitions from work restrictions to full fitness for work). Where transitional return-to-work is available, the occupational therapist will make reasonable effort to coordinate a return-to-work plan, with the cooperation of the primary care provider, involving the worker, the employer, and the WCB. The duration of the return-to-work plan will be based on:

- Clinical judgment regarding type and severity of injury.
- The stages of tissue healing.
- The occupational requirements of the pre-injury job, and
- The availability of transitional return-to-work.

Where any return-to-work partner is not cooperative with return-to-work planning, the occupational therapist will advise the WCB that a barrier to recovery has occurred, asking the WCB to make contact with the individual. The resultant return-to-work plan will be forwarded to the WCB through a Practitioner Return to Work (PRTW) form document and will be resent should revisions to the original plan occur.

14. Term of Agreement

These service provider guidelines and service fees are in effect until March 31, 2016 and will remain in effect until a new agreement is reached.

15. Ongoing Relationship

Ongoing input from occupational therapists will be obtained by the WCB Medical and Health Care Services and the Saskatchewan Society of Occupational Therapists. Where occupational therapists want to provide input about the care of WCB clients
that is not file specific, they should contact the President of Saskatchewan Society of Occupational Therapists or the Saskatchewan Society of Occupational Therapists’ Third Party Payers Committee who will then request to meet with the Manager of WCB Health Care Services.
Schedule B
Service Fees and Fee Codes for Saskatchewan Workers’ Compensation Board
Primary Occupational Therapy Service Providers

The following WCB fee codes and fees are to be used to bill for services provided to WCB clients by OTs. Hourly rates are considered one unit of care. OTs will bill by 15 minute blocks or 0.25 units, and will round up to the next 15 minute block or 0.25 unit.

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee Code</th>
<th>Effective March 01, 2014</th>
<th>Effective April 01, 2014</th>
<th>Effective April 01, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Assessment (per use)</td>
<td>900</td>
<td>$86.46</td>
<td>$89.05</td>
<td>$91.72</td>
</tr>
<tr>
<td>Subsequent Visit (per use)</td>
<td>901</td>
<td>$42.08</td>
<td>$43.34</td>
<td>$44.64</td>
</tr>
<tr>
<td>Return-to-Work Planning (per hour)</td>
<td>902</td>
<td>$98.88</td>
<td>$101.85</td>
<td>$104.91</td>
</tr>
<tr>
<td>Individual Functional conditioning (per hour)</td>
<td>903</td>
<td>$98.88</td>
<td>$101.85</td>
<td>$104.91</td>
</tr>
<tr>
<td>Individualized Upper Extremity Conditioning (per hour)</td>
<td>904</td>
<td>$98.88</td>
<td>$101.85</td>
<td>$104.91</td>
</tr>
<tr>
<td>Conferencing (per hour)</td>
<td>905</td>
<td>$98.88</td>
<td>$101.85</td>
<td>$104.91</td>
</tr>
<tr>
<td>Jobsite or Home Assessment (per hour)</td>
<td>906</td>
<td>$98.88</td>
<td>$101.85</td>
<td>$104.91</td>
</tr>
<tr>
<td>Education (group or individual, per hour)</td>
<td>907</td>
<td>$98.88</td>
<td>$101.85</td>
<td>$104.91</td>
</tr>
<tr>
<td>Functional Abilities Evaluation (per hour)</td>
<td>908</td>
<td>$98.88</td>
<td>$101.85</td>
<td>$104.91</td>
</tr>
<tr>
<td>Telephone Conversation (per hour)</td>
<td>909</td>
<td>$98.88</td>
<td>$101.85</td>
<td>$104.91</td>
</tr>
<tr>
<td>Initial Report (TXI) with Functional Outcome Measures (per report)</td>
<td>910</td>
<td>$56.50</td>
<td>$58.20</td>
<td>$59.95</td>
</tr>
<tr>
<td>Mileage to/from Jobsite/Home (per km)</td>
<td>911</td>
<td>$0.39</td>
<td>$0.40</td>
<td>$0.41</td>
</tr>
<tr>
<td>Initial Report (TXI) without Functional Outcome Measures (per report)</td>
<td>915</td>
<td>$46.50</td>
<td>$47.90</td>
<td>$49.34</td>
</tr>
<tr>
<td>Progress/Discharge Report (TXP) with Functional Outcome Measures (per report)</td>
<td>920</td>
<td>$35.10</td>
<td>$36.15</td>
<td>$37.23</td>
</tr>
<tr>
<td>Progress/Discharge Report (TXP) without Functional Outcome Measures (per report)</td>
<td>925</td>
<td>$25.90</td>
<td>$26.68</td>
<td>$27.48</td>
</tr>
<tr>
<td>Orthotics and Splint Construction /Fitting/Modification (per hour)</td>
<td>33</td>
<td>$98.88</td>
<td>$104.80</td>
<td>$104.91</td>
</tr>
<tr>
<td>Pre-manufactured Therapeutic Equipment and Supplies for Custom Devices</td>
<td>33</td>
<td>Provider’s cost + 15% handling fee</td>
<td>Provider’s cost + 15% handling fee</td>
<td>Provider’s cost + 15% handling fee</td>
</tr>
<tr>
<td>Response to WCB request for PFI rating information</td>
<td>930</td>
<td>$180.00</td>
<td>$185.40</td>
<td>$190.96</td>
</tr>
</tbody>
</table>

Notes:
1. Includes practitioner’s time spent developing the return-to-work contract with the WCB client and employer, and time spent monitoring and trouble-shooting.
2. Includes time used for treatment and assessment; involves training for functional tasks (e.g., lifting, carrying, pushing, pulling, etc.); is group supervised (minimum of two in group) unless specific instruction is required.
3. Divided by number in group with individual therapy billed only where medically necessary (i.e. cognitive conditions, teaching new exercises). Unless cognitively challenged, the WCB expects only one or two individual billings per file at the primary level.
4. Involves attendance at the worksite for the purpose of analyzing the job duties or making job site modifications; Up to two hours for reporting will be permitted with approval required for any additional reporting; travel time will only be paid for travel outside of the practitioner’s usual municipality of work.
5. Does not include calls for authorization to treat or reports on progress.
6. The TXI/TXP forms with functional outcome measures were not devised at the time of the approval of the agreement and cannot be billed until the forms are developed.
7. Includes, but not limited to materials including arm rests, casts, fiberglass casts, braces, wrist supports, back supports, support stockings, truss, obesity supports, and orthopaedic boots, as appropriate.
Schedule C
WCB Billing Process
Example – Monthly Billing
Occupational Therapy

<table>
<thead>
<tr>
<th>Fee Descriptor</th>
<th>Level: P, S, T</th>
<th>Fee Code</th>
<th># of Treatments or Units</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent Visit</td>
<td>P</td>
<td>901</td>
<td>1</td>
<td>$44.64</td>
</tr>
<tr>
<td>Return-to-Work Planning</td>
<td>P</td>
<td>902</td>
<td>3</td>
<td>$314.73</td>
</tr>
<tr>
<td>Telephone Conversation</td>
<td>P</td>
<td>909</td>
<td>1</td>
<td>$104.91</td>
</tr>
<tr>
<td><strong>Total of all services for billing period</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$464.28</strong></td>
</tr>
</tbody>
</table>

Billing period is June 1 to June 30, 2015. Treatment start date is June 12, 2015.

Service provided was a subsequent visit, three hours of return-to-work planning, and a 55 minute telephone conversation.

The fee schedule directs that “hourly rates are considered one unit of care. OTs will bill by 15 minute blocks or 0.25 units, and will round up to the next 15 minute block or 0.25 unit.” Therefore, a 55 minute telephone conversation will be rounded up to one hour or one unit of care at a cost of $104.91.
### Schedule D
WCB Billing Process
Example – Adjustments to Previous Billing Periods
Occupational Therapy

<table>
<thead>
<tr>
<th>TREATMENT BILLING SUMMARY</th>
<th>THER</th>
<th>BILLING PERIOD: 01/06/15 - 30/06/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MONTHLY/BI-MONTHLY BILLINGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SERVICE PROVIDER: ABC Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>999 - 1st St. Saskatoon, SK S4X 7S9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone: 777-9999 Fax: 777-8888</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver Billing Number: OCC079990</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLAIMANT’S NAME: Sally Smith</td>
<td></td>
<td></td>
</tr>
<tr>
<td>111 Albert St. Saskatoon, SK S7K 9C4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary start date: 12/06/15 Secondary start date: Tertiary start date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fee Descriptor</th>
<th>Level: P, S, T</th>
<th>Fee Code</th>
<th># of Treatments or Units</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Subsequent Visit</td>
<td>P</td>
<td>901</td>
<td>(3)</td>
<td>($133.92)</td>
</tr>
<tr>
<td>Subsequent Visit</td>
<td>P</td>
<td>901</td>
<td>2</td>
<td>$89.28</td>
</tr>
<tr>
<td>Telephone Conversation</td>
<td>P</td>
<td>909</td>
<td>0.25</td>
<td>$26.23</td>
</tr>
<tr>
<td>Total of all services for billing period</td>
<td></td>
<td></td>
<td></td>
<td>$70.87</td>
</tr>
</tbody>
</table>

In billing period June 1 to June 30, 2015 three subsequent visits were billed in error. Only two subsequent visits were provided.
7.2.12 Medical Fees – Registered Nurse (Nurse Practitioner) (PRO 55/2014)

Document Date 29 July 2014

Purpose To establish fees and standards of care for NR(NP)s.

DEFINITION

Registered Nurse (Nurse Practitioner) (RN(NP)) means a registered nurse who has met the qualifications for licensure in the RN(NP) category in the province of Saskatchewan, as defined by The Registered Nurses Act, 1988.

BACKGROUND

1. Upon Workers’ Compensation Board (WCB) approval, a worker entitled to benefits under The Workers’ Compensation Act, 2013 (the “Act”) is also entitled to (Section 103):
   a. Any medical aid that may be necessary because of the work-related injury.
   b. Any other treatment by a health care provider.
   c. Any prosthetic or apparatus that may be necessary as a result of the injury, and
   d. Any travel and sustenance costs associated with receiving medical treatment as a result of the injury.

2. The WCB is authorized to determine health care services fees (Section 104).

3. Section 24(3) of The Registered Nurses Act, 1988 provides a general overview of the services RN(NP)s are able to provide. For instance, this section allows RN(NP)s to:
   a. Order, perform, receive and interpret reports of screening and diagnostic tests;
   b. Prescribe and dispense drugs;
   c. Perform minor surgical and invasive procedures; and
   d. Diagnose and treat common medical disorders.

4. The mandate of the Saskatchewan Registered Nurses’ Association (SRNA) and The Registered Nurses Act, 1988 do not provide the SRNA with the authority to sign an agreement or negotiate on behalf of its members. However, the SRNA has agreed to provide advisory and resource services to the Workers’ Compensation Board (WCB) when required.
PROCEDURE

General

1. To provide services to injured workers, RN(NP)s must:
   a. Be accredited by the WCB.
   b. Hold current licensure with the SRNA as an RN(NP).

2. RN(NP)s must comply with:
   a. Accreditation Standards and Service Provider Guidelines for RN(NP)s (Schedule A).
   b. RN(NP) Service Rates for Reporting (Schedule B).
   c. The Saskatchewan Ministry of Health Payment Schedule for Insured Services Provided by a Physician.
   d. The practice standards and ethical requirements of the SRNA.

Service Guidelines

3. Schedule A provides the accreditation standards and service provider guidelines for RN(NP)s treating injured workers.

4. The RN(NP) will send an initial report (PPI) to the WCB within three business days of the initial assessment.

5. If the worker needs more treatment after the initial assessment, the RN(NP) will send a progress report (PPP) to the WCB:
   a. Every three weeks, or
   b. When the worker’s condition changes.

6. If the worker needs care from another provider, the RN(NP) will:
   a. Provide a written referral directly to that provider, or
   b. Ask MHCS to arrange for care in the initial report (PPI) or progress report (PPP).

7. The RN(NP) will recommend an assessment team review in the initial report (PPI) or progress report (PPP) if the worker:
   a. Is not recovering from the injury, or
   b. Needs psychological and/or pain management services.
8. If the assessment team review or a functional capacity evaluation recommends secondary or tertiary level care, MHCS will ask the RN(NP) to confirm the recommendation before arranging care.

9. Within the first week of treatment, the RN(NP) will contact the employer to see if they can accommodate the worker’s return-to-work. If accommodated work is available, the RN(NP) will develop a return-to-work plan with the help of the:
   a. Worker.
   b. Employer, and
   c. WCB.

10. The RN(NP) will send the WCB a return-to-work report (PRTW):
    a. Before the plan starts, and
    b. If the plan needs revisions.

11. The RN(NP) will tell the WCB through a progress report (PPP) if the worker or employer is not cooperating with the return-to-work plan.

12. The RN(NP) will send a discharge report (PPP) to the WCB within three business days of discharge.

Assessment/Progress/Discharge Review

13. Claims Entitlement Specialists (CES) will review initial reports (PPI) and progress/discharge reports (PPP) that the WCB gets within the first four weeks post-injury. Case Managers (CM) will review reports that the WCB gets after four weeks unless Claims Entitlement retains the file.

14. CESs and CMs can request the assistance of the Medical Officer at any time during the review of claims.

15. If the CES, CM or Medical Officer finds that the WCB should deny coverage, the file manager will tell the RN(NP).

Evaluations

16. MHCS will perform ad hoc file reviews to ensure quality assurance.

17. MHCS will issue letters to RN(NP)s that do not comply with Schedule A or Schedule B. These letters will outline appropriate corrective actions. Failure to comply may result in the loss of WCB accreditation.
Continuing Education

18. RN(NP)s must comply with the Continuing Competence Program developed by the SRNA.

Complaints and Dispute Resolution

19. Workers can report complaints of any nature to the WCB. The WCB employee receiving the complaint may refer the complaint for resolution to other WCB staff including the Manager of Health Care Services. If the complaint alleges professional incompetence or misconduct by a care provider, the Manager of Health Care Services will direct the complaint to the SRNA.

20. MCHS will note all complaints and resolutions on the service provider's accreditation file.

21. Workers that want to see a different RN(NP) should contact their Case Manager or MHCS.

Fees

22. RN(NP)s will bill for services according to:
   a. The Saskatchewan Ministry of Health Payment Schedule for Insured Services Provided by a Physician, and
   b. RN(NP) Service Rates for Reporting (Schedule B).

23. Schedule B provides increases to RN(NP) service rates for reporting on:
   a. September 1, 2014.
   b. May 1, 2015.
   c. May 1, 2016.

24. To prevent financial hardship to the injured worker, RN(NP)s will:
   a. Direct bill the WCB, not the worker, and
   b. Avoid extra billing by adhering to the approved fee schedules.

25. If the WCB denies the worker's claim after the RN(NP) provides services, the WCB will only pay for reports submitted prior to the date of notification of disallowance. The WCB will not pay office visit and treatment fees.

ATTACHMENTS

Schedule “A” – Accreditation Standards and Service Provider Guidelines for RN(NP)s
Schedule “B” – RN(NP) Service Rates for Reporting
Act Sec # 55, 103, 104(1), 115(c); The Registered Nurses Act, 1988
Effective Date 01 September 2014
Application All licenced nurse practitioners providing services to WCB clients on and after the effective date.
Supersedes PRO 57/2012 Registered Nurse (Nurse Practitioner)
Complements PRO 53/2006 Medical Aid Billings – Payment
PRO 05/96 Health Care Services
SCHEDULE “A”
Accreditation Standards and Service Provider Guidelines for RN(NP)s

1. **Intent**
   
The intent of this document is to set out the accreditation standards and the service provider guidelines for RN(NP)s providing services to injured workers.

2. **Introduction**
   
All RN(NP)s providing services to injured workers will comply with:

- Accreditation standards and Service Provider Guidelines for RN(NP)s (Schedule A).
- RN(NP) Service Rates for Reporting (Schedule B).
- The Saskatchewan Ministry of Health Payment Schedule for Insured Services Provided by a Physician.
- The practice standards and ethical requirements of the SRNA.
- *The Workers’ Compensation Act, 2013*

By providing care to injured workers, RN(NP)s indicate to the WCB their understanding of, and willingness to comply with, this agreement.

3. **Professional Affiliation and WCB Accreditation Requirements**

To be a WCB accredited RN(NP)s, RN(NP)s must hold current licensure with the SRNA as a RN(NP). Qualified RN(NP)s that want to provide care to injured workers are required to apply for WCB accreditation, provide evidence of completion of a nursing program at an accredited university or technical institution and provide evidence of current licensure with the SRNA as an RN(NP).

WCB accreditation ensures injured workers receive care from qualified RN(NP)s that are independent of adjudication decisions and employer influence. As part of a collaborative team, RN(NP)s will make decisions regarding continued treatment, return-to-work, and the need for assessment team review, based on objective and documented medical findings. RN(NP)s must function as objective care providers, independent of the insurance benefits issues, and therefore must refuse to advocate on behalf of employers or workers regarding causation or ongoing benefits. When requested, RN(NP)s will remind employers or workers of the WCB appeals processes and the Fair Practices Office, both of whom have access to medical expertise to address any concerns raised.

The RN(NP)s will not include in any advertising or promotional material information regarding affiliation with the WCB.

4. **Practice Guidelines**

   **Intake and Assessment Guidelines**
To ensure early reporting of work injuries, the RN(NP) will send a report detailing the examination of a worker who may have sustained work-related injury to the WCB within three business days of the initial assessment, utilizing the Physician’ Initial Report (PPI).

Where further consultations are required, a Physician’s Progress/Discharge Report (PPP) will be submitted every three weeks or as the worker’s condition changes, whichever occurs first.

Where the claim of an injured worker for WCB benefits is denied by the WCB, the client and RN(NP) will be notified. The WCB will pay for already submitted report fees. However, the WCB will not pay office visit and treatment fees. No further reports need to be submitted, unless WCB requests further reports.

The WCB, RN(NP)s, employers, and workers will ensure services are provided, distributed, and funded without any conflict of interest. If the WCB, RN(NP), employer or worker recognizes or perceives a conflict of interest, all parties are to be provided written notice of the conflict. The following are considered to be conflicts of interest:

- RN(NP)s referring workers to providers or clinics where the referrer has some aspect of control (e.g., the referrer is an owner, director, officer or stakeholder of the clinic);
- RN(NP)s providing health care treatment services to workers for work-related injuries without advising the WCB;
- Any officer, director, employee or agent of the RN(NP)s approaching WCB personnel, other than senior management of WCB, to promote the business of the RN(NP);
- RN(NP)s that enter into agreements with employers for the treatment of workers for work-related injuries;
- The conflict of interest situation will be reviewed by the Manager WCB Health Care Services, who may, as necessary, consult SRNA.

Management Guidelines

Injured workers will receive care commensurate with the type and severity of the injury and the stages of tissue healing including recommendations for return to suitable employment while recovery occurs.

Where the RN(NP) recommends that the services of an exercise or massage therapist or any other care provider are required, the RN(NP) will provide a written referral to the exercise or massage therapist or ask WCB to arrange for this care using the Physician’s Initial Report (PPI) or Physician’s Progress/Discharge Report (PPP).

Where the RN(NP) believes that diagnostics or the services of a specialist are required, the RN(NP) may ask the WCB to expedite the referral in the Physician’s Initial Report (PPI) or Physician’s Progress/Discharge Report (PPP).
Discharge Guideline

The RN(NP) will discharge the injured worker from injury related care when the RN(NP) considers the worker has recovered from the effects of the work injury or the WCB notifies that injury related benefits have ended. The RN(NP) faced with a worker who does not agree with the WCB decision will encourage the worker to use the WCB appeal process.

Identifying the Need for Re-Assessment

Where more comprehensive care is needed because:

- the worker is not progressing and is not recovering from the work injury,
- psychological and/or pain management services are required,

the RN(NP) will notify the WCB that an assessment team review is required to determine if secondary or tertiary level care is more appropriate. The Physician’s Initial Report (PPI) or Physician’s Progress/Discharge Report (PPP) may be used to request the assessment service if WCB has not already arranged a review.

Where a worker, as a result of an assessment team review or functional capacity evaluation requires secondary or tertiary level care, the WCB Health Care Services Coordinator will contact the RN(NP) to obtain agreement with these and other recommendations made by the team, then assist by making the necessary referrals.

5. Facility

The RN(NP)s examining room will have adequate space, facilities and equipment to fulfill services required by injured workers.

6. Continuing Education

All RN(NP)s shall comply with Continuing Competence Programs developed by the SRNA.

7. Storage of Health Information and Charting

There will be a written report for each client within the RN(NP)s treatment facility, which includes the findings of initial assessment, treatment provided or arranged, findings of periodic reviews, details of the worker’s job duties, efforts made toward the establishment of transitional and full return-to-work, and a discharge summary.

Charting and storage of health information will meet all requirements of the employer, SRNA, The Health Information Protection Act (HIPA), The Workers’ Compensation Act, and any other applicable legislation. Where the worker requests a copy of the client chart, the information, excluding information received from the WCB, will be provided in the manner directed by the HIPA. The worker is advised that WCB documents in the RN(NP)s files should be requested from WCB personnel.

The Workers’ Compensation Act, 2013 states:
Section 55
“Any health care professional who attends to or is consulted with respect to an injury
to a worker shall:

a. furnish the board with any reports with respect to the examination or treatment of
the worker that are relevant to the injury for which compensation is claimed;

b. give all reasonable and necessary information, advice and assistance to the
injured worker or the worker’s dependants in making an application for
compensation; and

c. furnish any certificates and proofs that the board may require.”

To ensure all injured workers receive the benefits to which they are entitled, and to
ensure accurate information when employer rates are set, any RN(NP) providing
treatment to a client injured in the course of employment shall report the injury to the
WCB via the Physician’s Initial Report (PPI).

The worker should also be advised to report the injury to the WCB via telefile 1-800-
787-9288 or by completing a Worker’s Report of Injury form, which may be attached
to the RN(NP)s reports.

RN(NP)s providing treatment to injured workers are considered to have reported the
work-related injury when they submit the Physician’s Initial Report (PPI) to the WCB.

9. **WCB Reporting Forms**

WCB reporting forms and frequency of reporting are subject to periodic revision.
Physician’s Initial Reports (PPI) will be sent to the WCB within three business days
of the initial assessment.

Physician’s Progress/Discharge Reports (PPP) will be submitted to the WCB every
three weeks or when the worker’s condition changes, whichever occurs first, and
within three days of discharge.

Where the RN(NP) is monitoring a return-to-work arrangement, the return-to-work
schedule will be provided to the return-to-work partners and WCB prior to its
commencement, using the Practitioner’s Return to Work Report (PRTW). If revisions
are necessary, the RN(NP) will provide notification to the WCB.

WCB report forms are available on-line at [www.wcbsask.com](http://www.wcbsask.com) and may be submitted
electronically to the WCB and printed off for use with other of the return-to-work
partners.

10. **Confidentiality Requirements**

All health related and personal information received during the course of treatment
of a WCB client will be treated in a confidential manner, and no information will be
revealed to any person or party other than those persons to whom reports are to be
made or to such other persons as may, from time to time, be designated by the
WCB. Information pertaining to functional ability and or restrictions may be provided to the employer for the purposes of establishing a return-to-work arrangement.

All public relations work, interviews, public appearances and press releases related to services being provided to injured workers will require WCB approval.

The RN(NP) will not, without prior written approval of the WCB, publish or allow to be published any work that relies upon or uses information obtained by the RN(NP), the SRNA or its members in carrying out the terms of this agreement, except for retroactive research where the workers treated are not identifiable.

11. Quality Assurance and Performance Evaluation Measures

RN(NP)s will provide evidence-based care.

Performance and quality of care may be measured by the WCB.

12. Fees for Service

*The Workers’ Compensation Act, 2013* states:

Section 103(1)

“Every worker who is entitled to compensation or who is disabled only on the day of the injury is entitled without charge to:

a. any medical aid that may be necessary as a result of the injury;

b. any other treatment by a health care professional.”

The RN(NP), to meet the requirements of the WCB Act, or the employer of the RN(NP), direct bills the WCB for services unless the WCB has provided written notification that health care benefits are not being extended for the injury. The Saskatchewan Ministry of Health Payment Schedule for Insured Services Provided by a Physician is used for clinical services while Schedule B is used to bill for WCB specific services such as completion of report forms, billing the fees designated for RN(NP)s.

In order to prevent financial hardship to the worker, extra billing of the worker and/or billing for other services shall not occur.

13. Return-to-Work

Within the first week of treatment, the RN(NP) will contact the employer to determine the availability of transitional return-to-work. Where transitional return-to-work is available, the RN(NP) will coordinate a return-to-work, with the cooperation of the, worker, employer, and the WCB.

The return-to-work plan will be forwarded to the WCB using the Practitioner Return-to Work form and will be resubmitted should revisions to the original plan occur. The duration of the return-to-work plan will be based on clinical judgment regarding type and severity of injury, the stages of tissue healing, the physical requirements of the pre-injury job, and the availability of transitional return-to-work.
Where any return-to-work partner is not cooperative with return-to-work planning, the RN(NP) will advise the WCB via the Physician’s Progress/Discharge Report (PPP) that a barrier to recovery has occurred.

14. **Term of this Document**

These service provider guidelines and service fees are in effect until March 31, 2017.

15. **Ongoing Relationship**

The WCB will maintain a relationship with the SRNA for the purpose of sharing information regarding the relationship between RN(NP)s and WCB.
Schedule “B”
RN(NP) Service Rates for Reporting

RN(NP)s will bill for services according to:

- The Saskatchewan Ministry of Health Payment Schedule for Insured Services Provided by a Physician for professional services, and
- RN(NP) Service Rates for Reporting (Schedule B) for reporting services.

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
<th>September 1, 2014</th>
<th>May 1, 2015</th>
<th>May 1, 2016</th>
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<tr>
<td></td>
<td>Reports</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1650</td>
<td>- Initial (PPI)</td>
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<tr>
<td>1651</td>
<td>if submitted electronically by PPI template or typed</td>
<td></td>
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<tr>
<td></td>
<td>clinical notes containing similar information, add:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$12.26</td>
<td>$12.62</td>
<td>$13.00</td>
</tr>
<tr>
<td>1660</td>
<td>- Progress (PPP)</td>
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<td>1661</td>
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<td>clinical notes containing similar information, add:</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>$12.26</td>
<td>$12.62</td>
<td>$13.00</td>
</tr>
<tr>
<td>1119</td>
<td>Complicated Consultations</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Conditions involving more than one area of the body;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Chronic Clients (those with Injuries older than 12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>weeks), add:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1097</td>
<td>Special Opinion, on Request (relationship or percentage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>of functional impairment), add:</td>
<td>$232.78</td>
<td>$239.76</td>
<td>$246.96</td>
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<tr>
<td>1177</td>
<td>Research Fee when requested by the WCB (per 10 minutes)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Telephone Consultations (initiated by the WCB or a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>health care provider currently treating the injured</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>worker. Synopsis of the consultation to be included in</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>patient’s chart)</td>
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<tr>
<td>1165</td>
<td>a) First 10 minutes:</td>
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<td>1166</td>
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<td>$57.29</td>
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<tr>
<td>1167</td>
<td>c) Each additional 15 minutes</td>
<td>$55.62</td>
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<td>$59.01</td>
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<td>1179</td>
<td>RHCS4 - Treatment Implementation</td>
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<td>$33.42</td>
<td>$34.42</td>
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<tr>
<td></td>
<td>If received by the WCB within 5 days of the report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>request, an additional amount will be added.</td>
<td>$25.75</td>
<td>$26.52</td>
<td>$27.32</td>
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</tbody>
</table>
7.2.13 Medical Fees – Physicians (PRO 55/2015)

Document Date 13 October 2015

Purpose Implementation of fees for services provided by physicians who are licensed to practice in Saskatchewan.

BACKGROUND

1. The Workers’ Compensation Act, 2013 (the “Act”) directs that medical aid shall be furnished or arranged for by the Board as it may approve (Section 103(2)).

2. The Act states that the fees for medical aid furnished by any health care professional are those that are determined by the WCB (Section 104(1)).

3. The Act instructs that the WCB may expend moneys from the fund for any expenses incurred in the administration of this Act and, without restricting the generality of the foregoing, the WCB may expend money for any medical aid provided pursuant to the Act to injured workers and any specialized treatment or other medical aid that the board considers necessary and that is not provided for in the Act (Section 115(c)).

PROCEDURE

1. The Saskatchewan Workers’ Compensation Board (WCB) and the Saskatchewan Medical Association (SMA) have reached an Agreement regarding the treatment of injured workers, reporting to the WCB and the remuneration of physicians. The Agreement includes physician rate schedules effective October 01, 2015.

2. The WCB shall pay physicians the same rates as specified by the Saskatchewan Ministry of Health in the Saskatchewan Health Payment Schedule for Insured Services provided by a Physician.

3. The Agreement between the WCB and the SMA directs that all physician service rates will be adjusted annually beginning April 1, 2016 using the negotiated SMA - Ministry of Health General Practitioner Composite Index (“GP index”) for fee for service payment.

4. The Chief Medical Officer (CMO) will ensure the fee schedules are updated annually to reflect the fees specified in the GP index over the term of the Agreement. If increases to the GP index are unavailable at any annual date for adjustment, the adjustment will occur within 30 days of the index becoming available and communicated to the WCB by the SMA.

5. When a claim is subsequently denied following the provision of services, the WCB will be responsible for the payment of physician services not specified in the
Saskatchewan Ministry of Health’s Saskatchewan Health Payment Schedule for Insured Services provided by a Physician.

6. The term of the Agreement shall be for a period of five years commencing on October 1, 2015 and expiring on September 30, 2020.

ATTACHMENTS

Schedule “A” – Physician Service Rates for Reporting

Schedule “B” – Physician Service Rates Not Covered by Saskatchewan Health

<table>
<thead>
<tr>
<th>Act Sec #</th>
<th>103, 104(1), 115(c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Date</td>
<td>01 October 2015</td>
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<tr>
<td>Application</td>
<td>The SMA and all physicians licensed to practice in Saskatchewan.</td>
</tr>
<tr>
<td>Supersedes</td>
<td>PRO 51/2009 Medical Fees - Physicians</td>
</tr>
<tr>
<td>Complements</td>
<td>POL 18/2010 Medical Review Panels</td>
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<td></td>
<td>POL 02/2006 Medical Boards – Repeal</td>
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<td></td>
<td>PRO 05/2013 Injuries – Heart Attack</td>
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### Schedule “A”
#### Physician Service Rates for Reporting

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<th>Service Description</th>
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<th>01-Oct-2015</th>
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</thead>
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<td>650</td>
<td>- Initial (PPI)</td>
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<td>660</td>
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<td>$35.10</td>
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<td>If submitted electronically by PPP template or typed clinical notes containing similar information, add:</td>
<td>$11.90</td>
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<tr>
<td>119</td>
<td>Complicated Consultations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Conditions involving more than one area of the body; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Chronic Clients (those with Injuries older than 12 weeks), add:</td>
<td>$90.30</td>
<td>$94.82</td>
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<tr>
<td>97</td>
<td>Special Opinion, on Request (relationship or percentage of functional impairment), add:</td>
<td>$226.00</td>
<td>$237.00</td>
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<tr>
<td>178</td>
<td>Research Fee when requested by the WCB (per 10 minutes)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>- Specialist</td>
<td></td>
<td>$45.20</td>
</tr>
<tr>
<td></td>
<td>- General Practitioner</td>
<td></td>
<td>$40.70</td>
</tr>
<tr>
<td>177</td>
<td>Telephone Consultations (initiated by the WCB or a health care provider currently treating the injured worker. Synopsis of the consultation to be included in patient’s chart)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) First 10 minutes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Specialist</td>
<td></td>
<td>$45.20</td>
</tr>
<tr>
<td></td>
<td>- General Practitioner</td>
<td></td>
<td>$40.70</td>
</tr>
<tr>
<td></td>
<td>b) 10 to 15 minutes:</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>- Specialist</td>
<td></td>
<td>$60.20</td>
</tr>
<tr>
<td></td>
<td>- General Practitioner</td>
<td></td>
<td>$54.00</td>
</tr>
<tr>
<td></td>
<td>c) Each additional 15 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Specialist</td>
<td></td>
<td>$60.20</td>
</tr>
<tr>
<td></td>
<td>- General Practitioner</td>
<td></td>
<td>$54.00</td>
</tr>
<tr>
<td>179</td>
<td>RHCS4 – Treatment Implementation</td>
<td></td>
<td>$31.50</td>
</tr>
<tr>
<td></td>
<td>If received by the WCB within 5 days of the report request, an additional $25 will be automatically added to the payment for this form.</td>
<td></td>
<td>$25.00</td>
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</table>
## Schedule “B”
### Physician Service Rates Not Covered by Saskatchewan Health

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
<th>01-Apr-2012</th>
<th>01-Oct-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>640</td>
<td>Counseling</td>
<td>$43.00</td>
<td>$45.15</td>
</tr>
<tr>
<td></td>
<td>For patient counseling regarding early return-to-work, and or completion of return-to-work plan for work injuries expected to have temporary restrictions. Billable for counseling sessions occurring at initial visit and maximum of once every four weeks thereafter that patient not engaged in return-to-work plan. Must be documented in patient’s chart. Per 10 minutes or major portion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>199</td>
<td>Hospital Management</td>
<td>$119.00</td>
<td>$125.00</td>
</tr>
<tr>
<td></td>
<td>Billed by most responsible physician (MRP) and or physician completing discharge summary, for inpatient hospital stays. Includes discussion with patient regarding expectations for recovery and return-to-work. Billed at or near time of discharge, with notation in patient’s chart. Per hospital stay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>89</td>
<td>Traumatic Brain Injury Consultation</td>
<td>$942.00</td>
<td>$989.00</td>
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<td></td>
<td>- Chair</td>
<td>$377.00</td>
<td>$396.00</td>
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<tr>
<td>1189</td>
<td>Actual time spent in excess of 2.5 hours (per hour)</td>
<td>$377.00</td>
<td>$396.00</td>
</tr>
<tr>
<td>189</td>
<td>- Member</td>
<td>$753.00</td>
<td>$791.00</td>
</tr>
<tr>
<td>1089</td>
<td>Actual time spent in excess of 2.5 hours (per hour)</td>
<td>$301.00</td>
<td>$316.00</td>
</tr>
<tr>
<td>42</td>
<td>Cardiac (per hour)</td>
<td>$377.00</td>
<td>$396.00</td>
</tr>
<tr>
<td></td>
<td>- Chair</td>
<td>$377.00</td>
<td>$396.00</td>
</tr>
<tr>
<td>142</td>
<td>- Member</td>
<td>$753.00</td>
<td>$316.00</td>
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<td>5</td>
<td>Cardiopulmonary – Medical Consultant</td>
<td>$1,130.00</td>
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<td>- Chair</td>
<td>$377.00</td>
<td>$396.00</td>
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<td>1150</td>
<td>Actual time spent in excess of 3 hours (per hour)</td>
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<td>$396.00</td>
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<tr>
<td>150</td>
<td>- Member</td>
<td>$903.00</td>
<td>$948.00</td>
</tr>
<tr>
<td>1050</td>
<td>Actual time spent in excess of 3 hours (per hour)</td>
<td>$301.00</td>
<td>$316.00</td>
</tr>
<tr>
<td>15</td>
<td>Medical Review Panel</td>
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<td>$1,581.00</td>
</tr>
<tr>
<td></td>
<td>- Chair</td>
<td>$377.00</td>
<td>$396.00</td>
</tr>
<tr>
<td>1115</td>
<td>Actual time spent in excess of 4 hour (per hour)</td>
<td>$377.00</td>
<td>$396.00</td>
</tr>
<tr>
<td>1015</td>
<td>- Member</td>
<td>$1,205.00</td>
<td>$1,265.00</td>
</tr>
<tr>
<td>1215</td>
<td>Actual time spent in excess of 4 hours (per hour)</td>
<td>$301.00</td>
<td>$316.00</td>
</tr>
<tr>
<td>190</td>
<td>Medical Board</td>
<td>$753.00</td>
<td>791.00</td>
</tr>
<tr>
<td></td>
<td>- Member</td>
<td>$301.00</td>
<td>$316.00</td>
</tr>
<tr>
<td>85</td>
<td>Chaperone Fee (per 15 minutes)</td>
<td>$75.30</td>
<td>$79.07</td>
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</tbody>
</table>

**Doc # 7.2.13  Medical Fees – Physicians (PRO 55/2015)**
7.2.14 Health Care Services – Exercise Therapists (PRO 53/2015)

Document Date 07 July 2015

Purpose To provide administrative guidelines for approving and evaluating exercise therapy services.

BACKGROUND

1. Upon Workers’ Compensation Board (WCB) approval, a worker entitled to benefits under The Worker’s Compensation Act, 2013 (the “Act”) is also entitled to (Section 103):
   a. Any medical aid that may be necessary as a result of the injury.
   b. Any other treatment by a health care professional.
   c. Any prosthetic or apparatus that may be necessary as a result of the injury, and
   d. Any transportation or sustenance occasioned by the medical aid.

2. The WCB is authorized to determine health care services fees (Section 104).

PROCEDURE

General

1. Exercise therapists who hold a Certified Exercise Physiologist (CEP) designation and are providing services to WCB clients can access the following at www.wcbsask.com:
   a. The Accreditation Standards and Service Provider Guidelines for Exercise Therapists Providing Primary Level Services to WCB clients (“practice standards”).
   b. Accreditation requirements.
   c. Fees.
   d. Reporting forms, and
   e. Primary Authorization to Treat forms.

The Saskatchewan Kinesiology and Exercise Science Association (SKESA) and the WCB will negotiate changes to these documents as needed.

2. The Claims Entitlement Specialist (CES) or Case Manager (CM) will review completed Primary Authorization to Treat forms with attached referrals to make sure:
   a. The service is related to the work injury.
   b. The CEP is WCB accredited.
c. The referral is made by a:
   i. Physician
   ii. Physical Therapist, or
   iii. Chiropractor.

d. The referral notes the goals of exercise therapy.

3. Exercise therapy is considered a component of Physical Therapy and/or Chiropractic services offered by a clinic that has obtained WCB authorization to treat and invoice.

4. An initial assessment report will be sent to the WCB within three working days of the first appointment. This report should include the objectives of the treatment, as well as an anticipated discharge date. Progress reports (TXP) only need to be filed if there are changes to the treatment plan or anticipated discharge date. The discharge summary (TXD) should be sent within three days of discharge.

5. Payment will only be authorized for services performed by an accredited CEP who appears on the WCB Approved Provider List.

6. The WCB may refuse payment if conditioning is provided prior to the specified timelines acknowledged in the practice standards (i.e., aerobic conditioning, regional conditioning, functional conditioning, and functional testing).

7. WCB will cease funding for treatment when no functional gains are being made or when there are indications that the client has recovered from the work injury.

8. If a claim is subsequently denied following approval, WCB will be responsible for payment up to the date of disallowance notification.

9. Compliance with the practices standards may be evaluated through a survey process performed jointly by the WCB and SKESA.

Act Sec # 55, 103, 104, 111, 115(c)
Effective Date 01 August 2015
Application All injured workers requiring exercise therapy services.
Supersedes PRO 56/2012 Medical Fees – Exercise Therapists
Complements POL 05/96 Health Care Services
7.2.15 Medical Fees – Psychologists (PRO 51/2014)

Document Date 18 February 2014

Purpose To establish fees and guidelines for psychologists treating workers.

BACKGROUND

1. Upon Workers’ Compensation Board (WCB) approval, a worker entitled to benefits under The Workers’ Compensation Act, 2013 (the “Act”) is also entitled to (Section 103):
   a. Any medical aid that may be necessary because of the work-related injury.
   b. Any other treatment by a health care provider.
   c. Any orthotic appliance or apparatus that may be necessary as a result of the injury, and
   d. Any travel and sustenance costs associated with receiving medical treatment as a result of the injury.

2. The WCB is authorized to determine health care services fees (Section 104(1)).

3. Under the advice of the WCB Psychological Consultant, the WCB developed practice guidelines.

PROCEDURE

General

1. To provide services to injured workers, psychologists must:
   a. Be accredited by the WCB.
   b. Be fully licenced members in good standing of the SCP, and
   c. Hold the Authorized Practice Endorsement (APE).

2. Psychologists must comply with:
   a. Practice Guidelines for Psychologists Providing Primary Level Services and Assessment Services to WCB Clients (Schedule A).
   b. Service Fees and Fee Codes for WCB Psychology Service Providers – Primary Level Care and Assessment Services (Schedule B).
   c. The ethical requirements of the SCP.
   d. The continuing education requirements set by the SCP, and
   e. The Act.
3. Accredited psychologists are responsible for all assessments, treatment and reports. Psychologists cannot delegate these responsibilities to interns or other providers within the same office without the approval of the Manager of Health Care Services or the WCB Psychological Consultant. MHCS will note on the claim file if the psychologist can delegate their responsibilities.

**Practice Guidelines**

4. Schedule A provides the practice guidelines for psychologists treating injured workers.

5. If a physician refers the worker to the psychologist, the psychologist must send a Primary Level Authorization to Treat – Psychology/Counsellors form to the WCB before treating the worker. Psychologists can only begin treatment once they hear from the WCB. The WCB will not pay for treatment that begins before approval.

6. If the WCB refers the worker to a psychologist, the psychologist does not need to send a Primary Level Authorization to Treat form to the WCB before treating the worker.

7. Treatment must begin within two weeks from the date of the referral.

8. The psychologist will send an initial report (PSYI) to the WCB within three business days of the initial assessment. After the initial assessment, unless the WCB says otherwise, psychologists can provide whichever occurs first:
   a. Three treatments, or
   b. Three hours of service.

9. Within the first week of treatment, the psychologist must get consent from the worker to release information for the purpose of WCB reporting. The psychologist will then contact the employer to see if they can accommodate the worker’s return-to-work. If accommodated work is available, the psychologist will develop a return-to-work plan with the help of the:
   a. Worker.
   b. Employer.
   c. Primary care provider, and
   d. WCB.

10. If the worker needs more treatment after the initial three treatments or three hours of service, the psychologist will send a progress report (PSYP) to the WCB within three business days of the last treatment. Unless the WCB says otherwise, psychologists can provide whichever occurs first:
    a. Three treatments, or
b. Three hours of service.

The psychologist will send progress reports (PSYP) to the WCB for each extension within three business days of the last treatment.

11. If the worker has not had treatment for more than 30 days and needs more treatment, the psychologist must send a Primary Level Authorization to Treat – Psychology/Counsellors form. Psychologists can only begin treatment once they hear from the WCB. The WCB will not pay for treatment that begins before approval. However, if treatment is ongoing but at a pace that exceeds 30 days between treatment sessions, Psychologists may start treatment before hearing from the WCB (e.g., the worker has Post Traumatic Stress Disorder flair-ups and requires treatment three to six times a year).

12. If the WCB denies further services or re-adjudicates a worker’s entitlement to psychology benefits after initially confirming that the WCB would fund care, the WCB will pay for services up to the date of notification. The WCB will charge the costs of these claims to the administrative fund.

13. If psychologists send initial reports (PSYI) later than three days of the initial assessment, or progress/discharge reports (PSYP) later than three days of the third visit, exclusive of the initial assessment, the WCB will subtract 30 percent from the rate noted in the fee schedule. MHCS will contact psychologists (by phone and in writing) that continually send PSYI or PSYP reports late to the WCB. MHCS will issue a final warning if the late reporting continues. Thereafter, the WCB will not pay for services that psychologists provide if reports are late.

14. MHCS may arrange a mental health assessment if the worker does not go back to regular job duties after four weeks from the date of injury. If the worker is not progressing, the psychologist will tell the WCB that the worker needs another assessment. The psychologist can continue treating the worker while waiting to hear from the WCB only if the worker will benefit.

15. MHCS will arrange neuropsychological and vocational-psychological assessments.
   a. Within three weeks of a neuropsychological assessment, the neuropsychologist will send reports to the WCB and primary care provider. The reports will include the WCB question template.
   b. Within two weeks of a vocational-psychological assessment, the psychologist will send reports to the WCB and primary care provider.

16. The psychologist will send a discharge report (PSYP) to the WCB within three business days of discharge.
Assessment/Extension Review

17. Claims Entitlement Specialists (CES) will review Primary Level Authorization to Treat – Psychology/Counsellors forms, initial reports (PSYI) and progress/discharge reports (PSYP) that the WCB gets within the first four weeks post-injury. Case Managers (CM) will review reports that the WCB gets after four weeks unless Claims Entitlement retains the file.

18. CESs and CMs can request the assistance of the WCB Psychological Consultant at any time during the review of claims.

19. If the CES, CM or WCB Psychological Consultant finds that the WCB should deny coverage, the file manager will tell the psychologist.

Evaluations

20. Psychologists treating workers automatically agree to participate in any quality assurance programs that the WCB develops.

21. MHCS will send letters to psychologists that do not comply with Schedule A. Letters will outline appropriate corrective actions. Psychologists that do not comply may lose their WCB accreditation.

Complaints and Dispute Resolution

22. Workers can report complaints of any nature to the WCB. The WCB employee receiving the complaint may refer the complaint for resolution to other WCB staff including the Manager of Health Care Services. If the complaint alleges professional incompetence or misconduct by a care provider, the Manager of Health Care Services will direct the complainant to the SCP.

23. MHCS will note all complaints and resolutions on the service provider’s accreditation file.

24. Workers who want to see a different provider can either contact one directly, or see the primary care provider who made the initial referral.

Fees

25. Schedule B provides increases to psychological service fees on:
   a. 01 April 2014.
   b. 01 April 2015, and
   c. 01 April 2016.
These fees will remain in effect until the WCB determines further increases.
26. Workers will never pay for psychological services. Psychologists will always direct bill the WCB. Psychologists will adhere to Schedule B and will not extra bill workers.

27. The WCB will stop paying for psychological care when the:
   a. Worker is not making any functional gains (unless awaiting further treatment).
   b. Worker is recovered from the effects of the work-related injury.
   c. Psychologist does not maintain accreditation credentials.
   d. Psychologist does not send required psychological reports.

ATTACHMENTS

Schedule “A” - Practice Guidelines for Psychologists Providing Primary Level Services and Assessment Services to WCB Clients

Schedule “B” – Service Fees and Fee Codes for Saskatchewan Workers’ Compensation Board Psychology Service Providers – Primary Level Care and Assessment Services


<table>
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<th>Act Sec #</th>
<th>55, 103, 104, 115(c)</th>
</tr>
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<td>Effective Date</td>
<td>01 April 2014</td>
</tr>
<tr>
<td>Application</td>
<td>All claims where workers require primary psychological care</td>
</tr>
<tr>
<td>Supersedes</td>
<td>PRO 54/2010 Medical Fees – Psychologists</td>
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<tr>
<td>Complements</td>
<td>POL 02/97 Health Care Services Fees</td>
</tr>
</tbody>
</table>
1. **Introduction**

The intent of this document is to set out the WCB service provider guidelines for Psychologists providing the following services to WCB clients, hereafter referred to as “care providers”:

a. Primary level assessment and counselling services
b. Mental health assessment team reviews
c. Neuropsychological assessments
d. Vocational-psychological assessments

All care providers to WCB clients shall comply with the guidelines in this document, in addition to any practice standards and ethical requirements of the licensing body – the Saskatchewan College of Psychologists (SCP).

Any care provider accredited to provide care to WCB clients who does not wish to be bound by any current or upcoming agreement should immediately notify WCB Health Care Services that the care provider wishes to withdraw from providing services to WCB injured workers.

By virtue of providing care to a WCB client, care providers indicate their willingness to follow the provisions of any current or subsequent agreement with a professional standards or regulatory body.

WCB accreditation is designed to ensure WCB clients receive care from well-qualified professionals who are independent of adjudication, insurance decisions, and employer influence. WCB providers provide information regarding the need for continued treatment, return to work (RTW) and the need for further assessment and treatment. The “Psychologist Support Package” should be consulted for additional details.

2. **Practice Standards**

General Requirements and Standards for Psychology Care Providers:

NOTE: Items 1 – 9 provide general standards for providers. Item 10 contains the information regarding standards for specialized services.

a. All care providers providing services to WCB clients shall be fully licensed members in good standing with the Saskatchewan College of Psychologists and shall hold the Authorized Practice Endorsement (APE). The APE designation legally entitles the provider to communicate diagnostic information (i.e., formal
diagnoses, symptoms, traits, symptom levels, and overall assessment of functioning). The WCB requires such information on an ongoing basis.

b. The decision to accredit a psychologist as a WCB provider is internal to the WCB. Holding a license to practice and an APE designation are necessary, but not sufficient qualifications.

c. Psychologists providing primary level care shall hold at a minimum a Master’s or Doctoral degree in clinical or counselling psychology.
   i. Including clinical training and internships from a provincially or state accredited university (i.e., an institution created by an act of legislature or equivalent);
   ii. Distance education models and “on-line” degrees not requiring actual residency at a university are not considered acceptable;
   iii. Continuing education and workshop attendance is not considered equivalent to academic and formally supervised training;
   iv. Degrees in other fields will not qualify, even if the degree holder is licensed by the College of Psychologists;
   v. Practitioners who do not qualify to provide services to the WCB may consider consulting the standards for re-qualification of the Canadian and American Psychological Associations;
   vi. Specific service areas beyond primary care have additional qualification requirements. See item 10 in this section for details.
   vii. The WCB’s decision is final in all determinations.

d. For qualification at the Master’s level it is expected that the full 3-4 month summer internship is complete, and for the Doctoral level, that the 12 month pre-doctoral internship is complete. This is in addition to usual practice requirements for the clinical or counselling degree.
   i. Internships in non-health care settings are not considered sufficient to meet this requirement (e.g. a school or child guidance setting). Practitioners will be asked to provide an attestation that the internship has occurred in a health care setting.
   ii. Practitioners must practice in areas that they are qualified to do so by their academic and supervised service delivery training.
   iii. The WCB’s decision is final in all determinations.

e. Psychologists shall have the ability to practice independently without supervision. The only exception may be in situations of fully qualified practitioners at the doctoral level, following the pre-doctoral internship, with only research requirements outstanding in qualification for the doctoral degree. There is a two year limit to obtain independent licensure.
   i. This typically applies to practitioners who are awaiting award of a doctorate following the completion of the pre-doctoral internship and who did not receive a Master’s degree following a baccalaureate;
   ii. They are considered on a case by case basis, and are time limited;
iii. Such an arrangement is considered temporary and is approved only by the discretion of the WCB, which will make decisions on a case by case basis, taking into account, among other things, the merits of the individual situation and its needs for services.

iv. It will be usually required that all documents submitted to the WCB are co-signed by a WCB-accredited provider.

v. There is no precedent set by approval in any specific situation. The WCB’s decision is final in all cases.

f. Psychologists intending to practice as providers for the WCB should ensure that their psychological training is sufficient to justify their competency to practice with the WCB. Professional associations and licensing bodies may also have advice about training. Among the relevant areas are:
   i. Provision of psychological services in legal situations;
   ii. Health psychology and psychology in medical situations;
   iii. Psychological trauma;
   iv. Employment and work issues;
   v. Psychological testing and assessment;
   vi. Ethical issues when working in quasi-legal situations and with third parties.

   Practitioners will be asked to provide an attestation that they reviewed the standards document and any advisories on the WCB website.

g. Psychologists who wish to provide psychological services to WCB clients shall apply for WCB accreditation as a WCB psychological service provider. Information required for consideration of accreditation includes:
   i. Copies of all relevant academic degrees or diplomas;
   ii. University academic transcripts from provincially or state accredited institutions;
   iii. Copy of current practice license (dated to current year, or renewal card);
   iv. Copy of APE certificate;
   v. Copy of academic internship certificates (not continuing education certificates);
   vi. Copy of malpractice insurance (malpractice insurance is available from the Canadian Psychological Association);
   vii. WCB accreditation application form.

h. All assessment, treatment and reports shall be provided by the accredited care provider and shall not be delegated to others (i.e., psychometrists, students, interns, etc.), or to other providers in the same office, without the agreement of the Manager of WCB Health Services or the WCB Psychological Consultant.
   i. Practicum students and interns may accompany and observe the service provision only if the WCB accredited psychologist is present.
   ii. Specific test supervision and administration of instruments for specialized assessment services (neuropsychological, mental health and vocational assessments) may involve psychological assistants for these specific functions only. The accredited provider shall provide all other aspects of the assessments other than these routine testing functions as is usual in
psychological assessment practice. The accredited provider has the responsibility for the entire assessment in such situations.

iii. The WCB’s determination is final in all decisions about the conduct of assessments.

iv. Care providers shall not include in any advertising or promotional material information regarding affiliation or accreditation with the WCB.

i. Advanced Psychological Services. The WCB requires additional qualifications to provide psychological services in several specific service areas. These requirements are in addition to those stated above. The areas of advance psychological services are: mental health assessments, neuropsychological assessments, and vocational-psychological assessments. The additional qualifications are:

   i. Mental Health Assessments:
   (a) Doctoral level practice degree, including pre-doctoral internship;
   (b) 5 years of experience post-doctorate;
   (c) The WCB’s determination shall be final in all situations.

   ii. Neuropsychological Assessments:
   (a) Doctoral level practice degree, including pre-doctoral internship;
   (b) Evidence of specialization in neuropsychology; the pre-doctoral internship shall contain evidence of neuropsychology specialization;
   (c) Completion of one year (minimum) post-doctoral fellowship or the equivalent in documented post-doctoral supervised practice, with full submission of the details of the supervision as required by the WCB;
   (d) 5 years of experience post doctorate;
   (e) The WCB’s determination shall be final in all situations.

   iii. Vocational-Psychological Assessments:
   (a) Minimum of a Master’s degree in psychology;
   (b) 5 years of experience in providing vocational assessments and documentation of this experience as requested by the WCB;
   (c) The WCB’s determination shall be final in all situations.

3. Authorization to Treat and Invoice

On receipt of a client not referred by the WCB who identifies that the need for psychological care is related to work injury, the care provider shall submit to the WCB a form titled “Primary Level – Authorization to Treat” located on the WCB website, which will elicit from the WCB a response regarding WCB’s responsibility for the condition necessitating treatment and for direct billing of the WCB.

If the worker has not had treatment for more than 30 days and wants more treatment, the psychologist must send a Primary Level Authorization to Treat – Psychology/Counsellors form. Psychologists normally have to wait to hear from the WCB before they can resume treatment, otherwise they will not get paid. Psychologists can only start treatment before hearing from the WCB if treatment is ongoing but at a pace that exceeds 30 days between treatment sessions (e.g., the
worker has Post Traumatic Stress Disorder flair-ups and requires treatment three to six times a year).

Forms, letters and other documentation should be faxed to the WCB which scans documents directly to computer-viewable files, allowing all appropriate personnel at WCB to access the file. Follow up hard copies of facsimiled reports are neither required nor desired.

Once direct billing has been confirmed by the WCB, intake and initial assessment shall move forward as expeditiously as possible.

It is expected that workers referred to treatment will be seen as soon as possible, and no later than 2 weeks following the date of referral.

An initial assessment report shall be submitted to the WCB within three days of the first appointment, using a form (PSYI) provided by the WCB for psychology intake reports.

Progress reports are required every three sessions or three hours of service provision, whichever occurs first. Reports shall be submitted at least monthly using a form or format (PSYP) provided by the WCB. Discharge reports are also required within 3 days of the discharge using the PSYP form.

The WCB requires diagnostic information and recommendations based on objective and well-documented psychological and medical findings. Where a diagnosis or treatment plan is being revised, objective psychological assessment, which may include WCB-referred mental health assessment, is required. Diagnosis is considered to be all of the DSM-IV-TR axes, which includes level of functioning and improvement in symptom levels. Further information is available in the WCB Advisories to Psychologists on the WCB website (http://www.wcbsask.com/care-providers/psychologist/).

The WCB has responsibilities to several stakeholders. The WCB personnel must consider all claim-related information when making decisions, of which medical and psychological information is but one part of the whole.

Advocacy or lobbying on behalf of the employer or worker regarding causation or ongoing benefits is considered undesirable and poor professional practice;

a. Psychologists treating WCB workers have both an individual client in the worker and a corporate client in the WCB;

b. A care provider is advised to avoid an advocacy role by directing the worker to the WCB appeals process and the Fair Practices office;

c. The Psychology Advisories should be consulted for further information.

Where conflict or potential conflict of interest exists, or a dual relationship, the care provider shall inform the WCB and other parties as appropriate. If the care provider’s employer has a financial relationship with the employer of an injured worker, that relationship shall be disclosed to the worker in writing so that the worker may make an informed choice regarding choice of care provider.
4. **Treatment Guidelines**

Client shall receive care for the diagnosis arising out of the work injury. Non-work injury related diagnoses should not be the focus of treatment. Notwithstanding this, if brief attention to non-work related issues will smooth the path to return to work (RTW), such brief attention is not ruled out, e.g. part of a session meeting with worker and spouse to provide information or clarification. This shall be reported to the WCB on PSYI or PSYP or additional letter to the WCB.

Psychologist shall ensure that consent for treatment, and consent for release of information to the WCB is discussed and documented. The psychologist has a statutory requirement to report to the WCB, which does not obviate the responsibility to manage consent in accordance with normal practice standards. The Psychologist must make the worker aware of the WCB reporting requirements.

Psychologists shall establish communication with employers at the outset of treatment and the worker needs to be aware that the Psychologist will be communicating with the employer and other RTW partners (e.g., union).

Temporary restrictions for work, if any, should be clearly communicated to the worker, the employer, the Primary Care Provider (usually the family physician), and the WCB as soon as possible, generally no later than the second or third appointment – otherwise as soon as the information is available – so that discussions of alternate work and accommodated return to work can be arranged. A psychologist’s communication of temporary restrictions for return to work will generally be accepted so as to facilitate return to the workplace, which has been clearly shown to encourage recovery.

The “return to work partners” (employee, employer and WCB) need to be guided by the psychologist and primary practitioner until return to work at pre-injury duties has been achieved. It is expected that psychologists shall arrange for RTW discussions as soon as possible, arranging for communication with all parties. This will involve direct discussion with employers in many or most cases regarding functional restrictions for work. Psychologists need to ensure that the appropriate consent is obtained to provide work restriction information.

a. It is work restriction information that is to be disclosed so as to facilitate return to work; general information release of medical or psychological information is not considered appropriate, and the psychologist should inform employers that they may communicate directly with WCB regarding such requests for additional information.

b. Because of the requirement to communicate with the involved parties, it is important that such consent is obtained at the start of the treatment. If a worker refuses such communication with the employer, the psychologist shall inform the WCB as soon as possible.

It is important that RTW information contain information about restrictions, progressions toward full duties, increases of hours of work and overall time frames for full return to work. Employers are entitled to receive information about restrictions
for work and return to work from the treating practitioners, but not diagnostic or other personal and/or medical information.

Suggestions for permanent restrictions will generally require more information, generated in most cases by a referral by WCB for a mental health or other assessment. It is not considered helpful to create expectations for a worker of permanent restrictions, for redeployment in the workforce, retraining, etc., before the required additional information and assessments is gathered by WCB.

In most cases, actual behavioral treatment is supported to assist the worker with managing any form of return to work, e.g., desensitization followed by in vivo exposure (i.e., the patient confronting feared objects, activities, or situations in the presence of a psychologist).

5. **Discharge Guidelines**

Clients should be discharged from treatment when there are no functional gains being made, when the client has recovered from the work injury, when WCB advises of no further responsibility, or when three treatments are completed and the WCB has not received a PSYP form. The WCB may also decide to cease funding if the care provider fails to maintain the accreditation credentials or neglects to file the required psychological reports.

Where a previously discharged worker requests care after discharge or after non-attendance at the clinic greater than 30 days, the care provider will need to submit the Primary Level – Authorization to Treat form, to confirm funding prior to resuming care. There may be rare exceptions to this where follow-up treatment at greater intervals has been pre-approved by the WCB case manager, but it should never be assumed.

6. **Identifying the Need for Assessment**

When the worker with a mental health claim has not resumed regular job duties within four weeks of injury, or when the worker is not progressing satisfactorily and has not recovered from the work injury, the care provider should advise WCB that a Mental Health Assessment Review is indicated as a means of preventing chronic disability. Exceptions may occur when the return to work process is delayed only by a short interval; this should not be assumed. The psychologist will continue to provide treatment while waiting for an assessment only where there is a benefit to continued treatment.

Input of the WCB Psychology Consultant can be obtained by contacting the WCB at 787-4370 or toll-free at 1-800-667-7590 or calling directly to 933-7913.

Once the mental health assessment report is received, the WCB Health Services Unit will communicate with the Primary Practitioner regarding his or her wishes related to the recommendations that have been made, advising the current psychologist if services are to be continued.
Practitioners may advise the WCB as to their opinions regarding other assessments, e.g. neuropsychological, but should be cautious because there is a risk of creating expectations that this will be approved by the WCB. The decision to make such a referral rests with the WCB based on consideration of all parts of the file.

7. **Record Keeping**

Although the WCB requires specific forms to be completed and submitted, psychologists shall comply with all usual standards regarding clinical notes that form part of clinical record for that worker, but not submitted to the WCB. At times, the Psychology consultant may ask to see additional file information including raw test results, test profiles and WCB may ask to see clinical notes.

Charting and storage of health information shall meet all requirements of the Saskatchewan College of Psychologists and all professional ethical standards, the Health Information Privacy Act (HIPA), *The Workers’ Compensation Act, 2013*, and any other applicable legislation.

When the worker requests a copy of the client chart or file, the information, excluding information received from the WCB, shall be provided in any manner directed by the SCP and consistent with professional ethical codes. The worker is to be advised that WCB documents (i.e., claim, medical and psychological documents created by others) should be requested from WCB (the “owner” of those documents) and that the policies and procedures of the WCB will apply to provision of these documents.

8. **Duty to Report Work Injury**

*The Workers’ Compensation Act, 2013* states:

Section 55

Any health care professional who attends to or is consulted with respect to an injury to a worker shall:

(a) Furnish the board with any reports with respect to the examination or treatment of the worker that are relevant to the injury for which compensation is claimed;

(b) Give all reasonable and necessary information, advice and assistance to the injured worker or the worker’s dependents in making an application for compensation; and

(c) Furnish any certificates and proofs that the board may be required

To ensure all injured workers receive the benefits to which they are entitled, and to ensure accurate information when employer rates are set, a psychologist providing treatment to a client injured at work shall report the injury to the WCB via the PSY form.

The worker should also be advised to report the injury to WCB via telefile 1-800-787-9288 or by completing a Worker’s Report of Injury form, which may be attached to the care provider’s form. WCB forms for workers are also available online at [http://www.wcbsask.com/](http://www.wcbsask.com/).
Employers also have a legal requirement to report to the WCB any injury or illness arising out of work. Care providers shall ensure they are not party to any claim suppression by reporting treatment of work injury in the manner described in this document.

9. **Reporting to WCB**

Where the psychologist is providing primary level counselling services, the initial assessment findings shall be sent to the WCB and the Primary Care Provider within three days of the assessment using form PSYI.

A request for extension/progress note shall be sent after each three treatments where further treatment is required using form PSYP.

A discharge summary shall be sent within three days of discharge.

Neuropsychological Assessment reports shall be provided to the WCB and the Primary Care Provider within three weeks of the date of the assessment. The Neuropsychologist may use a report format of choice, but must attach the WCB question template.

The Vocational/Psychological report shall be sent to the WCB within two weeks of the assessment date using the reporting format of the psychologist.

Reporting forms are posted to the WCB website [http://www.wcbsask.com](http://www.wcbsask.com) for use of Psychologists and may be revised from time to time.

Where the care provider is monitoring a RTW arrangement, a RTW schedule and particulars shall be provided to the WCB prior to its commencement. If revisions are necessary, notification of WCB should occur.

WCB reporting processes are subject to periodic revision.

10. **Confidentiality**

All health-related and personal information received during the course of treatment of a WCB client shall be treated in a confidential manner, and no information will be revealed to any person or party other than those persons for whom consent has been obtained and for whom there is legal requirement to do so, and as designated by the WCB.

Information pertaining to functional ability only may be provided to the employer for purposes of establishing a return to work arrangement. Employers are not entitled to diagnostic information or personal details. Professional practice consent is the responsibility of the psychologist, including the use of appropriate consent forms.

All public relations work, interviews, public appearances, and press releases related to services being provided to WCB clients require WCB approval.

No care provider shall, without prior written approval of the WCB, publish or allow to be published any work that relies upon or uses information or data obtained by the
care provider, except for program evaluation research where the workers treated are not identifiable as a group.

No care provider shall use their accreditation or provision of services to the WCB in an advertising or similar public communications.

WCB shall be informed of plans for research involving WCB patients, with full discussion and information to be disclosed for consideration before research commences.

11. Return to Work (RTW)

Within the first week of treatment, a treatment care provider shall contact the employer of any worker not at full work to determine the availability of accommodated duties (work suitable to the worker’s medical and psychological findings as he/she transitions from work restrictions to full fitness for work).

Where accommodated work is made available by the employer, who has a legislated requirement to do so, the care provider shall make reasonable effort to coordinate a RTW plan, with the cooperation of the Primary Care Provider, the worker, the employer and the WCB.

The duration of the RTW plan shall be based on clinical judgment regarding the injury and resulting condition, the expected recovery time frames, available from the Medical Disability Advisory and from WCB Health Services.

Where any RTW partner is not cooperative with RTW planning, the care provider shall advise the WCB that a barrier to recovery has occurred, asking the WCB for assistance. The resulting RTW plan will be forwarded to the WCB as an addendum or a separate document and shall be resubmitted should revisions to the original plan occur.

12. Facility

There shall be adequate space, facilities, and equipment so as to provide care. It is expected that care will be delivered in a setting that provides for appropriate client privacy and confidentiality.

The space shall be adequately accessible for the type of clients served;

The space shall be adequately private or sound-proofed;

In the absence of the standards from the professional association and licensing body, adequacy shall be determined by WCB.

13. Continuing Education

When new staff joins a practice or clinic, they shall apply for accreditation before providing services.

New staff shall be fully oriented to the requirements of providing services to WCB clients, also including training in any relevant emergency procedures, and processes
established within the clinic to provide care and return to work planning to WCB clients, including review of this document.

Compliance with continuing education (CE) requirements set by the Saskatchewan College of Psychology (SCP) is required as a minimum. Care providers are encouraged to participate in continuing education specific to health psychology, rehabilitation, pain and psychosocial problem management

14. Quality Assurance

By virtue of accepting WCB clients for treatment, all care providers agree to participate in any quality assurance programs developed by WCB.

Ethical and practice processes per professional guidelines and licensing bodies should also be reviewed and are the responsibility of the psychologist.

15. Terms of Agreement

These Service Provider Guidelines and Service Fees shall be honored by all parties until revised versions are endorsed by the WCB. If discussions regarding the Service Provider Guidelines or Service Fees are in process, these documents shall stay in effect until such time as the new terms for Service Provider Guidelines and Service Fees are implemented.

16. Ongoing Relationship

The WCB values the input of psychologists into decisions affecting care of workers. Ongoing input will be obtained via the WCB Psychology Consultant.
### SCHEDULE “B”

**Service Fees and Fee Codes For WCB Psychology Service Providers**

**Primary Level Care and Assessment Services**

The following WCB fee codes and fees are to be used to bill for services provided to WCB clients by psychologists accredited by the WCB to provide primary level services to WCB clients. Prorated fees are billed to the next higher one-quarter hour, with clients scheduled in an ethical manner.

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<th>SERVICE</th>
<th>CODE</th>
<th>April 1, 2014</th>
<th>April 1, 2015</th>
<th>April 1, 2016</th>
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<tr>
<td>Initial Assessment or Counselling Session</td>
<td>4000</td>
<td>$123.05/hr</td>
<td>$131.66/hr</td>
<td>$140.88/hr</td>
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<tr>
<td>PhD level provider</td>
<td>4001</td>
<td>$98.44/hr</td>
<td>$105.33/hr</td>
<td>$112.70/hr</td>
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<tr>
<td>MA level provider**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocational Psychological Assessment***</td>
<td>3008</td>
<td>$129.20/hr to a maximum of 20 hrs</td>
<td>$138.25/hr to a maximum of 20 hrs</td>
<td>$147.92/hr to a maximum of 20 hrs</td>
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<tr>
<td>Neuro-Psychological Assessment***</td>
<td>3007</td>
<td>$184.58/hr to a maximum of 17 hours</td>
<td>$197.50/hr to a maximum of 17 hours</td>
<td>$211.32/hr to a maximum of 17 hours</td>
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<td>Mental Health Assessment***</td>
<td>3000</td>
<td>$129.20/hr to a maximum of 15 hours</td>
<td>$138.25/hr to a maximum of 15 hours</td>
<td>$147.92/hr to a maximum of 15 hours</td>
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<tr>
<td>Primary Level Care Initial Assessment (PSYI form) Report fee if submitted within three days of the initial assessment</td>
<td>4003</td>
<td>$50.61</td>
<td>$54.15</td>
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<td>Primary Level Care Initial Assessment (PSYI form) Report fee if submitted later than three days of the initial assessment</td>
<td>4013</td>
<td>Subtract 30 percent</td>
<td>Subtract 30 percent</td>
<td>Subtract 30 percent</td>
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<td>Primary Level Care Progress/Discharge (PSYP form) Report if submitted within three days of every third visit, exclusive of the initial assessment visit</td>
<td>4004</td>
<td>$31.46</td>
<td>$33.66</td>
<td>$36.02</td>
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<td>Primary Level Care Progress/Discharge (PSYP form) Report fee if submitted later than three days of the third visit, exclusive of the initial assessment visit</td>
<td>4014</td>
<td>Subtract 30 percent</td>
<td>Subtract 30 percent</td>
<td>Subtract 30 percent</td>
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</table>

*Fees for Psychologists working with secondary and tertiary assessment teams and treatment centers are negotiated with the Coalition of Physical Rehabilitation Centers (CPRCS).

**Includes additional time spent on communication with WCB and employers and time spent preparing reports other than the PSYI and PSYP such as RTW planning and documentation.

***May bill 60% of the expected billing where the worker does not attend assessment or where the WCB provides less than 48 hours cancellation notice.

Contact Numbers:

Medical Accounts Inquiry Line: 306-787-4412
Psychology Consultant: 306-933-7913

Invoice Inquiries:
Manager, Health Care Services: 306-787-7760
**WCB BILLING PROCESS**

**EXAMPLE – MONTHLY BILLING**

<table>
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<th>Service Provider: ABC Clinic</th>
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<tr>
<td>999 – 1st St.</td>
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<tr>
<td>Saskatoon, SK S4X 7S9</td>
</tr>
<tr>
<td>Phone: 777-9999 Fax: 777-888</td>
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<tr>
<td>Caregiver Billing Number: PSY 079990</td>
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<table>
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<th>Claimant's Name: Sally Smith</th>
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<tbody>
<tr>
<td>111 Albert ST.</td>
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<tr>
<td>Saskatoon, SK S7K 9C4</td>
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<tr>
<td>Claim Number: 1007 9786</td>
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<table>
<thead>
<tr>
<th>Fee Descriptor</th>
<th>Fee Code</th>
<th>Number of Units of Care</th>
<th>Total</th>
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<tbody>
<tr>
<td>Mental Health Assessment</td>
<td>3000</td>
<td>15</td>
<td>$2,218.80</td>
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<tr>
<td>Initial Assessment (PHD)</td>
<td>4000</td>
<td>3</td>
<td>$422.64</td>
</tr>
</tbody>
</table>

**Total of all services for billing period:** $2,641.44

Billing period is June 1 to June 30, 2014
Treatment start date is June 12, 2014
Service provided was a three hour Initial Assessment (PHD) and a 15 hour Mental Health Assessment.
In billing period June 1 to June 30, 2014, a 15 hour Mental Health Assessment was billed in error. Only a 14 hour Mental Health Assessment was provided.
7.2.16 Health Care Services – Massage Therapists (PRO 52/2015)

Document Date 29 April 2015

Purpose To provide administrative guidelines for approving and evaluating massage therapy services.

BACKGROUND

1. Upon Workers’ Compensation Board (WCB) approval, a worker entitled to benefits under The Workers’ Compensation Act, 2013 (the “Act”) is also entitled to (Section 103):
   a. Any medical aid that may be necessary because of the work-related injury.
   b. Any other treatment by a health care provider.
   c. Any prosthetic or apparatus that may be necessary as a result of the injury, and
   d. Any travel and sustenance costs associated with receiving medical treatment as a result of the injury.

2. The WCB is authorized to determine health care services fees (Section 104).

3. The practice standards, accreditation requirements, fees, reporting forms and primary authorization to treat forms for massage therapists (MT) providing services to WCB clients are available at www.wcbsask.com. The Massage Therapy Association of Saskatchewan (MTAS) and the WCB will negotiate changes to these documents as needed.

PROCEDURE

General

1. The Claims Entitlement Specialist (CES) or Case Manager (CM) will review completed Primary Authorization to Treat forms with attached referrals to make sure:
   a. The service relates to the work injury.
   b. The MT and massage therapy clinic have WCB accreditation.
   c. The referral is made by a:
      i. Physician
      ii. Physical Therapist, or
      iii. Chiropractor.
   d. The referral notes the goals of massage therapy.
   e. The worker is currently receiving active therapy (e.g., exercise therapy) from a:
i. Physical therapist, or
ii. Chiropractor.

2. The CES or CM will tell the MT in writing if they are authorized to provide care and invoice the WCB. If the MT is authorized, the CES or CM will also tell the MT:
   a. The WCB will only pay for up to five massage therapy treatments per claim.
   b. To direct bill the WCB.
   c. If an initial assessment, progress and/or discharge reports will be funded.

3. The WCB will not pay for any services provided before the MT receives approval.

4. The WCB will stop paying for massage therapy when the worker:
   a. Is not making any functional gains
   b. Has met the goals of massage therapy, or
   c. Receives five massage therapy treatments.

Evaluations

5. Medical and Health Care Services (MHCS) will perform ad hoc file reviews to ensure quality assurance.

6. MHCS will run monthly reports to track and evaluate quantitative variances and trends.

7. MHCS and the MTAS will monitor compliance with the:
   a. Service fees.
   b. Practice standards.

8. MHCS will issue letters to MTs that do not comply with the service fees or standards. These letters will outline appropriate corrective actions. Failure to comply with these actions may result in the loss of WCB accreditation.

Complaints and Dispute Resolution

9. Workers can report complaints of any nature to the WCB. The WCB employee receiving the complaint may refer the complaint for resolution to other WCB staff including the Manager of Health Care Services. If the complaint alleges professional incompetence or misconduct by a care provider, the Manager of Health Care Services will direct the complaint to the MTAS.

10. MCHS will note all complaints and resolutions on the service provider’s accreditation file.
11. Workers that want to see a different provider should discuss concerns with the primary care provider who made the initial referral.

**Act Sec #** 103, 104, 111, 115(c)
**Effective Date** 01 June 2015
**Application** All claims on and after the effective date
**Supersedes** PRO 50/2013 Medical Fees – Massage Therapists
**Complements** POL 05/96 Health Care Services
7.2.18 Medical Fees – Hearing Services (PRO 50/2015)

Document Date 17 April 2015

Purpose To provide administrative guidelines for approving and evaluating hearing services.

BACKGROUND

1. Upon Workers’ Compensation Board (WCB) approval, a worker entitled to benefits under The Workers’ Compensation Act, 2013 (the “Act”) is also entitled to (Section 103):
   a. Any medical aid that may be necessary because of the work-related injury.
   b. Any other treatment by a health care provider.
   c. Any prosthetic or apparatus that may be necessary as a result of the injury, and
   d. Any travel and sustenance costs associated with receiving medical treatment as a result of the injury.

2. The WCB is authorized to determine health care services fees (Section 104).

3. The Saskatchewan Association of Speech Language Pathologists and Audiologists (SASLPA) declined to represent its members in discussions with the WCB. Alternatively, the Saskatchewan Hearing Instrument Practitioners Society (SHIPS) helped develop practice standards, business rules and fees for hearing service providers.

PROCEDURE

General

1. The Claims Entitlement Specialist (CES) or Case Manager (CM) will review audiograms, hearing aid prescriptions and completed Primary Level Authorization to Treat – Hearing Services forms to make sure the:
   a. Service relates to the work injury. If required, the CES or CM can ask for help from the Medical Officer.
   b. Manufacturer’s cost of the prescribed hearing aid does not exceed $900 (plus 10 percent handling fee and actual shipping fee).
   c. Hearing service provider and clinic have WCB accreditation.

2. The CES or CM will notify the hearing service provider in writing if they are authorized to provide care and invoice the WCB. If the hearing service provider is
authorized, the CES or CM will notify the hearing service provider to direct bill the WCB.

3. The worker will pay all additional costs if they want an upgraded hearing aid that costs more than $900.

4. If the worker buys a hearing aid before submitting a claim to the WCB, and the claim is accepted, the WCB will pay up to $900.

5. Workers can see any WCB accredited hearing service provider:
   a. To receive a prescribed hearing aid.
   b. Regarding the service or repair of a prescribed hearing aid.

**Evaluations**

6. Medical and Health Care Services (MHCS) will perform ad hoc file reviews to ensure quality assurance.

7. MHCS will monitor compliance with the:
   a. Service fees.
   b. Business rules.
   c. Practice standards

8. If audits of hearing service provider files and WCB files show that prescribed hearing instruments are not medically justified, the prescribing hearing service provider may be subject to reconciliation costs.

9. MHCS will issue letters to hearing service providers that do not comply with the service fees, business rules or practice standards. These letters will outline appropriate corrective actions. Failure to comply with these actions may result in the loss of WCB accreditation.

**Complaints and Dispute Resolution**

10. Workers can report complaints of any nature to the WCB. The WCB employee receiving the complaint may refer the complaint for resolution to other WCB staff including the Manager of Health Care Services. If the complaint alleges professional incompetence or misconduct by a care provider, the Manager of Health Care Services will direct the complaint to the hearing service providers’ professional association.

11. MCHS will note all complaints and resolutions on the service provider’s accreditation file.
ATTACHMENTS

Schedule A – Practice Standards for Hearing Service Providers
Schedule B – Hearing Service Fees and Fee Codes – Effective 01 June 2015
Schedule C – Sample Invoice – Hearing Service Providers

Act Sec # 103, 104
Effective Date 01 June 2015
Application All new hearing loss claims on and after the effective date
Supersedes PRO 50/2010 Medical Fees – Hearing Service Providers
Complements POL 11/2012 Injuries – Hearing Loss
PRO 11/2012 Injuries – Hearing Loss
Schedule A
Practice Standards for Hearing Service Providers

The WCB has been unsuccessful in obtaining input from the SASLPA for the development of practice standards and a fee schedule to cover hearing service providers supplying services to WCB clients. By the provisions of Sections 103(2)¹ and 104(1)² of the Act, the WCB set a fee schedule in 2006, after reviewing the processes and fees of other jurisdictions, in particular Manitoba WCB whose injured worker population and business costs closely approximate those of the Saskatchewan WCB. In 2007, the Saskatchewan Ministry of Health and the Regina Qu’Appelle Health Region HAP were consulted to resolve the issues arising from legislative authority of both the Ministry of Health and the WCB to set medical fees. To serve injured workers in close proximity to their homes, a fee schedule has been developed that allows both HAP and private clinics to be reimbursed by the WCB.

In 2009, SHIPS indicated interest in serving WCB workers and expressed a willingness to sign a relationship agreement that SHIPS to be the sole representative of hearing service providers unless SASLPA signed a relationship agreement with the WCB. SHIPS offered to provide the WCB with input regarding standards of care, accreditation of hearing service providers, and appropriate fees.

All care providers supplying hearing services to WCB clients must comply with these standards of care noted below. In addition, hearing service providers must comply with the code of ethics governing their discipline (i.e., Canadian Association of Speech Language Pathologists and Audiologists, SASLPA or an appropriate professional association registered as a non-profit organization in Saskatchewan). These codes of ethics include standards for the delivery of hearing services and the environment in which these services are delivered.

At the discretion of the WCB, compliance to these standards and fees may be evaluated through audits of hearing service provider files and WCB files.

¹ Medical aid shall be furnished or arranged for by WCB as it may approve.
² The fees for medical aid furnished by any health care professional shall be determined by WCB.
1. **Qualifications with WCB Accreditation**
   All services, including hearing evaluations and hearing instrument fittings, will be provided by a WCB accredited hearing service provider who is:
   a. an audiologist currently licensed and is in good standing with SASLPA;
   b. a hearing instrument practitioner currently registered and is in good standing with a professional association that is registered as a non-profit organization; or
   c. a graduate of a minimum two year program at an accredited university or technical school with a directly supervised practicum of 840 hours; and has current malpractice insurance.

2. **Clinic Standards**
   a. Each clinic must have a sound-treated room, which adheres to American National Standards Institute (ANSI) standards, and or equipment that eliminates the need for a sound-treated room.
   b. There shall be adequate space, facilities and equipment to fulfil the needs of the services, and accessibility must be adequate for the types of clients served. Clients will be tested in a permanently standing clinic, though temporary clinics may be approved by the WCB in remote areas.
   c. The following test equipment must be available:
      i. Clinical audiometer capable of air, bone, masking, and speech testing;
      ii. Acoustic immittance;
      iii. Real ear measurement;
      iv. Electroacoustic hearing aid analyzer;
      v. Stethoscope;
      vi. Otoscope;
      vii. Modifying tools;
      viii. Ultrasonic cleaner; and
      ix. Digital hearing aid programming equipment.
   d. Audiometric equipment must be calibrated at least once every year.

3. **Audiometric Assessment**
   a. Complete audiometric testing is required for hearing instrument recommendations. The assessment must include:
      i. Air conduction thresholds at 250, 500, 1000, 2000, 3000, 4000, 6000, and 8000 Hz.
      ii. Bone conduction thresholds from 500 to 4000 Hz.
      iii. Acoustic immittance.
      iv. Speech reception thresholds and word recognition ability.
      v. Tonal uncomfortable loudness levels and or speech discomfort levels.
vi. Any other tests required for the chosen hearing instrument selection procedure.

vii. All hearing instrument fittings should be documented using “real ear” or sound field-testing to determine effectiveness.

4. **Minimal Guidelines to the Fitting of Amplification**

   a. Pure tone average at 1 KHz, 2 KHz and 3 KHz, which equals or exceeds 30 dB.

   b. Normal hearing sensitivity to 2 KHz with a loss equal or greater than 40 dB at 3 KHz and 50 dB at 4 KHz.

5. **Auditory Evoked Potential Battery**

   Auditory evoked potential battery is indicated when a client meets any or all of the following criteria:

   a. Results of previous standard audiometric evaluation are suspect.

   b. A sudden change in thresholds or fluctuations in thresholds is noted between evaluations.

   The auditory evoked potential battery must include the following tests:

   c. Otoacoustic Emissions.

   d. Auditory Brainstem Response.

   e. Cortical Evoked Response Audiometry.

   Where a client has not had a complete audiology evaluation within six months of the auditory evoked potential battery, or if a sudden change or fluctuation is reported, a repeat audiogram will be performed.

6. **Advertising**

   Advertisements will be factual about the services and products offered. Any descriptions and claims will not be misleading, either directly or by implication, about the services and products offered or about their suitability for the purpose recommended. The following practices are prohibited:

   a. Direct or indirect mass marketing such as telemarketing or letter box mailing to provide services to eligible clients.

   b. The use of testimonials referring to clients or to services provided by a clinic.

   c. The use of the term WCB, Saskatchewan Workers’ Compensation Board, or the WCB’s logos or graphic representations, in advertising, publications or any other public representation.

7. **Ongoing Education**

   There shall be a planned orientation program attended by all new staff. All hearing service providers shall be encouraged to participate in continuing education programs, as per the requirements of the licensing or registering body, and must be up-to-date on current audiology practices and treatment protocols.
8. **Record Keeping**
   Where the worker requests services due to possible work-related hearing loss, there shall be a formal in-clinic record for each client, which will include the assessment of findings and services provided.
   Where the worker reports hearing loss and attributes this to employment, the hearing service provider shall submit an audiogram and the Primary Level Authorization to Treat – Hearing Services form to the WCB, with a prescription for a suitable hearing instrument, where appropriate, with attention to the WCB fee schedule.
   Once a diagnosis of noise-induced hearing loss is confirmed, decisions regarding the relationship between the hearing loss injury and employment will be made by the WCB’s Operations staff. Once Operations staff authorize direct billing of the WCB, using the Primary Level Authorization to Treat – Hearing Services form, the hearing instrument should be issued to the worker.
   The Primary Level Authorization to Treat – Hearing Services form should also be submitted to the WCB as per the fee schedule requirements.
   The worker has an option to purchase an upgrade to the hearing instrument prescribed by the hearing service provider. If such a purchase is made, this shall be recorded in the clinic’s file, as well as the communication to the WCB.
   There will be a written record of all equipment calibrations. This record shall be submitted to the WCB on request to verify compliance to standards.

9. **Quality Assurance**
   Within each clinic there shall be a program to evaluate the quality of services provided, including an evaluation of outcomes.
   For each new fitting, a minimum of one follow up visit is required with a maximum of two visits per year. A copy of the validation survey shall be provided to the WCB.

10. **Invoicing WCB**
    To avoid conflict of interest issues that may arise as a result of the prescriber of hearing instruments also being the supplier, the WCB has limited the “mark up” of hearing aids, supplies, etc. to 10 percent of the cost of hearing instruments for private hearing service providers. HAP providers shall invoice the WCB using the Ministry of Health fee schedule. The rates payable are included in the fee schedule in effect.
    Where the WCB has authorized the issuance of a hearing instrument, the client should not be billed for any services included in the WCB fee schedule unless the worker has chosen to purchase an upgrade from the hearing instrument approved by the WCB.

11. **Term**
    As per the effective date as endorsed by WCB Executive to December 31, 2017.
Schedule B

Hearing Service Fees and Fee Codes – Effective 01 June 2015

Full audiological assessment – 200

<table>
<thead>
<tr>
<th>Saskatchewan HAP Fee</th>
<th>Private (Non-HAP) Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>As per the Ministry of Health Fee Schedule</td>
<td>$118.21</td>
</tr>
</tbody>
</table>

- Business rules
  - To be conducted by WCB accredited Audiologist or Hearing Instrument Practitioner
  - Comprehensive evaluation including history of hearing problems.
  - Otoscopic evaluation
  - Pure – tone air conduction testing, and masking when indicated to include the following frequencies: 250, 500, 1000, 2000, 3000, 4000, 6000, and 8000Hz
  - Pure tone bone conduction testing to include the above noted frequencies and masking when indicated (Please note that the WCB requires all frequencies, including 3000Hz, for determining and injured worker’s degree of permanent impairment)
  - Speech audiometry including speech reception threshold testing, determination of uncomfortable levels, most comfortable levels and speech discrimination testing level
  - Assessment of the function the middle ear system or impedance audiometry; and
  - Depending on the results of the impedance testing, referral for additional testing, as may be required
  - A detailed written report of the audiological test results, including recommendations regarding appropriate amplification, signed and dated by the individual performing the test
  - May be repeated every *Three years *see HAP except where worker experiences a sudden onset of tinnitus or sudden unilateral hearing loss after illness in a worker who has bilateral hearing aids
Hearing instrument – 202

<table>
<thead>
<tr>
<th>Saskatchewan HAP Fee</th>
<th>Private (Non-HAP) Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Manufacturer’s cost not to exceed $900 plus 10% handling fee and actual shipping fee</td>
</tr>
<tr>
<td></td>
<td>Loss and damage not to exceed $300 plus 10% handling fee and actual shipping fee</td>
</tr>
</tbody>
</table>

- Business rules
  - Fee to include a three year standardized warranty
  - Includes the hearing aid but no accessories ** See list of items not funded
  - Includes directional microphone except in CIC (Completely in the canal) models
  - Manufacturer’s invoice to be attached to WCB invoice stamped “Not for payment”
  - This fee to include aids for those workers still in the work force who require a product suitable for multi person discussion and noisy background situations
  - Where the injured worker chooses an upgraded product, the worker will pay the difference between the aid that was recommended and the aid chosen; notwithstanding the $900 ceiling. The worker will not pay additional fitting/follow up or other fees payable by WCB
  - Fee where worker has lost a hearing aid, with pre-approval
  - WCB will approve replacement aids only where the current aid cannot be adjusted in response to a significant change in hearing, where there are signs of inadequate gain available, improper amplification for hearing loss, improper fit resulting in feedback, where repair is no longer cost effective, with pre-approval
**Repair fee – 205**

<table>
<thead>
<tr>
<th></th>
<th>Saskatchewan HAP Fee</th>
<th>Private (Non-HAP) Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>As per the Ministry of Health Fee Schedule</td>
<td>Manufacturer’s price plus 10% handling fee and actual shipping fee</td>
<td></td>
</tr>
</tbody>
</table>

- **Business rules**
  - Not billable while warranty period in effect
  - From end of warranty period (end of third year) to end of fourth year post issuance, $300 may be invoiced to WCB without pre-authorization
  - Pre-authorization is required on any aid greater than four years post issuance date
  - Manufacturer’s invoice must be included when billing for a repair fee and stamped “Not for Payment”
  - Fee payable once per transaction with the manufacturer (not the aid)
  - Where a receiver has been replaced, no fee is billable during the warranty period of the replacement receiver

**Batteries – 206**

<table>
<thead>
<tr>
<th></th>
<th>Saskatchewan HAP Fee</th>
<th>Private (Non-HAP) Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$0.75 per cell</td>
</tr>
</tbody>
</table>

- **Business rules**
  - Batteries are provided to injured workers to last till the next service visit without pre-authorization
  - Where a worker runs out of batteries, more may be issued without pre-authorization but
  - No service fee is billable to the WCB
Fitting/dispensing – 213

<table>
<thead>
<tr>
<th>Saskatchewan HAP Fee</th>
<th>Private (Non-HAP) Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>As per the Ministry of Health Fee Schedule</td>
<td>$525</td>
</tr>
</tbody>
</table>

- Business rules
  - Selection of appropriate hearing aid device
  - Ear mold impression
  - Programming of the hearing aid device
  - Real Ear Measurements (REM) for fitting verification
  - Verification of audibility, comfort and tolerance
  - Speech mapping if available
  - Quality control checks (electroacoustic checks)
  - Appropriate training and counselling regarding usage of hearing aid device
  - Counselling injured worker regarding the realistic expectation of the benefits during and after adjustment period
  - Follow up with the injured worker within the hearing aid manufacturer’s noted trial period (follow up visit to include adjustments, counselling, repair and re-programing if necessary)
  - **Includes the allotted two service visits within the first year after new aid is issued including labor on repair, cleaning, re-tubing, vacuuming, readjustments and verification
  - Provide all product manuals and warranty information; and
  - Any warranty work required without additional handling/shipping fees.
  - WCB does not fund extended warranty
Service fee – 214

<table>
<thead>
<tr>
<th>Saskatchewan HAP Fee</th>
<th>Private (Non-HAP) Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>As per the Ministry of Health Fee Schedule</td>
<td>$30 per ear</td>
</tr>
</tbody>
</table>

- **Business rules**
  - Includes minor in house repairs, performance checks, reprogramming, cleaning, vacuuming, re-tubing, and adjustments
  - Fee includes all incidental parts and projects required for regular maintenance of aids including domes, tubes, microphone covers, wind covers, wax guards, filters, microphones and component parts
  - For all other parts, see Repair fee
  - Worker will be provided a six month supply of batteries to last till next service visit, billable to WCB without pre-authorization
  - Limit of two visits per year without WCB pre-authorization
  - Service fees are billable only after the one year anniversary of the fitting/dispensing date as the first year service fees are included in the fitting/dispensing fee
  - Applicable only if service provided by or supervised by an audiologist or hearing instrument practitioner
  - Includes labor for all warranty items during warranty period

Ear molds (behind the ear models) – 215

<table>
<thead>
<tr>
<th>Saskatchewan HAP Fee</th>
<th>Private (Non-HAP) Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>As per the Ministry of Health Fee Schedule</td>
<td>Manufacturer's price plus 10% handling fee and actual shipping fee</td>
</tr>
</tbody>
</table>

- **Business rules**
  - This fee applies to molds for each ear
  - Maximum of one per ear every two years without pre-authorization
Mailing fee – 216

<table>
<thead>
<tr>
<th>Saskatchewan HAP Fee</th>
<th>Private (Non-HAP) Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not to exceed $15</td>
</tr>
</tbody>
</table>

- Business rules
  - Billable only for hearing aid mailed or couriered to injured worker with receipt for both the mailing/courier and insurance both attached to the invoice stamped “Not for payment”
  - Only payable if there is an urgent medical need for the repair or if the worker is not in that city on a regular basis for personal needs

Custom ear molds – 217

<table>
<thead>
<tr>
<th>Saskatchewan HAP Fee</th>
<th>Private (Non-HAP) Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Manufacturer’s price plus 10% handling fee and actual shipping fee</td>
</tr>
</tbody>
</table>

- Business rules
  - May be issued without pre-authorization where domes/tips are not effective and excessive feedback occurs
  - May be replaced once every two years without pre-authorization, with WCB billed after the warranty period has expired only
  - Includes mold impressions

*Hearing instruments will be funded minus accessories. The following and other accessories should not be issued or authorization to issue requested: dry aid kits, drying system, sleeve molds, remote controls, easy phone auto t-coil, battery tester and charger, Oticon streamer, ear wax removal system, wax receptor, etc.

- WCB reserves audit privileges and post payment reconciliation where inappropriate billing has occurred.

Where in doubt, clarification may be obtained from the Health Services Manager at 306-787-7760 who may consult the executive of Sask. Hearing Instruments Practitioner regarding the spirit of the negotiation that led to the above fee schedule.
## Sample Invoice – Hearing Service Providers

**SERVICE PROVIDER:** ABC HEARING CENTRE  
999 – 1st St.  
Saskatoon, SK  S4X 7S9  
Phone: 777-9999  
Fax: 777-8888

**WORKER NAME:** Sally Smith  
111 Albert St.  
Saskatoon, SK  S7K 9C4

**PERSONAL HEALTH #:** 123 456 789  
**DATE OF BIRTH:** Dec 1, 1995  
**CLAIM NUMBER:** 1007-9783  
**EMPLOYER:** 123 Welding, Regina  
**CLINIC/CAREGIVER BILLING NUMBER:** SK 0000 AUD 004321

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Fee Description</th>
<th>Fee Code</th>
<th># of Units</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 01/17</td>
<td>Full audiological assessment</td>
<td>800</td>
<td>1</td>
<td>$118.21</td>
</tr>
</tbody>
</table>
| Jan 1/17        | Hearing instrument        | 202      | 1          | $900 (hearing aid)  
|                 |                           |          |            | $90 (handling fee)  
|                 |                           |          |            | $15 (shipping fee)  |
| **Total**       |                           |          |            | **$1,123.21** |
BACKGROUND

1. Section 103 of The Workers’ Compensation Act, 2013 (the “Act”) states that upon approval by the Workers’ Compensation Board (WCB), a worker entitled to benefits is also entitled to:
   a. Any medical aid that may be necessary because of the work-related injury.
   b. Any other treatment by a health care provider.
   c. Any orthotic appliance or apparatus that may be necessary as a result of the injury, and
   d. Any travel and sustenance costs associated with receiving medical treatment as a result of the injury.

2. Section 104(1) of the Act directs that the WCB shall determine health care services fees.

3. The WCB strives to ensure the injured worker’s best recovery from a work injury. This includes a safe and suitable return to work as soon as medically possible. This goal can be achieved by ensuring:
   a. Active treatment at the primary level, and
   b. Timely access to secondary and tertiary services where required.

4. The WCB has established the Health Care Advisory Committee (HCAC) to evaluate the medical care provided to injured workers. This includes recommendations regarding secondary and tertiary treatment.

5. The WCB has concluded discussions with the Coalition of Physical Rehabilitation Centres of Saskatchewan (CPRCS). The CPRCS represents the majority of the secondary and tertiary rehabilitation centres in Saskatchewan.

6. The CPRCS has agreed to continue to support the Secondary and Tertiary Treatment Centre Manual (Service Guidelines). The Service Guidelines ensure that health care providers apply professional standards in the treatment of WCB clients.
7. The WCB has agreed to provide fee increases to reflect the increased costs of providing care.

PROCEDURE

1. All secondary and tertiary treatment centres providing services to WCB clients will comply with:
   a. The Service Guidelines.
   b. The Service Fees and Fee Codes for Saskatchewan Workers' Compensation Board Secondary and Tertiary Centres (Fee Schedule).
   c. The ethical requirements of their WCB accredited licensing body or professional organization.
   d. Current and future WCB policies, and
   e. All sections of the Act.

Service Guidelines

2. The Service Guidelines provide the accreditation standards and service provider guidelines for secondary and tertiary treatment centres treating injured workers. The WCB will post a current edition of the Service Guidelines on the WCB website.

3. With guidance from the HCAC, the WCB will make the final decision on the accreditation of any centre or team. The WCB will base its decision on the need for services in a geographical area.

4. Prior to providing treatment to WCB clients, the treatment centre and members of the treatment team must:
   a. Meet all the requirements of their professional licensing body, and
   b. Be accredited as a WCB service provider.

5. Each treatment centre will identify a Clinical Coordinator who:
   a. Will have a minimum of 42 months post-graduate experience with a minimum of two years experience as a full-time member of a secondary/tertiary team.
   b. Will oversee all services provided at the secondary/tertiary level.
   c. May provide treatment, and
   d. Will act as liaison between the treatment team, the WCB Health Care Services (HCS) Facilitator, the primary health care provider (PCP), and the employer.

6. Treatment centres will be required to maintain a treatment team with a minimum one-to-one ratio of licensed providers versus non-licensed providers.
Selection of Treatment Centre

7. The secondary or tertiary treatment of a WCB client will require:
   a. Prior approval by the PCP.
   b. Recommendation by an assessment team, and
   c. Intake arranged by a WCB HCS Coordinator, or
   d. Direct referral from the PCP who received the assessment team recommendations.

8. The WCB will avoid requesting services from a treatment centre that has a financial relationship with the injured worker’s employer. When the WCB allows the PCP to choose the treatment centre, the WCB will disclose any known relationship. This will provide the PCP and the injured worker the opportunity for an informed decision.

9. Where the PCP does not choose a treatment centre, the WCB will try to retain a client in the same clinic that provided primary care. All the while, the WCB will make efforts to:
   a. Maintain a one week intake standard, and
   b. Ensure fair distribution of these clients.

10. Primary level treatment will end once the PCP has agreed to the recommendation of the assessment team. The secondary or tertiary team will provide the recommended care within the treatment centre. The PCP will continue to see the injured worker and monitor progress.

Reporting

11. Treatment centres will forward Initial Assessment, Progress (including a report from psychology or counselling), RTW and Discharge reports to the WCB, with a copy to the PCP:
   a. At three week intervals throughout the treatment program.
   b. Prior to RTW commencing, or
   c. At discharge.

12. On the first day of each month, treatment centres will submit an online outcome report. The report will indicate any clients discharged during the previous month.

Evaluations

13. The WCB will determine a Composite Index Score and an employer-attached RTW Score for each treatment program. The WCB will use this data to evaluate the performance of the treatment centre.
14. The WCB will meet its obligations under the Act and demonstrate appropriate auditing and quality assurance processes by:
   a. Auditing client charts and billing practices, and
   b. Surveying clients of the treatment centre as needed.

15. The HCS Facilitator will communicate monthly with the treatment centre. Additional communication may occur if the HCS Facilitator requires more information on the client’s progress.

16. The HCAC will continue to evaluate the medical care provided to injured workers.

Complaint Process

17. Workers can report complaints of any nature to the WCB. The HCS Facilitator, the Quality Measurement Specialist or the Manager of HCS will direct the complaint to the Clinical Coordinator.

18. HCS will note all complaints and resolutions on the service provider’s accreditation file.

19. Workers may request a different treatment centre through the PCP who made the initial referral.

Fees

20. The fee schedule under Schedule “A” is effective 01 January 2014. The fee schedule will remain in effect until the WCB and the CPRCS reach a new agreement.

21. To prevent financial hardship to the injured worker, treatment centres will:
   a. Ensure their billing is directed to the WCB, not the worker, and
   b. Avoid extra billing by adhering to the approved fee schedule.

22. The WCB may refuse payment or rescind some of the fees for treatment if:
   a. A person who is unaccredited by the WCB provides treatment to a WCB client, or
   b. A WCB accredited person provides treatment outside their scope of practice.

Confidentiality

23. The WCB will not disclose any health-related or personal client information to any person or party other than those who have:
   a. Consent, or
   b. Designation by the WCB.
ATTACHMENTS

Schedule “A” – Service Fees & Fee Codes For Saskatchewan Workers’ Compensation Board Secondary and Tertiary Treatment Centres


Schedule “C” – WCB Billing for Secondary and Tertiary Treatment Centres – Example – Adjustments to Previous Billing Summary

Act Sec # 55, 103, 104, 111, 115
Effective Date 01 January 2014
Application All secondary and tertiary treatment program health care providers.
Supersedes PRO 54/2011 Medical Fees – Secondary and Tertiary Treatment Centres
Complements POL 08/2014 Continuum of Care
POL 05/96 Health Care Services
POL 02/97 Health Care Services Fees
PRO 53/2014 Medical Fees – Assessment Teams
Schedule “A”
Service Fee and Fee Codes
For Saskatchewan Workers’ Compensation Board
Secondary and Tertiary Treatment Centres

The following WCB fee codes and fees are to be used to bill for services provided to WCB clients by secondary and tertiary treatment centres accredited by Saskatchewan WCB.

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee Code</th>
<th>May 1, 2012</th>
<th>January 1, 2014</th>
<th>May 1, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Biomechanical Assessment</td>
<td>2500 3500</td>
<td>$99.40/hr</td>
<td>$105.45/hr</td>
<td>$108.62/hr</td>
</tr>
<tr>
<td>Biomechanical Treatment¹</td>
<td>2501 3501</td>
<td>$57.98/hr</td>
<td>$61.51/hr</td>
<td>$63.36/hr</td>
</tr>
<tr>
<td>Initial Conditioning Assessment</td>
<td>2504 3504</td>
<td>$99.40/hr</td>
<td>$105.45/hr</td>
<td>$108.62/hr</td>
</tr>
<tr>
<td>Individual Conditioning Instruction</td>
<td>2505 3505</td>
<td>$99.40/hr</td>
<td>$105.45/hr</td>
<td>$108.62/hr</td>
</tr>
<tr>
<td>Group Supervised Conditioning²</td>
<td>2506 3506</td>
<td>$22.59/hr</td>
<td>$23.97/hr</td>
<td>$24.69/hr</td>
</tr>
<tr>
<td>Functional Ability Evaluation</td>
<td>2512 3512</td>
<td>$112.95/hr</td>
<td>$119.83/hr</td>
<td>$123.43/hr</td>
</tr>
<tr>
<td>Individual Functional Conditioning Fee (Work Sim)</td>
<td>2507 3507</td>
<td>$99.40/hr</td>
<td>$105.45/hr</td>
<td>$108.62/hr</td>
</tr>
<tr>
<td>Group Functional Conditioning Fee (Work Sim)</td>
<td>2503 3503</td>
<td>$90.36/hr</td>
<td>$95.87/hr</td>
<td>$98.74/hr</td>
</tr>
<tr>
<td>Education</td>
<td>2511 3511</td>
<td>$112.95/hr</td>
<td>$119.83/hr</td>
<td>$123.43/hr</td>
</tr>
<tr>
<td>Initial File Review &amp; Conferencing³</td>
<td>2508 3508</td>
<td>$124.25/hr</td>
<td>$131.82/hr</td>
<td>$135.77/hr</td>
</tr>
<tr>
<td>RTW or RTA Planning and Monitoring</td>
<td>2502 3502</td>
<td>$115.97/hr</td>
<td>$123.03/hr</td>
<td>$126.72/hr</td>
</tr>
<tr>
<td>Job Site Evaluation⁴</td>
<td>2510 3510</td>
<td>$124.25/hr</td>
<td>$131.82/hr</td>
<td>$135.77/hr</td>
</tr>
<tr>
<td>Service</td>
<td>Fee Code</td>
<td>May 1, 2012</td>
<td>January 1, 2014</td>
<td>May 1, 2015</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------</td>
<td>-------------</td>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Psychology/Counselling&lt;sup&gt;5&lt;/sup&gt;</td>
<td>2529</td>
<td>--</td>
<td>$105.45/hr</td>
<td>$108.62/hr</td>
</tr>
<tr>
<td>(assessment and/or treatment)</td>
<td></td>
<td></td>
<td>$99.40/hr BA level</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2519</td>
<td>--</td>
<td>$144.82/hr</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$132.53/hr MA level</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2509</td>
<td>3509</td>
<td>$181.03/hr</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$165.67/hr PHD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2517</td>
<td>3517</td>
<td>$206.53</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$189.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$200.51</td>
<td></td>
</tr>
</tbody>
</table>

1) May be billed only where biomechanical care was provided; modality services are not billable and would be unlikely at secondary/tertiary level treatment.

2) Not to be billed same day with Individual Conditioning Instruction (2505/3505).

3) Fee for file review not to exceed one hour.

4) Public Service Commission mileage rate will be paid only for out of town travel (requires authorization of insurer prior to incurring of cost).

5) Fee to be divided by # in group where group sessions provided.

Note: Health care providers are asked to prorate billings, rounding up to the next quarter hour.
Schedule “B”
WCB Billing Process
Secondary and Tertiary Treatment Centres
Example – Billing Summary

TREATMENT BILLING SUMMARY
FOR MONTHLY/BIMONTHLY BILLINGS

Profession
Physiotherapist

Worker’s Last Name, First Name & Initial (Please Print)
Sally Smith

Clinic Name, Address & Postal Code
ABC Clinic
999 – 1st St.
Saskatoon, SK S4X 7S9

Address
111 Albert St.
Saskatoon, SK

Clinic Billing #
CHI012345

Post Code Code
S7K 9C4

Provider’s Name, Address & Postal Code
ABC Clinic
999 – 1st St.
Saskatoon, SK S4X 7S9

Provider’s Professional Designation
Physiotherapist

Patient’s Phone #
555-1234

Address
111 Albert St.
Saskatoon, SK

Fax #
777-8888

Postal Code
S7K 9C4

Email:

Billing Period: December 1 – December 30, 2013

Primary Start Date: 12/12/13

Secondary Start Date: __________

Tertiary Start Date: __________

Fee Descriptor | Level | Fee Code | Number of Units | Total
--- | --- | --- | --- | ---
Initial Visit | T | 3500 | 1 | $99.40
Subsequent Visit | T | 3501 | 3 | $173.94
Individual Functional Conditioning Fee (Work Sim) | T | 3507 | 2 | $198.8

Total $472.14

Health Care Services
Section 7 – Page 158
Doc # 7.2.19  Medical Fees – Secondary and Tertiary Treatment Centres (PRO 57/2013)
**Schedule “C”**

**WCB Billing Process**

Secondary and Tertiary Treatment Centres

Example – Adjustments to Previous Billing Summary

---

**TREATMENT BILLING SUMMARY**

**FOR MONTHLY/BI-MONTHLY BILLINGS**

<table>
<thead>
<tr>
<th>Profession</th>
<th>Worker’s Last Name, First Name &amp; Initial (Please Print)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapist</td>
<td>Sally Smith</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinic Name, Address &amp; Postal Code</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Clinic 999 – 1st St. Saskatoon, SK S4X 7S9</td>
<td>111 Albert St. Saskatoon, SK</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinic Billing #</th>
<th>Postal Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHI012345</td>
<td>S7K 9C4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider’s Name, Address &amp; Postal Code</th>
<th>Patient’s Phone #</th>
<th>WCB Claim #</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Clinic 999 – 1st St. Saskatoon, SK S4X 7S9</td>
<td>555-1234</td>
<td>1234-5678</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider’s Professional Designation</th>
<th>Date of Birth (dd/mm/yy)</th>
<th>Personal Health #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapist</td>
<td>28/01/86</td>
<td>123456789</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Injury (dd/mm/yy)</th>
<th>Area of Injury</th>
<th>Employer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/12/13</td>
<td>shoulder</td>
<td>X Company</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer Address</th>
<th>TERTIARY START DATE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>123 Hoffer Place, Saskatoon, SK S7K 2X1</td>
<td>dd/mm/yy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>777-9999</td>
<td>777-8888</td>
</tr>
</tbody>
</table>

**Billing Period:** December 1 – December 30, 2013

**PRIMARY START DATE:** 12/12/13

**SECONDARY START DATE:**

<table>
<thead>
<tr>
<th>Fee Descriptor</th>
<th>Level</th>
<th>Fee Code</th>
<th>Number of Units</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomechanical Treatment</td>
<td>T</td>
<td>3501</td>
<td>(3)</td>
<td>$(173.94)</td>
</tr>
<tr>
<td>Biomechanical Treatment</td>
<td>T</td>
<td>3501</td>
<td>2</td>
<td>$115.96</td>
</tr>
</tbody>
</table>

**Total:** $(57.98)

In billing period December 1 to December 30, 2013 three subsequent visits were billed in error. Only two subsequent visits were provided.

*Please note that these are examples only and the fees used may not be the same fees which are applicable to your specific group. Please refer to the WCB fee codes and fees applicable to your specified group.*
7.2.20 Medical Fees – Assessment Teams (PRO 53/2014)

Document Date 25 March 2014

Purpose To establish the fee schedule and standards of care for assessment teams.

BACKGROUND

1. Upon WCB approval, a worker entitled to benefits under The Workers’ Compensation Act, 2013 (the “Act”) is also entitled to (Section 103):
   a. Any medical aid that may be necessary because of the work-related injury.
   b. Any other treatment by a health care provider.
   c. Any orthotic appliance or apparatus that may be necessary as a result of the injury, and
   d. Any travel and sustenance costs associated with receiving medical treatment as a result of the injury.

2. The WCB is authorized to determine health care services fees (Section 104(1)).

3. The WCB has adopted the Physical Functional Capacity Evaluation (PFCE) model which incorporates:
   a. Physical examination.
   b. Consistency of effort testing, and
   c. Care provider opinion with the functional testing provided in a basic Functional Capacity Evaluation (FCE).

4. The PFCE model ensures a valid opinion for re-employment planning where the worker demonstrates permanent restrictions to their pre-injury job duties.

PROCEDURE

General

1. Assessment teams must comply with:
   b. The Service Fees and Fee Codes for Secondary/Tertiary Assessment Teams Providing Services to Saskatchewan Workers’ Compensation Board Clients (Schedule A).
   c. The ethical requirements of their WCB accredited licensing body or professional organization.

2. There are three levels of assessment and treatment:
   a. Primary.
   b. Secondary, and
   c. Tertiary.
   These levels progress towards increased program complexity, scope and resources, depending on the needs of the worker.

3. Assessment teams will ensure the worker’s:
   a. Optimal recovery from an injury, and
   b. Return to safe, meaningful employment.

Service Guidelines

4. The care provider or Case Manager will tell MHCS if the worker needs an assessment team review. MHCS will arrange an assessment team review with an accredited team of health care providers.

5. MHCS will select an assessment team (i.e., secondary or tertiary) based on the:
   a. Length of time the worker has been away from regular job duties, and or
   b. Presence of psychosocial and pain management issues.

6. Assessment teams will include three to four health care providers (i.e., physician, physical therapist, occupational therapist, chiropractor or psychologist). The team will provide a:
   a. Medical examination.
   b. Biomechanical examination.
   c. Functional ability assessment, and
   d. Psychosocial screen.
   MHCS may request the services of other health care providers.

7. In accordance with the Secondary and Tertiary Assessment Team Manual, assessment team members will:
   a. Examine workers at risk for delayed recovery.
   b. Complete functional testing.
   c. Review reports provided by the worker’s health care providers.
   d. Review reports provided by MHCS.
e. Confirm the diagnosis.

f. Make recommendations to the primary health care provider regarding:
   i. Treatment and return-to-work, or
   ii. Re-employment planning.

g. Send reports to the WCB as per the reporting timelines listed in the manual, and

h. Tell the worker to make an appointment with their primary health care provider to discuss:
   i. The assessment team report, and
   ii. Any recommended changes to treatment and or return-to-work.

8. The assessment team report may recommend:
   a. Further primary, secondary, tertiary, or other care
   b. Specialist and diagnostic services should occur at the same time as other treatment
   c. The timeline for return to work planning, which may include an immediate return to work, or
   d. The worker’s condition is preventing a return to the pre-injury job.

9. To help the assessment team, MHCS will give the assessment team appropriate documents from the worker’s file.

10. MHCS will implement the assessment team’s recommendations if the primary care provider agrees.

Evaluations

11. MHCS will evaluate secondary and tertiary assessment teams twice a year using:
   a. Quality assurance evaluations, and
   b. Performance evaluations.

Continuing Education

12. The WCB recommends that each assessment team physician should complete a Continuing Medical Education (CME) recognized training course in pain management by June 1, 2016.

Complaints and Dispute Resolution

13. Workers can report complaints of any nature to the WCB. The WCB employee receiving the complaint may refer the complaint for resolution to other WCB staff including the Manager of Health Care Services. If the complaint alleges professional
incompetence or misconduct by a care provider, the Manager of Health Care Services will direct the complainant to the providers' professional association.

14. MHCS will note all complaints and resolutions on the service provider's accreditation file.

15. Workers that want to see a different provider should contact their Case Manager or MHCS.

Fees

16. Schedule A provides increases to assessment team fees on:
   a. June 1, 2014.
   b. June 1, 2015, and
   c. June 1, 2016.
   These fees will remain in effect until the WCB and CPRCS reach a new agreement.

17. Fees noted as hourly rates are considered one unit of care. Assessment teams will bill by 30 minute blocks or 0.5 units, and will round up to the next 30 minute block or 0.5 unit.

18. To prevent financial hardship to the injured worker, assessment team providers will:
   a. Direct bill the WCB, not the worker, and
   b. Avoid extra billing by adhering to the approved fee schedule.

ATTACHMENTS

Schedule A – Service Fees and Fee Codes for Secondary/Tertiary Assessment Teams Providing Services to Saskatchewan Workers’ Compensation Board Clients

Schedule B – WCB Billing Process – Example - Billing Summary – Assessment Teams

Schedule C – WCB Billing Process – Example - Adjustments to Previous Billing Summary – Assessment Teams

Act Sec #    58, 103(1), 103(2), 104(1), 104(2), 111.
Effective Date 01 June 2014
Application All secondary/tertiary musculoskeletal assessment teams.
Supersedes PRO 51/2012 Medical Fees – Assessment Teams
Complements POL 02/97 Health Care Services Fees
              POL 08/2014 Continuum of Care
              POL 05/96 Health Care Services
              PRO 05/96 Health Care Services
Schedule “A”  
Service Fees and Fee Codes  
for Secondary/Tertiary Assessment Teams Providing Services  
to Saskatchewan Workers’ Compensation Board Clients

The WCB will pay for the following fees if the WCB requests a secondary/tertiary assessment team review. Fees noted as hourly rates are considered as one unit of care. Teams will bill by 30 minute blocks or 0.5 units, and will round up to the next 30 minute block or 0.5 unit.

The WCB retains the right to audit the records and invoices of care providers who have provided services to a WCB client.

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee Code</th>
<th>June 1, 2014</th>
<th>June 1, 2015</th>
<th>June 1, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Assessment</td>
<td>3001</td>
<td>$1,304.37</td>
<td>$1,343.50</td>
<td>$1,383.81</td>
</tr>
<tr>
<td>Functional Testing</td>
<td>3002</td>
<td>$131.45</td>
<td>$135.39</td>
<td>$139.45</td>
</tr>
<tr>
<td>Tertiary Assessment</td>
<td>3003</td>
<td>$336.46/hr</td>
<td>$346.55/hr</td>
<td>$356.95/hr</td>
</tr>
<tr>
<td>Physical Functional Capacity Evaluation (PFCE)</td>
<td>3004</td>
<td>$149.53/hr(^4)</td>
<td>$154.01/hr(^4)</td>
<td>$158.63/hr(^4)</td>
</tr>
<tr>
<td>Specialist on Assessment Team</td>
<td>3005</td>
<td>$604.10</td>
<td>$622.22</td>
<td>$640.88</td>
</tr>
<tr>
<td>Sedentary Tolerance FCE(^4)</td>
<td>3010</td>
<td>$149.53/hr(^3)</td>
<td>$154.01/hr(^3)</td>
<td>$158.63/hr(^3)</td>
</tr>
<tr>
<td>Admin/Consultant services(^5)</td>
<td>3011</td>
<td>$131.16/hr</td>
<td>$135.10/hr</td>
<td>$139.15/hr</td>
</tr>
<tr>
<td>Specialist Post Conference(^6)</td>
<td>3012</td>
<td>$77.25</td>
<td>$79.57</td>
<td>$81.95</td>
</tr>
<tr>
<td>No show or short notice fee</td>
<td></td>
<td>60% of the expected fee</td>
<td>60% of the expected fee</td>
<td>60% of the expected fee</td>
</tr>
</tbody>
</table>

\(^1\)Maximum of two hours is billable for each of these services.  
\(^2\)Maximum of nine hours is billable for admin time and direct client time for team members only. Includes either three or more self report tools or one Type C Psychometric tool plus the Psychologist’s interview with the worker. Psychology time only is billable; the time spent by the injured worker completing the psychometric tool is not.  
\(^3\)This fee payable as an hourly rate to a maximum of 12 hours per PFCE. Once the new template is introduced, a maximum of 14 hours is billable.  
\(^4\)For sedentary tolerance FCE, fee code 3004 should be billed plus any applicable fees from the Secondary/Tertiary Treatment schedule (generally includes repeat examinations, conferencing).  
\(^5\)Fee paid where WCB has asked a care provider to perform ad hoc administrative duties. Requires memo or contact from WCB Health Care Services specifically offering this fee.  
\(^6\)Fee payable with fee code 3005 only where the specialist participates in the post conference in person or by telephone (i.e., a written report does not qualify).
Schedule “B”
WCB Billing Process
Example – Billing Summary
Assessment Teams

<table>
<thead>
<tr>
<th>Fee Descriptor</th>
<th>Fee Code</th>
<th>Number of Units of care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary Assessment</td>
<td>3003</td>
<td>8</td>
<td>$2,855.60</td>
</tr>
<tr>
<td>Additional Specialist</td>
<td>3005</td>
<td>1</td>
<td>$640.88</td>
</tr>
</tbody>
</table>

Total: $3,496.48
Schedule “C”
WCB Billing Process
Example - Adjustments to Previous Billing Summary
Assessment Teams

### INVOICE

<table>
<thead>
<tr>
<th>ASSESSMENT TEAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE PROVIDER: <strong>ABC Physiotherapy</strong></td>
</tr>
<tr>
<td>123 Scarth Street</td>
</tr>
<tr>
<td>Regina, SK S4R 9T1</td>
</tr>
<tr>
<td>Phone: <strong>777-9999</strong> FAX: <strong>777-8888</strong></td>
</tr>
<tr>
<td>BILLING PERIOD: <strong>01/06/16 – 30/06/16</strong></td>
</tr>
<tr>
<td>Caregiver Billing Number: <strong>AST 000456</strong></td>
</tr>
<tr>
<td>CLAIMANT’S NAME: <strong>Jane Doe</strong></td>
</tr>
<tr>
<td>111 Albert St.</td>
</tr>
<tr>
<td>Saskatoon, SK S7K 9C4</td>
</tr>
<tr>
<td>Claim Number: <strong>123 45678</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fee Descriptor</th>
<th>Fee Code</th>
<th>Number of Units of care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary Assessment</td>
<td>3003</td>
<td>(8)</td>
<td>($2,855.60)</td>
</tr>
<tr>
<td>Tertiary Assessment</td>
<td>3003</td>
<td>2</td>
<td>$713.90</td>
</tr>
</tbody>
</table>

**Total of all services for billing period:** $713.90

In the above adjustment invoice, eight tertiary units were invoiced in error. Only two tertiary units were provided by the assessment team.

*Please note that these are examples only and the fees used may not be the same fees which are applicable to your specific group. Please refer to the WCB fee codes and fees applicable to your specified group.*
7.2.22 Medical Fees – Acquired Brain Injury (PRO 52/2012)

Document Date 17 September 2012

Purpose To establish a fee schedule and standards of care for providers of Acquired Brain Injury (ABI) services.

BACKGROUND

1. The Workers’ Compensation Act, 2013 (the “Act”) confirms that the responsibility for the provision and funding of health care for injured workers lies with the Workers’ Compensation Board (WCB) in consideration of the exemption of injured workers by the Canada Health Act.

2. Historically, the WCB has negotiated identical agreements (including practice standards and a fee schedule) with the three health districts that provide ABI treatment services (i.e., the Prince Albert Parkland Health Region, the Regina Qu’Appelle Health Region, and the Saskatoon Health Region).

3. This procedure reflects the new agreements entered into by the WCB and each of the ABI service providers.

PROCEDURE

1. All ABI teams providing services to WCB clients will comply with:
   a. The practice standards established cooperatively with the WCB, as contained in Schedule “A”.
   b. The ABI Service Fees and Fee Codes for WCB Service Providers (Schedule “B”).
   c. The ethical requirements of their licensing body or professional organization.
   d. WCB’s corporate values and standards.
   e. Current and future WCB policies, and
   f. All sections of the Act.

2. The ABI team accepts referrals from workers, their families and friends as well as health care providers where the worker has sustained an ABI. Where the ABI resulted from an accepted work injury, the ABI team will assess the worker, providing the WCB Case Manager with an initial report and an estimate of costs within one month.

3. The ABI team will obtain:
a. The agreement of the primary care provider prior to implementing any treatment, and

b. The agreement of the WCB Case Manager prior to billing the WCB.

4. The treatment plan will be updated every six months or sooner if the treatment plan or the cost estimates change. Changes to the cost estimates will require authorization from the WCB Case Manager. Any changes to the treatment plan will require the ABI team to obtain the agreement of the primary care provider.

5. The ABI team will ensure that each worker receives a neuropsychological examination six months post injury to confirm the diagnosis and the appropriateness of the treatment plan. Where the ABI team’s neuropsychologist cannot accommodate the worker within a two-week timeline, the ABI team will ask the WCB Health Care Services department to arrange a timely assessment.

6. The quality of care is assured by required compliance with the ABI Practice Standards. Compliance will be reviewed by the Health Care Services department.

7. To prevent the secondary effects of the work injury and to ease the transition back into the workplace, early transitional return to work (RTW), followed by an appropriate permanent RTW plan, will be implemented by the ABI team in consultation with the WCB Case Management Team. A concurrent goal will be the worker’s reintegration into their home community to ensure quality of life.

8. Progress reports shall be forwarded to WCB by the Case Manager of the ABI team after every three appointments with a worker or at three month intervals, whichever comes sooner. The Case Manager of the ABI Team will also forward a discharge report within one month of termination of services by the ABI team.

9. To prevent financial hardship to the injured worker, the ABI team will:
   a. Ensure their billing is directed to the WCB, not the worker, and
   b. Avoid extra billing by adhering to the approved fee schedule.

10. The term of the agreements with the Prince Albert Parkland Health Region, the Regina Qu’Appelle Health Region, and the Saskatoon Health Region is effective from October 1, 2012 to September 30, 2015.

**ATTACHMENTS**

Schedule “A” – Acquired Brain Injury (ABI) Practice Standards for WCB Service Providers

Schedule “B” – Acquired Brain Injury (ABI) Service Fees and Fee Codes for WCB Service Providers


Act Sec # 58, 103(1), 103(2), 104(1), 104(2), and 111.
Effective Date 01 October 2012
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All injured workers requiring ABI treatment services.
Supersedes PRO 53/2008 Acquired Brain Injury Teams
Complements POL 05/96 Health Care Services
Schedule “A”
Acquired Brain Injury (ABI) Practice Standards
for WCB Service Providers

Representatives of Saskatchewan Health, the ABI Program, and WCB Health Care Services have agreed on standards of care and a fee schedule for the treatment of WCB injured workers. By virtue of accepting WCB injured workers for treatment, management of the ABI teams in Prince Albert, Regina, and Saskatoon agree to abide by the standards and fee agreement. Managers of the three ABI teams also agree that each health care professional on the ABI teams will adhere to the bylaws, codes of ethics, etc. of their respective professional RHA and will meet the legislative requirements of the WCB and the legislation governing the provision of health care in the Province of Saskatchewan.

STANDARDS

A. STANDARDS OF CARE:

All services of the ABI team shall be under the direction of a care provider licensed or registered by a self-regulating body to practise in the Province of Saskatchewan.

Each assessment will be conducted by a team of ABI providers, one of which will be a member of a self-regulating profession.

Each assessment will include a combination of professionals qualified to assess the injured worker for cognitive presentation and/or physical presentation, depending on the injured worker’s specific circumstances.

Where the injury is greater than 6 months duration, the initial assessment will include a neuropsychological assessment by an in-house neuropsychologist (i.e., if one has not occurred). Where the brain injury is not of 6 months duration, the neuropsychological assessment will be delayed until that point in time, with a report forwarded to the WCB within two weeks of the assessment. Should an in-house neuropsychologist not be available within a two-week timeline, the ABI team will contact WCB Health Care Services, who will arrange for an independent neuro-psychological assessment.

The Case Manager on the ABI team will be a member in good standing with an organization that governs the practice of such care providers in the Province of Saskatchewan.

If services are outsourced by the regional health authority, professional liability insurance will be in place.
Students, under direct supervision of ABI team members, may also provide services to WCB injured workers. However, as students are supernumerary members of the team, their services will not be billable.

Injured workers with significant physical pathology will have, within their treatment team, a care provider with physical medicine skills, who is a member of a self-regulating profession.

Once assessed, the ABI team will provide the WCB with an estimate of the services and costs required to treat the injured worker.

Should the initial costs or services be exceeded, the ABI team will provide the WCB Case Manager with a written request for extension, detailing the further services to be provided and the further costs to be incurred.

Treatment plans and funding will be confirmed at least every six months.

To avoid financial hardship to the injured worker, direct billing privileges will be established with the WCB as soon as an injured worker is identified as having incurred a work injury.

The goal of the ABI services will be to provide effective services to the injured worker to encourage the injured worker’s return to the local community to work with local providers and to ensure quality of life.

Where appropriate, the ABI team will also work toward suitable return to work, working closely with the WCB Case Management Team, who offers vocational services.

**B. FACILITY**

There shall be adequate care providers, space, facilities and equipment to ensure the safety of the injured worker. Accessibility will be appropriate for the types of injured workers served.

Assessment, treatment and meetings to integrate the injured worker into the home community and to arrange care by local providers may occur in the worker’s home community.

**C. ONGOING EDUCATION**

There shall be a planned orientation program regarding this agreement and processes for management of WCB files provided to all new ABI staff by ABI staff familiar with these processes. Included will be training in emergency procedures and in the processes for cooperative Case Management with the WCB.
All ABI staff shall be encouraged to participate in continuing education programs and shall have knowledge of current ABI practice and treatment protocols.

D. RECORD KEEPING

Assessment findings shall be sent to WCB within one month of completion to allow for the required home and community visits.

The initial assessment shall include an estimate of services required and cost estimates.

Where the initially proposed treatment plan requires an extension, or the initial costs or services will be exceeded, the ABI team will provide the WCB Case Manager with a written request for extension, detailing the further services to be provided and the further costs to be incurred.

Once provision of services and direct billing has been authorized, WCB shall receive a report every three months or every three interactions, whichever comes first, detailing the services provided and progress toward assessment goals.

Treatment plans will be updated at least every six months.

A discharge summary shall be submitted to WCB within one month of discharge.

E. QUALITY ASSURANCE

Within each ABI team, there shall be a program to evaluate the quality and quantity of care provided, and it shall include an evaluation of outcomes.
Schedule “B”
Acquired Brain Injury (ABI) Service Fees and Fee Codes
for WCB Service Providers*

The following WCB Fee Codes and Fees are to be used to bill WCB for services provided to WCB injured workers by the ABI team. The WCB shall be invoiced monthly using the attached billing format.

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee Code</th>
<th>Fees effective October 1, 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuropsychological Assessment (this would include pre- and post-interviews, testing and report)</td>
<td>5000</td>
<td>$165.00/hour to a maximum of 17 hours (includes report)</td>
</tr>
<tr>
<td>ABI Team Assessment and Report*</td>
<td>5001</td>
<td>$85.00/hour per care provider**</td>
</tr>
<tr>
<td>Intervention and Treatment/ Follow-up*</td>
<td>5002</td>
<td>$75.00/hour per care provider**</td>
</tr>
<tr>
<td>Return to Work Planning and Monitoring*</td>
<td>5003</td>
<td>$90.00/hour per care provider**</td>
</tr>
<tr>
<td>Job Site or Home Evaluation *</td>
<td>5004</td>
<td>$90.00/hour**</td>
</tr>
<tr>
<td>Client-specific Education about Brain Injury to Injured Workers, their Family, and Community. (Includes initial telephone calls, educational materials and follow-up phone calls) *</td>
<td>5005</td>
<td>$90.00/per injured worker, includes telephone calls, educational materials and follow-up telephone call</td>
</tr>
<tr>
<td>Telephone Consultation (does not include telephone consultation with WCB regarding authorization to treat or request for extension)</td>
<td>5006</td>
<td>$90.00/hour**</td>
</tr>
<tr>
<td>Conference</td>
<td>5007</td>
<td>$90.00/hour**</td>
</tr>
<tr>
<td>Travel Time ***</td>
<td>5008</td>
<td>$45.00/hour per care provider**</td>
</tr>
<tr>
<td>Travel Distance (to include meals, hotels, etc.) ***</td>
<td></td>
<td>Public Service Commission rates</td>
</tr>
<tr>
<td>Flight Travel ***</td>
<td></td>
<td>Bill actual</td>
</tr>
<tr>
<td>Vehicle Travel ***</td>
<td></td>
<td>Public Service Commission rates</td>
</tr>
<tr>
<td>Psychology/Counselling</td>
<td>5009</td>
<td>PhD Level - $125/hr divided by the number in the group.**</td>
</tr>
<tr>
<td></td>
<td>5010</td>
<td>MA Level - $110/hr divided by the number in the group.**</td>
</tr>
</tbody>
</table>

*These fee codes and definers will have a no-show fee of 50% applied where the client is unavailable for the appointment, without prior notification of the ABI team.
**Partial units of time should be rounded up to the next higher ¼ hour.
*** Also payable where the worker does not notify of inability to attend appointment.
Note: No portion of assessment or treatment time may be double-billed (i.e., billed under more than one fee code for the same period of time).
## Schedule “C”
### WCB Billing Process
#### Example – Billing Summary
##### Acquired Brain Injury

### TREATMENT BILLING SUMMARY
#### FOR
##### MONTHLY/BI-MONTHLY BILLINGS

<table>
<thead>
<tr>
<th>Fee Descriptor</th>
<th>Fee Code</th>
<th>Number of Units</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and Report</td>
<td>5001</td>
<td>1</td>
<td>$85.00</td>
</tr>
<tr>
<td>Intervention and Treatment</td>
<td>5002</td>
<td>3</td>
<td>$225.00</td>
</tr>
</tbody>
</table>

Total of all services for billing period: $310.00

Billing period is June 1 to June 30
Treatment start date is June 12
Service provided was one assessment with report and two subsequent treatments.

*Please note that these are examples only. The fees used may not be applicable to your service group. Please refer to the WCB fee codes and fees applicable to your specified group.*
**TREATMENT BILLING SUMMARY**
**FOR**
**MONTHLY/BI-MONTHLY BILLINGS**

<table>
<thead>
<tr>
<th>Fee Descriptor</th>
<th>Fee Code</th>
<th>Number of Units</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and report</td>
<td>5001</td>
<td>(1)</td>
<td>($85.00)</td>
</tr>
<tr>
<td>Assessment and report</td>
<td>5001</td>
<td>2</td>
<td>$170.00</td>
</tr>
<tr>
<td>Intervention and Treatment</td>
<td>5002</td>
<td>3</td>
<td>$225.00</td>
</tr>
</tbody>
</table>

Total of all services for billing period: $395.00

In billing period June 1 to June 30, three subsequent visits were billed in error. Only two subsequent visits were provided. A telephone consultation had been provided but not billed.

*Please note that these are examples only. The fees used may not be applicable to your service group. Please refer to the WCB fee codes and fees applicable to your specified group.*
8.0 RE-EMPLOYMENT ASSISTANCE & RETURN-TO-WORK

8.1 Vocational Rehabilitation – Programs and Services (PRO 01/2011) ................................................................................................................................. 3
8.2 Equipment and Tools – Vocational Rehabilitation (PRO 05/2004) ................................................................................................................................. 7
8.3 Vocational Rehabilitation – Self-Employment Plans (PRO 11/2014) ................................................................................................................................. 10
8.4 Return to Work – Temporary Helper (PRO 08/2010) ................................................................................................................................. 15
8.6 Vocational Rehabilitation – Moving Allowance (PRO 02/2014) ................................................................................................................................. 18
8.7 Modifications – Home, Vehicle and Work (PRO 04/2015) ................................................................................................................................. 21
8.1 Vocational Rehabilitation – Programs and Services (PRO 01/2011)

Document Date 02 February 2011

Purpose To establish guidelines for vocational rehabilitation programs and services.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved policy outlining the vocational rehabilitation programs and services offered to an injured worker with permanent restrictions.

2. The following procedure provides detailed guidance for implementation POL 01/2011, Vocational Rehabilitation – Programs and Services.

PROCEDURE

1. Normally, the Case Manager (CM) will oversee plans to return a worker to the pre-injury employer. However, where an assessment team confirms that the worker will have restrictions that will complicate a return to the workforce (pre-injury employer or is non-employer attached), the Vocational Rehabilitation Specialist (VRS) and CM (as part of the Case Management Team) will make a joint decision to begin vocational planning, with the goal of developing an Individualized Vocational Plan (IVP).

2. The CM will ensure eligible workers are assessed by the VRS for personal care allowance and any payment made is in accordance with POL 10/2014, Allowance Personal Care.

Individualized Vocational Plan (IVP)

3. The CM is to be kept informed during the development of the IVP, however, the VRS will be responsible for providing its content.

4. The VRS will undertake any vocational assessments or testing necessary to determine the extent and scope of vocational programs and services required, evaluating those factors outlined in Policy Point 8.

5. Based on the employability assessment and transferable skills analysis (QuickNOC Pro), the VRS in consultation with the worker, will select the most suitable re-employment alternative following the Hierarchy of Objectives outlined in Appendix A. Programs and services will be matched to the selected objective. It is important to note these are a general guideline, with some objectives interchangeable, depending on individual circumstances.
6. The employability assessment and transferable skills analysis (QuickNOC Pro) are to be completed by the VRS within 20 working days from the date the Case Management Team decides to provide vocational rehabilitation services and the IVP within 12 weeks. These standards will be reviewed annually for any necessary revisions.

7. Where self-employment is the selected vocational objective, the IVP must be developed in accordance with PRO 11/2014, Vocational Rehabilitation – Self-Employment Plans and POL 09/2013, Estimating Earning Capacity – Commissioned Sales and Self-Employment.

8. The VRS will ensure the worker and appropriate WCB staff sign the IVP in accordance with the spending limits outlined under Points 14 and 15 below. A detailed analysis will be included with the IVP outlining the following:

   a. The suitable short and long-term objectives for re-employment, including outcome measures and time frames for success;
   b. Labor market research for suitable occupations (where applicable);
   c. The selection of programs and services required to meet the vocational objectives;
   d. The worker's responsibilities for successful completion of the IVP;
   e. The expectation that the worker will demonstrate active involvement in their own rehabilitation;
   f. Any costs necessary for modifications to the home, vehicle and work place to address mobility or accessibility issues (POL 04/2015, Modifications – Home, Vehicle and Work);
   g. The associated costs for implementation of the plan, including academic, technical or on-the-job training, equipment and tools not provided by an employer or required for a self-employment plan (POL 05/2004, Equipment and Tools – Vocational Rehabilitation), travel and sustenance expenses (POL 39/2010, Expenses – Travel and Sustenance) or relocation allowances (POL 02/2014, Vocational Rehabilitation – Moving Allowance);
   h. Ongoing entitlement to compensation benefits and an estimation of earnings potential (capacity).

9. Where the worker experiences an interruption in their vocational training program exceeding eight weeks, the VRS will explain to the worker that the worker is expected to actively seek employment. Where individual circumstances of the worker (e.g., age, location, suitable employment, etc.) and other conditions permit, the VRS may assess a worker as employable for periods less than the eight weeks. If the worker is considered employable for periods less than eight weeks, the VRS will include written justification in the IVP.
Reporting

10. The VRS will provide ongoing progress reports to the CM.

11. Where the VRS reports a worker is non-compliant with the vocational plan or absent from the program for any other reason, the CM may suspend benefits in accordance with POL 07/2014, Suspension of Benefits.

12. At the conclusion of the IVP, the VRS will provide a written Closure Report to the CM, with the following information included:
   a. Documentation of the worker’s marks and/or certificates achieved through the program attended;
   b. If employment has been obtained, where the worker is employed, job title, current wages and yearly wage increments (if applicable);
   c. Where applicable, an Earnings Replacement Referral/Estimated Earnings Capacity Report (ER); and
   d. If the worker is not employed, the rationale as to why this has not occurred and any recommendations for earnings replacement.

13. Where a worker has been considered employable, but has not obtained employment, the VRS will pay job search benefits in accordance with POL 17/2010, Termination of Compensation Benefits – Notice. Where the worker has chosen to relocate to seek or obtain confirmed employment, 8 to 12 weeks job search benefits will be provided (POL 02/2014, Vocational Rehabilitation – Moving Allowance).

Spending Limits

14. The CM is ultimately responsible for the claim, but delegates authority to the VRS to approve IVPs with estimated or cumulative costs up to $50,000. For those IVPs with estimated or cumulative costs greater than $50,000, the VRS and CM will co-sign and submit to the Team Leader for authorization.

15. Return to work costs will be paid and monitored by the VRS. If the actual costs exceed the estimate by 10 percent, an addendum will be attached to the IVP. If the actual costs are projected to exceed the estimate by less than 10 percent, the VRS will provide written rationalization through a vocation claims decision (VCD) memorandum. Where actual costs exceed $50,000, the VRS and CM will co-sign and submit to the Team Leader for authorization.

16. With the exception of the items listed under Point 12, no return to work costs will be paid unless they have been included in an approved IVP.

17. Reasonable costs associated with developing an IVP and or in support of the client’s efforts to investigate his/her employment options may be authorized by the VRS.
without having to include them in a formal IVP, provided the reason for the expense is documented:

a. Vocational testing/assessment fees and expenses.

b. Travel and sustenance expenses to attend employment or other vocational exploration interviews.

c. Employment Skills Development Workshop expenses.

d. Subject to the approval of the Team Leader, other unexpected expenses incidental to return to work planning or activities.

18. The VRS will authorize the payment of invoices received from external sources covering expenditures for return to work upgrading and job search services. The VRS will compare each invoice to service expectations. All invoices will be assessed for accuracy and reasonableness before authorization for payment is given. Payment Specialists will ensure that proper authorization from the VRS is provided before issuing a payment.

Act Sec # 19(1)(d), 51(a)(b), 69, 111(a), 111(b), 111(c), 115(e), 115(f)
Effective Date 01 February 2011
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All workers receiving vocational rehabilitation programs and services as of the effective date.
Supersedes PRO 06/2004 Vocational Rehabilitation – Programs and Services
Complements POL 01/2011 Vocational Rehabilitation – Programs and Services
POL 04/2015 Modifications – Home, Vehicle, and Work
POL 33/2010 Initial Entitlement and (Re)Employment Assistance – Dependent Spouses
POL 07/2014 Suspension of Benefits
POL 10/2014 Allowance – Personal Care
POL 05/2004 Equipment and Tools – Vocational Rehabilitation
POL 02/2014 Vocational Rehabilitation - Moving Allowance
POL 39/2010 Expenses – Travel and Sustenance - General
POL 09/2013 Estimating Earning Capacity – Commissioned Sales and Self-Employment
POL 17/2010 Termination of Compensation Benefits
POL 15/2014 Determination of Long-Term Loss of Earnings
PRO 11/2014 Vocational Rehabilitation – Self-Employment Plans
**8.2 Equipment and Tools – Vocational Rehabilitation (PRO 05/2004)**

**Document Date** 25 October 2004

**Purpose** To establish guidelines for the purchase of equipment and tools for vocational rehabilitation programs.

**BACKGROUND**

1. The Workers’ Compensation Board (WCB) has approved policy (POL 05/2004) for the provision of equipment and/or tools for injured workers engaged in vocational rehabilitation programs.

2. The following procedure provides staff with specific guidance with respect to purchase and/or recovery of equipment and tools.

**PROCEDURE**

1. All purchases must be identified in the IVP, including the conditions of purchase, and are subject to the requirements of the Procurement Procedure (Procedure PRO 07/2012).

2. Single purchases under $2500 are the property of the worker and will not be recovered by the WCB.

3. Where leasing equipment and/or tools is considered, as in Point 8 of the policy, the VRS must complete a cost analysis to be included in the IVP.

**Single Purchases $2500 and Greater**

4. For single item purchase(s) $2500 and greater:
   a. The Vocational Rehabilitation Specialist (VRS) will complete the necessary forms for registering the security interest with the appropriate Registry, Personal Property and/or Land Titles. The Corporate Solicitor may be consulted, as necessary.
   b. The security interest will be recorded to the worker’s file for the original purchase price of the item(s). The VRS will request confirmation that equipment and tools have been insured prior to the release of funds or distribution of items to the worker.
   c. Where the requirements of Point 11 of the policy are met, the VRS will ensure the security interest is removed from the appropriate registry and noted to the worker’s file.
Recovery of Equipment and/or Tools

5. WCB will recover single item purchases valued at $2500 and over based on the criteria outlined in Point 12 of the policy.

6. The VRS will notify the worker in writing of WCB’s intent to recover the equipment and/or tools, providing the worker the following options:
   a. Purchase the item(s) at its depreciated value. Depreciation varies with the type of asset. The VRS will consult Financial Services to determine the rate of depreciation for the equipment to be recovered.
      
      **Example:**
      
      The rate of depreciation = 1.7% per month; equipment used for six months.
      
      Number of months of use x 1.7% = total depreciation in percent (%)
      
      Total depreciation % x original purchase value of item = dollars depreciated
      
      Original purchase price – dollars depreciated = Depreciated Value
      
      Therefore:
      
      6 (months of use) x 1.7% = 10.2 % (total percent depreciation)
      
      10.2% x $3000 (original price of item) = $306 (dollars depreciated)
      
      $3000 - $306 = $2694 (Depreciated Value)

   b. Return the item(s). The VRS will notify Facilities to make arrangements for pick up of equipment and tools and transporting them to Regina for storage. Costs will be charged to the claim file.

7. Where a worker does not agree to voluntarily purchase or return the items within 30 days of discontinuance of the IVP, the VRS will notify Legal Services.

8. The worker’s file will continue to reflect WCB’s security interest until the item(s) or the depreciated value (at the time of notification in Point 5 above) has been recovered.

9. Where all efforts for recovery have failed, the Team Leader will suspend recovery activity, pending recommendation from the Corporate Solicitor.

10. Consistent with PRO 101/2001 – Disposal of Surplus Goods and Assets, Facilities will be responsible for storing, documenting and retrieving item(s) for reuse or for disposal. Arrangements for determining the condition of the retrieved items will be made by Facilities. Costs will be charged to the claim file.

11. The Manager of Vocational Services Support will review the inventory of stored items on a semi-annual basis and forward recommendations for continued storage or disposal to Facilities.
12. Prior to all new purchases, staffs are to contact the Purchasing Officer to review stored items against current equipment needs. Where none are suitable or available, new purchase requests may be forwarded via the Purchase Tracker, or authorization given to the worker to purchase directly from vendors.

- **Act Sec #**: 111(a), 115(e)
- **Effective Date**: 01 November 2004
- **Amendment**: References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
- **Application**: All equipment and tools for vocational rehabilitation
- **Supersedes**: n/a
- **Complements**: POL 05/2004 Equipment and Tools – Vocational Rehabilitation
- ****: POL 04/2015 Modifications – Home, Vehicle, and Work
- ****: POL 01/2011 Vocational Rehabilitation – Programs and Services
- ****: PRO 01/2011 Vocational Rehabilitation – Programs and Services
- ****: PRO 07/2012 Procurement Procedure
- ****: PRO 101/2001 Disposal of Surplus Goods/Assets
- ****: PRO 11/2014 Vocational Rehabilitation – Self-Employment Plans
8.3 Vocational Rehabilitation – Self-Employment Plans (PRO 11/2014)

Document Date 13 August 2014

Purpose To provide administrative guidelines for the approval and implementation of IVPs for self-employment.

DEFINITION

Client means an injured worker, or surviving dependent spouse.

Individualized vocational plan (IVP) means a plan approved and signed by the Workers’ Compensation Board (WCB) and signed by the client to meet a vocational goal. The IVP outlines the short and long-term goals for a suitable return-to-work plan.

BACKGROUND

1. POL 01/2011, Vocational Rehabilitation – Programs and Services governs vocational rehabilitation programs and services offered to clients, including IVPs for self-employment.

2. The following procedure provides administrative guidelines for the approval and implementation of IVPs for self-employment.

PROCEDURE

General

1. The Vocational Rehabilitation Specialist (VRS) will only consider an IVP for self-employment when there are no other options for re-employment (see the Hierarchy of Objectives noted in POL 01/2011, Vocational Rehabilitation – Programs and Services). In general, the VRS will only consider self-employment if the following two conditions are met:
   a. The client cannot return to their pre-injury job or work at a different job because of the work injury. The WCB may consider the impact of non work-related injuries and quality of life issues when making decisions about self-employment.
   b. Self-employment is cost-effective and has a high probability of success.

2. When the VRS finds that self-employment is the client’s only re-employment option, the VRS will talk to the client about the:
   a. Risks, benefits, and costs of running a business, and
   b. Client’s responsibilities in an IVP for self-employment.
3. The VRS will make purchases and get appropriate secondary approvals as required by:
   a. PRO 07/2012, Procurement Procedure.
   b. POL 05/2004, Equipment and Tools – Vocational Rehabilitation.

Business Plan/Feasibility Study

4. The VRS will approve the use of a business consultant to help the client create a business plan and feasibility study. The client must get pre-approval from the WCB before work begins on the plan.

5. The client will ensure the business plan and feasibility study are completed in a professional and timely manner.

6. The business consultant will direct bill the WCB, not the client.

Self-Employment Funding

7. The WCB will only approve business plans where the total value is $150,000 or less (including the cost of the business consultant). The WCB and the client will each provide a contribution towards the total value of the plan.

<table>
<thead>
<tr>
<th>Total Value of Plan</th>
<th>Client’s Contribution</th>
<th>WCB’s Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $40,000</td>
<td>5%</td>
<td>95%</td>
</tr>
<tr>
<td>$40,000 to $59,999</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>$60,000 to $79,999</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td>$80,000 to $99,999</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>$100,000 to $124,999</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>$125,000 to $150,000</td>
<td>30%</td>
<td>70%</td>
</tr>
</tbody>
</table>

8. The client will pay for:
   a. Legal fees.
   b. Licensing.
   c. Liability insurance, and
   d. WCB business coverage.

9. The client will also pay to register the business. The client will ensure that their name is noted as a business owner/partner on the registration.
10. The WCB will release funds in trust to the client’s lawyer according to the conditions noted in the IVP.

**IVP for Self-Employment**

11. The WCB will approve IVPs for self-employment in accordance with the approval limits noted in PRO 01/2011, Vocational Rehabilitation – Programs and Services. The WCB will only approve one IVP for self-employment.

12. The IVP for self-employment will include the following:
   a. Terms and conditions for self-employment.
   b. Expectations, risks and responsibilities of the client and the WCB.
   c. Conditions for funding.
   e. Earnings loss benefits payable.
   f. Business training programs that the client will take part in.
   g. Requirements for tools, equipment, vehicles, inventory, property and buildings (POL 05/2004, Equipment and Tools – Vocational Rehabilitation).
   i. The use of a business consultant to help the client create a business plan and feasibility study.

13. The VRS will approve appropriate business training associated with managing the business.

14. If the IVP allows the client to purchase tools, equipment, vehicles, inventory, property or buildings, the VRS will arrange for direct billing (PRO 07/2012, Procurement Procedure).

**Evaluation Criteria**

15. The VRS will evaluate the sustainability and cost effectiveness of the business. The VRS’s evaluation may include, but is not limited to, the following:
   a. A review of the business plan and feasibility study to see if
      i. There are market opportunities in the industry under consideration.
      ii. The business is expected to have a three-year net positive value (based on cash-flow projections).
      iii. The business has the potential to meet the client’s pre-injury earnings.
iv. All costs (e.g., business training programs, purchase of personal and real property) are within the WCB’s funding limitations.

b. A review of the client’s prior business experience, related expertise or transferable skills to see if they are suitable for business ownership.


d. Determining if the client can handle the nature of the work, hours, travel and other requirements given the client’s compensable and non-compensable medical restrictions. The client must be able to control the day-to-day operations of the business.

Security Interest

16. The VRS, following discussion with Legal Services, will register a security interest with Information Services Corporation (ISC) for the purchase of:

   a. Personal property, or
   b. Real property.

17. The VRS will get a legal description of the real property from the client or real estate agent prior to:

   a. Releasing funds for purchase, and
   b. Registering the security interest.

18. The VRS will note that a security interest is registered in the client’s file.

19. The VRS will remove the security interest twelve months after the business becomes a viable operation.

Financial Reviews

20. The VRS will review the client’s financial statements/ledgers within six months of the start of the business.

21. The VRS may speak to the business consultant that helped create the business plan and feasibility study.

22. If the client continues to get WCB sponsorship, the VRS will review the client’s financial statements/ledger’s every six months (or before then if necessary) until the business becomes a viable operation.

Determination of Long-Term Loss of Earnings

23. The VRS will monitor the actual earnings generated by the client’s employment. Earnings loss benefits will end when:
a. The client’s estimated earning capacity exceeds earnings at the commencement of loss (Consumer Price Index adjusted to date), or

b. The client demonstrates the ability to generate actual earnings equal to or in excess of the earnings at the commencement of loss (Consumer Price Index adjusted to date) for a period of time sufficient to reasonably predict future earnings (typically two to four months).

POL 09/2013, Estimating Earning Capacity – Commissioned Sales and Self-Employment will apply.

24. If the business fails within six months because of factors within the control of the client, the VRS will use the IVP for self-employment as the client’s estimated earning capacity in order to determine ongoing entitlement.

25. If the business fails within six months because of factors that are not within the control of the client (e.g., market conditions, increased productions costs, increased restrictions from the work injury, etc.), the VRS will do another employability assessment and transferable skills analysis (QuickNOC Pro). The VRS will not consider self-employment as an option for re-employment.

26. If the work injury recurs, the WCB will not reduce recurrent benefits by the amount the WCB gave towards the business. The client will make arrangements for the continuation of the business.

Closure Report

27. The VRS will forward a Closure Report to the Case Manager at the completion of the IVP. The report must include a final estimation of the client’s earnings capacity.

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<td>19(1)(d), 51(a), 51(b), 69, 81(5), 111, 115(e), 115(f)</td>
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Re-Employment Assistance & Return to Work

Doc # 8.3 Vocational Rehabilitation – Self-Employment Plans (PRO 11/2014)
8.4 Return to Work – Temporary Helper (PRO 08/2010)

Document Date 02 March 2010

Purpose To establish provision of temporary helpers in a return-to-work plan for self-employed or those employed under a contract for service.

BACKGROUND

The Workers’ Compensation Board (WCB) has approved the provision of a temporary helper during a return to work plan in accordance with POL 08/2010, Return to Work – Temporary Helper.

PROCEDURE

1. An injured worker with temporary restrictions due to a workplace injury may benefit from the assistance of a temporary helper during the recovery process that will help return the worker to pre-injury duties. Typically, the injured worker requiring the temporary helper will be self-employed or employed under a contract for service. Appendix A provides examples of situations where a temporary helper may be warranted.

2. To mitigate loss of earnings, the injured worker may return to work with the assistance of a temporary helper. The helper may complete duties the injured worker is unable to carry out in order to fulfil any contract obligations. As a result, the income generated by the business (self-employed) or employment contract should not be affected.

3. For reimbursement, the employer who hires the temporary helper must provide an original receipt detailing the temporary helper’s wages to the Case Manager (CM) or Claims Entitlement Specialist (CES). In some situations, the CM or CES will reimburse the injured worker or will pay the temporary helper directly for his/her services.

4. The CM or CES will compare the helper’s wage with the amount of compensation the injured worker would have been entitled to if he/she had not returned to work. Typically, the helper’s wages will be considerably less than that of the injured worker’s. The amount reimbursed for the helper’s gross wages will not exceed the amount WCB would pay the injured worker for full wage loss compensation.

ATTACHMENTS

Appendix A – Examples of Temporary Helper Situations
Act Sec # 19, 69, 111, 115
Effective Date 01 April 2010
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application Claims requiring a temporary helper.
Supersedes n/a
Complements POL 08/2010 Return to Work – Temporary Helper
POL 08/96 Return-to-Work Plans
POL 01/2011 Vocational Rehabilitation – Programs and Services
POL 15/2008 Allowance – Temporary Additional Expense
Appendix A
Examples of Temporary Helper Situations

Self-employed Courier Driver:

a. Prior to the injury, the driver has contracts with newspaper agencies totaling $3000 per month to deliver papers to numerous locations.

b. The driver suffers a compensable injury and is unable to load or unload the deliveries without assistance. As a result, the driver hires a temporary helper for $1600 for one month to accompany him/her and assist with the loading and unloading until he/she is able to resume all tasks.

c. With the assistance of the helper, the driver is able to fulfill his/her contracts and receive the full contract, and therefore, does not receive wage loss compensation. The WCB, however, will reimburse the injured driver for the temporary helper’s wages.

Contracted School Caretaker

a. A worker is contracted by a school division to clean the buildings and is paid $4000 per month.

b. The worker suffers a work-related injury and is unable to perform some of the physically-demanding aspects of the pre-injury job. The worker is able to perform light cleaning duties but hires a temporary helper to assist with heavier tasks like moving desks and emptying garbage cans. This temporary helper is paid $9.00 per hour for twenty hours per week until the worker is able to resume all pre-injury duties.

c. The school division will continue to pay the worker for the full $4000 per month and the WCB will reimburse the worker for the wages paid to the temporary helper.
8.6 Vocational Rehabilitation – Moving Allowance (PRO 02/2014)

Document Date 29 April 2014

Purpose To establish guidelines for the payment of moving allowances.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 02/2014, Vocational Rehabilitation – Moving Allowance. This policy provides staff and clients guidelines for the payment of moving allowances.

2. The following procedure provides guidance for the implementation of POL 02/2014.

PROCEDURE

General

1. Individualized Vocational Plans (IVPs), which include moving, are approved in accordance with PRO 01/2011, Vocational Rehabilitation – Programs and Services.

2. The Vocational Rehabilitation Specialist (VRS) may consider moving as part of the IVP if the commuting distance from home to work is greater than 75 kilometres (km) and if the move will eliminate, or substantially reduce, the earnings loss benefits being paid to the worker. Where the commuting distance is less than 75 km, approval will be based on individual circumstances. When determining if the WCB will pay for a move, the VRS will consider:
   a. The availability of suitable employment or programs;
   b. Earning potential; and
   c. Whether the worker’s physical restrictions make commuting a hardship.

3. Moving should be approved by the WCB in advance. The WCB may not pay for moving arrangements that were made before approval unless the worker gives good reason for not seeking prior approval.

4. In general, POL 39/2010, Expenses – Travel and Sustenance – General and PRO 54/2015, Expenses – Travel and Sustenance – PSC Rates will be followed to pay expenses. However, where suitable accommodations are not immediately available in the new community, and a hotel is available with a kitchenette, hotel and meal allowances may not reflect those noted in PRO 54/2015. In such instances, hotel and meal allowances will be determined by the VRS.
Relocation for Confirmed Employment

5. Moving may be approved where the worker secures permanent employment in another community that will eliminate, or substantially reduce, the earnings loss benefits being paid to the worker. The VRS will ensure that the total cost of the move is not greater than the value of the reduction of earnings loss benefits.

Relocation for Quality of Life

6. Where the worker’s resident community is unable to meet the worker’s needs given the lasting effects of the work-related injury, moving may be approved. The WCB will pay for moving costs where the VRS reasonably expects the worker’s quality of life will improve by moving. The move does not have to eliminate, or substantially reduce, the earnings loss benefits being paid to the worker. For example, it may be reasonable to pay for a move where a worker:
   a. Has serious permanent restrictions as a result of the work-related injury, to a community where family members can provide the support and assistance that would improve the worker’s quality of life;
   b. Requires medical services not available in the resident community, to a center that has the required services.

Relocation to Seek Employment

7. Moving may be approved for the purpose of actively seeking employment. When determining if moving is appropriate, the VRS will consider:
   a. Employment opportunities in the resident community versus the proposed community;
   b. The level of motivation demonstrated by the worker;
   c. Claim history; and
   d. Cost of moving.

The VRS must also identify what positions the worker will be seeking as well as the level of job search activity expected.

8. The VRS will ensure that the move has the significant potential to reduce the amount of earnings loss benefits being paid to the worker.

9. The move will be within Saskatchewan unless it can be demonstrated that the opportunities in other jurisdictions are significantly greater than in Saskatchewan.

10. A period of up to two weeks may be required to allow a worker to settle into their new community prior to starting or applying for employment. Benefits will continue during the settling in period.
11. The VRS will pay job search benefits for a minimum of eight to a maximum 12 weeks. The total amount of support provided for settling in and job search will not exceed 14 weeks.

Relocation for Retraining

12. Moving may be approved for the purpose of retraining. The VRS will ensure that the:
   a. Cost of moving is less than the projected cost of any allowances the worker may be entitled to (e.g., kilometre rates, accommodation subsidy, etc.) if the worker were to maintain a primary residence in the resident community; or
   b. Worker permanently moves to the proposed community after the training is completed and there are reasonable opportunities for employment.

Relocation Allowance

13. The VRS will inform the worker as to what allowances they are entitled to when moving from the resident community. Allowances will be provided in accordance with Points 12 and 13 of POL 02/2014.

14. The VRS will document and place on the file rationale for all decisions taken under this procedure.

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8.7 Modifications – Home, Vehicle and Work (PRO 04/2015)

Document Date 27 April 2015

Purpose To provide administrative guidelines for paying home, vehicle and work modifications.

BACKGROUND

POL 04/2015, Modifications – Home, Vehicle and Work establishes the process for paying for home, vehicle and work modifications.

PROCEDURE

General

1. The Vocational Rehabilitation Specialist (VRS) will approve modifications based on recommendations from:
   a. WCB approved architects
   b. Occupational therapists, or
   c. Any other expert the WCB engages.

2. Modifications should be approved by the VRS in advance. The VRS may not pay for modifications that start or are complete before approval unless the worker gives good reason for not seeking prior approval.

3. The VRS will make purchases and get appropriate secondary approvals as required by:
   a. PRO 07/2012, Procurement Procedure, and
   b. POL 05/2004, Equipment and Tools – Vocational Rehabilitation.

4. The VRS will provide information regarding modifications to the worker and their family in person and in writing.

Work Modifications

5. If the worker's workplace needs modifications, the VRS will see if the employer will share the costs with the WCB. If not, the VRS will approve full funding of the modifications.
Short-Term Needs

6. The VRS will approve minor home and work modifications if the worker is expected to recover within 18 months.

7. The VRS will see if the WCB can rent equipment for minor home and work modifications. If the VRS cannot rent, the VRS may approve the purchase of equipment.

Long-Term Needs

8. The VRS will approve major modifications if the worker's injury is long-term and severe.

9. Home modifications:
   a. The VRS will approve modifications to the worker's pre-injury home if it is structurally possible and financially feasible (e.g., no more than 50 percent of the appraised value of the structure). If it is not possible or feasible, the VRS will approve a payment equal to the costs of the proposed modifications to the pre-injury home. This money will help the worker get a different home (i.e., used or new home) that has modifications or that can be modified.
   b. The VRS will approve non-structural modifications to the pre-injury home (e.g., hand rails in the bathroom) if the worker is waiting:
      i. To get into a different home (e.g., being built), or
      ii. For modifications to a rental unit.
   c. The VRS may approve temporary lodging if the worker cannot stay in their pre-injury home without modifications.
   d. The VRS may approve modifications to rental homes if the:
      i. VRS gets written consent from the landlord to make modifications, and
      ii. Landlord agrees in writing that the WCB is not responsible for restoring the property back to normal once the worker moves out.
   e. The VRS will approve the repair or replacement of modifications that:
      i. Break down or wear out, or
      ii. Suffer accidental damage.
   f. If the worker needs to move from their pre-injury home because of the injury, the VRS will approve payment for moving costs.
   g. If the worker requests to move from their modified home for quality of life issues (e.g., the worker is getting older and wants to move closer to his or her children), the VRS may approve modifications to a different home. The WCB will not approve modifications based on personal preference (e.g., the worker does not like their community). The VRS may evaluate moves for other reasons on the
basis of need versus want. As a result, the VRS will make decisions on such requests on a case-by-case basis.

10. Vehicle modifications:

The following is intended as a guide to help VRSs make decisions regarding vehicle modifications. However, VRSs will assess coverage for vehicle modifications on a case-by-case basis.

a. The VRS will approve modifications to either:
   i. The worker’s pre-injury vehicle, or
   ii. A different vehicle.

b. The VRS will approve a one-time only payment for a reasonable replacement vehicle that takes into account the ability to modify to suit the worker’s needs. The VRS will deduct the value of the worker’s pre-injury vehicle from the amount approved to buy a different vehicle.

c. The vehicle for modification must:
   i. Meet the provincial and federal vehicle standards suitable for modifications, and
   ii. Be expected to remain serviceable for at least three years.

d. The VRS will approve the repair or replacement of modifications that:
   i. Break down or wear out, or
   ii. Suffer accidental damage.

e. The VRS will not approve the replacement of a vehicle involved in a motor vehicle accident. Modifications to the replacement vehicle are subject to Point 10(g) below, less the value the vehicle insurance company gives for the existing modifications.

f. The VRS will not approve the repair of damage caused by careless or destructive use.

g. If the worker wants to replace their vehicle after five years, the VRS will approve 100 percent of modification costs to the new vehicle. If the worker wants to replace their vehicle before five years, the VRS may approve modifications to the new vehicle at a reduced rate:
   i. Less than three years – The VRS will not approve any modification costs.
   ii. Greater than or equal to three years, but less than four years – The VRS will approve 60 percent of modification costs.
   iii. Greater than or equal to four years, but less than five years – The VRS will approve 80 percent of modification costs.

The VRS will ensure that the new vehicle uses the equipment from the old vehicle. If the new vehicle cannot use the old equipment, the VRS will approve the purchase of new equipment.
h. The VRS will not approve:
   i. Extra licensing costs.
   ii. Maintenance other than to the modifications.
   iii. Vehicle warranty.

i. The VRS will approve modifications if the worker has someone who will drive their vehicle (e.g., family, friend). The worker does not have to have the ability to drive in order to get modifications.

Act Sec #  111, 115
Effective Date  01 July 2015
Application  All workers severely injured before and after the effective date
Supersedes  N/A
Complements  

POL 04/2015 Modifications – Home, Vehicle and Work
POL 10/2014 Allowance – Personal Care
POL 02/2014 Vocational Rehabilitation – Moving Allowance
PRO 07/2012 Procurement Procedure
POL 01/2011 Vocational Rehabilitation – Programs and Services
POL 15/2008 Allowance – Temporary Additional Expense
POL 05/2004 Equipment and Tools – Vocational Rehabilitation
9.0 APPEALS

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9.1 Reversing Decisions (PRO 23/2014)

Document Date 10 December 2014

Purpose To provide administrative guidelines for reversing decisions.

DEFINITION

Client means an injured worker, surviving dependent spouse, or employer.

BACKGROUND

POL 23/2014, Reserving Decisions establishes the process for reversing decisions.

PROCEDURE

General

1. WCB staff will reverse decisions only after careful consideration.

Reviewing and Reversing Decisions

2. If Case Management or Claims Entitlement staff decide to reverse or significantly alter a decision, they must get approval from one of the following:
   a. Team Leader.
   b. Assistant Director of Operations, or
   c. Executive Director of Operations.

3. If Employer Services staff decide to reverse or significantly alter a decision, they must get approval from one of the following:
   a. Manager, or
   b. Director of Employer Services.

Communicating Decisions

4. If the WCB reverses a decision, the WCB staff member that made the reversal will:
   a. Discuss the reversal with the client in person or by phone, and
   b. Send a letter to the client that outlines the reasoning for the reversal.

Appeals – Reversed Decisions

5. Clients can appeal reversed claim decisions. The following policies will apply:
a. POL 21/2013, Appeals – Claims.
b. POL 20/2013, Appeals – Employer Accounts
c. POL 22/2013, Board Appeal Tribunal.

Act Sec # 18, 20(5), 100(1)
Effective Date 01 January 2015
Application Claim and employer account decisions
Supersedes PRO 51/2006 Reversing Decisions
Complements

- POL 23/2014 Reversing Decisions
- POL 20/2013 Appeals – Employer Accounts
- POL 21/2013 Appeals – Claims
- PRO 21/2013 Appeals – Claims
- POL 22/2013 Appeals – Board Appeal Tribunal
- POL 17/2010 Termination of Compensation Benefits – Notice
9.2 Appeals - Claims (PRO 21/2013)

Document Date 18 December 2013

Purpose To detail the appeals process for claim decisions.

BACKGROUND

1. POL 21/2013, Appeals – Claims has been approved, which provides workers and employers (or their representatives) with an easily accessible review or reconsideration of any claim decision.

2. The following guidelines ensure that staff apply Workers’ Compensation Board (WCB) policy and the appropriate provisions of *The Workers’ Compensation Act, 2013* (the “Act”) when reviewing a decision, keeping in mind the individual merits and justice of the issue.

3. Service quality is maintained by responsible managers at each stage, setting suitable standards for quality and timeliness, and monitoring claims to ensure that delays are minimized in:
   a. Collecting information needed for a well-informed decision.
   b. Arriving at an Appeals Officer decision or Board Appeal Tribunal decision.
   c. Implementing an Appeals Officer decision or Board Appeal Tribunal decision.

PROCEDURE

Appealing WCB Claim Decisions (Workers or Employers)

Review

1. The worker’s or employer’s first step should be to contact the staff member responsible for the original decision. The staff member will consider any new information provided by the worker or employer, and gather any additional information necessary.

2. The staff member will provide a written response or document any discussion with the worker or employer.

3. Where the original decision is upheld, the worker or employer will be reminded of the Appeal process.
Appeals Department

4. Upon receipt of a written request for a review, the Appeals Department will conduct an immediate initial review to determine if:
   a. The decision was previously considered by the Board Appeal Tribunal and ruled on and, if so, the request will be sent directly to the Board Appeal Tribunal.
   b. A reconsideration decision has been made and communicated by the original decision-maker.
   c. There is sufficient information on file to proceed with an appeal.
   d. There is new information in the appeal, which was not previously available.

5. Depending on the last three criteria noted in point 4 above, the review may be delayed and appropriate directions will be given to the Operations Division concerning further inquiries to collect additional information. The worker is advised by the Appeals Department in writing as to how the situation will be handled. Alternatively, Operations staff will be asked to review the original decision, and respond directly to the request.

6. The Appeals Department will monitor directions on such claims and where the decision is not changed by Operations staff, review by the Appeals Department will proceed on a priority basis.

7. Where it is determined that a review can proceed, the Appeals Department will immediately acknowledge the appeal in writing and provide the appellant a time estimate of when the review will take place.

8. The worker and employer are advised in writing of the decision(s) in dispute, and invited to provide additional information in support of their respective positions.

9. An Appeals Officer will review all claim information relevant to the issue in dispute. The Appeals Officer may then make inquiries to collect additional information, direct Operations staff to make such inquiries, or seek advice from a WCB medical consultant. Under normal circumstances, the review is limited to the decision(s) in dispute. However, the Appeals Officer has authority to consider other issues, which may come to light in the course of the review, in cases of blatant error or non-compliance with policies.

10. The worker or employer may request a meeting or telephone conference with the Appeals Officer. The purpose of such a meeting is to allow them the opportunity to provide additional information or clarify certain issues related to the appeal.

11. Following a thorough review, the Appeals Officer will provide a written appeal decision to the worker and employer. The appeal decision will provide detailed reasons, including the information used and the applicable authority as set out in the
Act and/or WCB policy. The worker or employer who submitted the appeal will be invited to discuss the decision with the Appeals Officer to facilitate understanding.

12. Where an appeal decision relates to multiple claims and/or multiple employers, each employer will only be provided with information directly related to their own interests.

13. Any decision or direction of the Appeals Officer will be carried out by Operations staff without delay.

**Board Appeal Tribunal**

14. If the worker or employer disagrees with the decision of the Appeals Officer, they may request a further review by the Board Appeal Tribunal as outlined in policy POL 22/2013, Appeals – Board Appeal Tribunal.

15. In accordance with Section 20 of the Act, WCB has established that only the Board Appeal Tribunal will have exclusive jurisdiction to reach a decision in the first instance, or to review an appeal, which includes the following issues:
   a. Section 29 of the Act regarding presumption claims filed prior to January 1, 2003 (PRO 04/2014).
   b. Section 73 of the Act regarding proposals for alternate forms of annuities (POL 13/2013).
   c. Section 82 of *The Workers’ Compensation Act, 1974* (the “Old Act”) regarding the commutation of pensions (POL 11/2010).
   d. Section 100 of the Act regarding payments to dependant(s) of an incarcerated worker (POL 05/94).
   e. Section 169 regarding applications as to whether court action is barred under the Act (POL 01/2013), and
   f. Matters relating to the *Canadian Charter of Rights and Freedoms* (POL 05/2005).

16. Where appeals are received by the Appeals Department citing the issues noted in Point 15 above, they will first review the appeal to determine if there is a bona fide issue of exclusive Board jurisdiction. If it is so determined, the appeal is forwarded to the Director, Board Services and Corporate Governance for consideration by a Board Appeal Tribunal.

**Medical Review Panel**

17. A Medical Review Panel will only be convened after all other avenues of appeal have been exhausted, and only for bona-fide medical questions (POL 18/2010 – Medical Review Panels).
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9.4 Appeals – Charter and Constitutional Issues (PRO 05/2005)

Document Date 21 September 2005

Purpose To establish guidelines for responding to appeals based on the Charter and/or Constitution.

BACKGROUND

1. WCB establishes its authority under POL 05/2005 to hear and determine appeals based on the Charter and/or Constitution and the body to which appeals of this nature must be directed.

2. The following procedure provides guidelines where appeals of this nature are directed to WCB.

PROCEDURE

1. All clients appealing a WCB decision based upon bona fide Charter/Constitutional grounds are required to submit a written request to an Assistant to the Board.

2. The Assistant to the Board will forward the client’s written request for an appeal and any other relevant documentation (i.e., client file) to the Board Members.

3. The written request must contain the specific section(s) of the Charter and/or Constitution upon which the client is basing his/her appeal and specifically how the client believes his/her Charter/Constitutional rights have been denied.

Example:

A client must state, that “[Policy # and Title] infringes upon Section 15 of the Charter as it discriminates against me on the basis of [age, disability, etc.]” The written request must also outline his/her rationale as to how the specific WCB policy infringes upon the client’s rights under Section 15 of the Charter.

It will not suffice for a client to write: “The WCB rejected my claim and therefore my Charter/Constitutional rights have been violated.”

4. All bona fide Charter/Constitutional issues directed to the Board Members will be acknowledged in writing, and include an outline of the bona fide Charter/Constitutional issues involved, with copies to all interested parties.

5. Where a client appeals a WCB decision to the Appeals Department, in whole or in part, based upon a bona fide Charter/Constitutional issue, the following will occur:
a. The Appeals Department shall inform the client in writing that only Board Members have the jurisdiction to decide such issues. The appeal will be forwarded to an Assistant to the Board.

b. Where there are other grounds set out in the client’s written appeal request unrelated to the Charter/Constitution, the Appeals Department will rule on the issue, following the normal appeals process under POL 21/2013.
   i. Should the appeal be allowed, there will be no need for the Charter/Constitutional question(s) to be heard by the Board Members.
   ii. If, however, the appeal is rejected, the client has the opportunity to appeal that decision to the Board Members in the same manner as any other appeal.

6. Where there is any uncertainty as to whether the client has raised a bona fide Charter/Constitutional issue, the Appeals Department is to seek advice from Legal Services.

7. Where a client challenges the constitutional validity of provisions within the Act itself, the WCB may provide notice of the challenge to the Attorney General of Saskatchewan in accordance with The Constitutional Questions Act, 2012, and if appropriate, the Attorney General of Canada. Charter/Constitutional challenges to the Act are to be dealt with in the same manner as any other such challenge to WCB policies.

Act Sec # 18(1), 20
Effective Date 01 October 2005
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All appeals and challenges involving the Charter and/or Constitution.
Supersedes n/a
Complements

POL 05/2005 Appeals – Charter and Constitutional Issues
POL 22/2013 Appeals – Board Appeal Tribunal
POL 21/2013 Appeals – Claims
PRO 21/2013 Appeals – Claims
POL 20/2013 Appeals – Employer Accounts
PRO 20/2013 Appeals – Employer Accounts
BACKGROUND

1. POL 20/2013, Appeals – Employer Accounts has been approved by the Workers’ Compensation Board (WCB), which provides employers or their representatives with the guidelines for reconsideration or review of any decision made regarding their employer account.

2. The following guidelines ensure that staff apply WCB policy and the appropriate provisions of The Workers’ Compensation Act, 2013 (the “Act”) when reviewing a decision.

PROCEDURE

Employer Services Staff Member Review

1. The first step employers (or their representatives) should take is to discuss their concerns with the Employer Services staff member responsible for the initial decision. The staff member will consider any new information provided by the employer, and gather any additional information necessary, to ensure there is sufficient information available to make a well-informed decision.

2. The Employer Services staff member will provide a written response with full reasons for the decision.

3. Where the original decision is upheld, the employer will be advised of the subsequent appeal process and will be provided with the Employer Appeals Fact Sheet.

Assessment Committee

4. The Assessment Committee consists of:
   a. Chairperson – Director, Employer Services
   b. Member – Manager, Employer Services (Employer Service Representatives).
   c. Member – Manager, Employer Services (Account Registration and Data Processing)
   d. Member – Manager, Employer Premiums, and
   e. Member – Director, Strategic Planning & Performance Measurement.
Of which any two are required for a quorum to consider an appeal. A decision of the majority of the members is the decision of the Assessment Committee.

5. The Assessment Committee will determine whether the decision has been reviewed by the original decision maker. Where this has not been done, the appeal will be returned for review at this level prior to being heard by the Assessment Committee. The Assessment Committee will monitor the development and where the decision is not changed by Employer Services staff, review by the Assessment Committee will proceed in a timely fashion.

6. The Assessment Committee will acknowledge the appeal in writing and provide an approximate time frame to review the decision.

7. The employer may request a meeting or telephone conference with the Assessment Committee. The purpose of such a meeting is to allow them the opportunity to provide additional information or clarify certain issues related to the appeal.

8. The Assessment Committee will provide a written appeal decision to the employer. The appeal decision will explain the issue(s) under consideration, the final decision and the detailed reasons for the decision, including the applicable authority as set out in the Act and/or WCB policy.

9. Where the employer disagrees with the decision of the Assessment Committee, they may request a further review by the Board Appeal Tribunal as outlined in policy POL 22/2013, Appeals – Board Appeal Tribunal.

Act Sec # 14, 15, 18, 20, 21, 22, 23, 29, 73, 80, 100, 169, 171, 173, 174
Effective Date 01 January 2014
Amended References updated in accordance with The Workers’ Compensation Act, 2013
Application Employers requesting reviews of decisions made by Employer Services staff.
Supersedes PRO 32/2010 Appeals – Employer Accounts
Complements POL 20/2013 Appeals – Employer Accounts
       POL 21/2013 Appeals – Claims
       PRO 21/2013 Appeals – Claims
       POL 20/2013 Appeals – Employer Accounts
       PRO 05/2005 Appeals – Charter and Constitutional Issues
       POL 13/2013 Annuities
       PRO 17/2013 Authority for Disclosure
       POL 03/2012 Benefit of Doubt
       PRO 03/2012 Benefit of Doubt
       POL 01/2013 Determination of a Worker’s Right to Bring Action
       POL 04/2014 Fatalities, Presumption
       POL 18/2010 Medical Review Panels
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9.8 Medical Review Panels (PRO 18/2010)

Document Date 02 June 2010

Purpose To establish guidelines for Medical Review Panels.

BACKGROUND

1. The Workers’ Compensation Board (WCB) has approved POL 18/2010, Medical Review Panels, which establishes guidelines for Medical Review Panels.

2. All procedures for Medical Review Panels are the responsibility of the Board Services Department.

3. The following procedure provides guidance for the implementation of the policy.

PROCEDURE

1. Board Services will provide an orientation to each new chairperson of the Medical Review Panel.

2. The information package provided to clients will include a fact sheet, an application form, a blank certificate and copies of the appropriate sections of the legislation.

3. Where the WCB requires clarification pertaining to the certificate of the Medical Review Panel, Board Services will request written clarification from the chairperson. A copy of the written request will be forwarded to the worker, or the dependant of the deceased worker or their representative. In seeking clarification of the Medical Review Panel’s decision, the WCB will not provide any information to the Medical Review Panel that was not already in its possession at the time of the decision.

4. Where amendments to the certificate of a physician or chiropractor are required, the amendments will be added and initialed by each Medical Review Panel member. Where the certificate requires significant changes, the amended copies must be signed by all members of the Medical Review Panel. A copy of the amended decision will be provided to the worker, the dependant of the deceased worker or their representative.

Act Sec # 59, 60, 61, 62, 63, 64, 65
Effective Date 02 June 2010
Amended References updated 01 January 2014 in accordance with The Workers’ Compensation Act, 2013
Application All claimants
Supersedes PRO 20/2001 Medical Review Panels
Complements POL 18/2010 Medical Review Panels
10.0 GOVERNANCE, SAFETY, PRIVACY AND ACCESS TO INFORMATION

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10.2 Information from Inquiries (PRO 16/2013)

Document Date 18 December 2013

Purpose To establish guidelines for claim and employer account inquiries.

DEFINITION

Inquiry means any claim or employer account information-gathering by the Workers’ Compensation Board (WCB) staff or by any other person the WCB may authorize. It does not include investigations conducted by the Internal Audit Department.

Third party means a person who is not the worker, employer, representative or health care provider in relation to any injury claim or employer account.

BACKGROUND

1. POL 15/2013, Privacy of Information has been approved, providing guidelines for staff concerning the access, collection and release of information within the control of the Workers’ Compensation Board (WCB).

2. There are many circumstances where information provided on standard forms, such as Worker’s Report of Injury, Employer’s Report of Injury, health care providers’ reports or Employer’s Payroll Statement, is not sufficient to determine entitlement or assessment issues and requires further inquiries.

3. In other cases, third parties may volunteer information, in person, by telephone, or in writing, concerning the claim of a worker or the circumstances of an employer.

4. The following procedure provides guidelines where WCB staff receives information from third parties or those named by another source regarding a client file.

PROCEDURE

1. Any information obtained or discussed during the course of inquiries will be recorded on the claim or employer account.

2. Where they have not already done so, third parties may be encouraged to confirm their statements in writing.

3. Third parties are to be advised that information they provide will be recorded, and at the request of a client, may be subject to disclosure. If there is no objection to this, a normal statement will be taken.

4. Where any third party declines to be identified, the information should be recorded as anonymous. The third party should be warned that anonymous information will
normally carry weight in the decision-making process only if corroborated by information from another source.

5. Third parties who have been identified as having relevant information will be contacted to obtain information directly from them, before they are identified on the claim file or employer account.

6. All persons interviewed are permitted to have a representative present during the interview if they wish.

7. Oral statements will be taken, and recorded on the claim or employer account, but signed written statements may also be taken at the discretion of the interviewer.

8. Staff who conduct inquiries in the field will not express opinions on decisions to be made on the claim or employer account. Parties involved are to be informed that decisions will be made by authorized WCB staff.

9. Staff will record field inquiries in a written report submitted to the claim or employer account.

10. Where an individual is believed to have critical information but refuses to divulge it, consideration may be given to invoking Section 21 of the Act to compel the individual to testify as a witness under oath. However, approval will first be sought from the Chief Executive Officer.

11. Where information obtained points to the possibility of deliberate falsehood or omission, the situation will be reported to Internal Audit.

Act Sec # 20, 21, 22, 25, 140, 172, 173, 174.
Effective Date 01 January 2014.
Amended References updated in accordance with The Workers’ Compensation Act, 2013.
Application All claims and employer accounts.
Supersedes PRO 05/2008 Information from Inquiries
Complements POL 15/2013 Privacy of Information
PRO 17/2013 Authority for Disclosure
PRO 18/2013 Records Management
PRO 19/2013 Information Complaints
10.3 Authority for Disclosure (PRO 17/2013)

Document Date 18 December 2013

Purpose To establish guidelines for disclosure of information, in writing, in person, by email, and over the telephone.

BACKGROUND

1. POL 15/2013, Privacy of Information, has been approved, providing guidelines for staff concerning the collection and disclosure of information within the control of the Workers’ Compensation Board (WCB).

2. The following procedure provides guidelines for WCB staff on disclosing claim or employer information.

PROCEDURE

General

1. Of necessity, information is disclosed in the course of:
   a. Making inquiries concerning injuries, treatment and disability, or concerning employers’ business activities, or
   b. Explaining decisions made by the WCB, including explanations required by Section 48 of The Workers’ Compensation Act, 2013 (the “Act”).

2. Written explanations should normally be prepared by the WCB staff in the form of correspondence. The correspondence will not include copies of claim documents. Copies of claim documents may be provided on request in accordance with Points 32 to 50.

3. In some cases, a personal health condition, a personal financial circumstance, or a family matter has played a part in decisions about the claim or employer account (e.g., Section 101 decisions). When explaining this to persons affected, particularly in writing, there should be no need to disclose details of the personal condition or circumstance.

4. Normally, workers, employers and primary health care providers should receive a written explanation of the reasoning leading to a decision. Others affected only need to be informed of the extent or duration of WCB payment.

5. Normally, the employer at time of injury is entitled to know the reasons for a claim decision, and is therefore sent a copy of the written explanation. Where there are
multiple claims with separate employers, the employers will receive separate explanations.

6. Staff are only to include personal information in the written explanation to the worker if it is evident that it is directly relevant to the issue and decision, and where it is absolutely necessary. In these cases, an employer at time of injury will receive a separate letter outlining the decision and reasoning.

7. In all cases, the onus is on the WCB to explain decisions, and disclose the information relevant to these decisions. Information that is relevant will have some reasonable connection with, and some value or tendency to prove or disprove a matter of fact significant to the decision (POL 15/2013, Privacy of Information).
   a. The decision maker will determine what information is relevant to the decision on a case-by-case basis. The relevant documents will only be those that directly relate to the evidence used to make the decision. This may include information that the decision maker did not use, but rather reviewed and discarded. For example, in determining duration there may be three medical reports that provide clear, direct evidence that the duration was too long, just right, etc. There may also be two other reports that are less current and, therefore, are not used. These two other reports would not be relevant.
   b. Where workers or employers then ask questions about a decision, in-depth discussion on the telephone or in person is called for. Such discussions should be recorded on the claim or employer account. This is separate from the additional right a worker or employer has in some circumstances, to obtain copies of the documents in the claim or employer account.

Identification and Authorization

8. Staff should identify the worker, employer or their respective representatives before providing any information in person.

9. Where staff recognizes a person on sight, information can be provided.

10. Where staff do not recognize a person, the following steps are to be taken:
   a. The person is required to present photo identification (e.g., driver’s licence), and
   b. The person’s signature should be verified against documents already on the claim or employer account (e.g., forms Worker’s Report of Injury - W1, Employer’s Authorization Letter of Representation - EREP, Worker’s Authorization Letter of Representation – WREP).

11. Questions should be answered by appropriate staff assigned to the claim or employer account.
12. Before providing any information to a worker’s representative, staff must ensure a valid Worker’s Authorization Letter of Representation (WREP) document or suitable alternative consent form is on the claim or at hand, indicating that this person acts on behalf of the worker. Such an authorization remains in effect until rescinded by the worker.

13. Before providing any information to an employer’s representative, staff must ensure a valid Employer Authorization Letter of Representation (EREP) document or suitable alternative consent form is on the employer account or at hand, indicating that this person acts on behalf of the employer. Such an authorization remains in effect until rescinded by the employer.

14. Where staff receive telephone requests for information from workers, employers or their respective representatives, these will be transferred to the appropriate staff assigned to the claim or employer account in question.

15. Staff should verify the identity of the person on the telephone by reference to information already on the claim or employer account.

16. Where staff are unsure of the identity of a person on the telephone, information should not be provided, and an alternative should be used:
   a. Call back to a number already on the claim or employer account.
   b. Fax the requested information to a number already on the claim or employer account, or
   c. The caller should be advised to make their request in writing.

17. Where information is provided on the telephone or in person, this should be recorded on the claim or employer account.

18. Certain information can never be provided on the telephone. For example, electronic banking information, social insurance number, or provincial health number.

19. Staff must avoid identifying the source of information which adversely affects entitlement to benefits, when the security of that source may be at risk as a result. One criterion for judging this would be whether the security of WCB staff has been in question on this claim or employer account.

20. Where there are concerns as to the sensitivity of information, staff should consult their supervisor.

21. Where a medical summary is requested, the request should be sent to Medical Services for response.
Third Party Requests

22. Inquiries from Members of the Legislative Assembly or Members of Parliament should be directed to the Executive Inquiry and Information Officer, who is empowered to discuss claims or employer accounts without written consent. If copies of documents are required, Sections 173 and 174 procedures will apply.

23. Where under a legal obligation to disclose information (for example, courts, law enforcement agencies, maintenance enforcement officials, ombudsman, employment insurance officials) and where the party is requesting copies of claim documents, the WCB will provide such copies double-enveloped and delivered via suitable means of assured delivery.

24. In accordance with POL 08/2013, Inter-jurisdictional Agreement on Workers’ Compensation (IJA), staff will respond to requests from other WCB jurisdictions for the exchange of IJA claim or employer account information. Staff should take the same identification precautions that are used with inquiries from workers and employers.

25. Information sharing agreements will be executed by the Chief Executive Officer or designate after review by the Corporate Solicitor. Legal Services will centrally store the original signed agreements with copies held in the relevant departments.

26. Although individual agreements will vary on specific terms, all third parties will be bound by a confidentiality clause regarding the use and storage of information requested, stating:
   a. Information is to be used only for the purpose requested.
   b. Information is to be used only by the parties to the agreement, except where subsequent disclosure is specifically permitted by the WCB (e.g., as evidence), and
   c. Information will be afforded adequate and appropriate security as outlined by the WCB.

27. Information sharing agreements for providing bulk data on a one-time basis will include these conditions:
   a. Will not use the information for commercial purposes, and
   b. The request is for the purpose of enhancing prevention, treatment or return-to-work programs.

Media Requests

28. The Director of Communications is designated as the WCB contact for all media inquiries and is authorized to provide information to the media after consultation with senior management.
29. Where the media approaches the WCB, the Director of Communications shall ask the media representative to obtain a signed waiver from the client before any information is disclosed.

Methods of Disclosure

30. Business may be conducted by email but out-going communications may not be private or secure and could be intercepted. The WCB has, therefore, ensured all email messages include a confidentiality disclaimer and will be considered acceptable, unless the respondent declines this method of communication.

31. Bulk data may be sent through email, postal service or courier service.

File Requests

32. Copies of claim documents may be provided on request to workers, dependents, worker representatives, employers or employer representatives.

Workers, Dependants and Representatives

33. To request copies of claim documents, a worker, dependant or worker representative should use a Worker’s Request for Copy of File (WROI) form. No formal appeal is prerequisite, and it is not necessary to identify the issue in dispute. However, in accordance with subsection 173(3), the information provided is to be used only for the purposes of a reconsideration or review of a decision of the WCB.

34. To request copies of claim documents, a worker’s representative must submit a Worker’s Authorization Letter of Representation (WREP) in addition to the Worker’s Request form.

35. Once the Request form is received, copies of claim documents will be reviewed to determine if any information should be redacted or removed. Typically this would be information that falls under Points 56 and 57 below.

36. After review, the claim documents will be provided to the claimant by means of a double-envelope system. This includes:
   a. An outside envelope with the name and address of the claimant, and
   b. An interior envelope with a bold notice to the effect of: "THIS DOCUMENT IS CONFIDENTIAL AND IS TO BE OPENED ONLY BY [WORKER’S NAME]."

37. The claim documents may be delivered by one of the following methods:
   a. Upon providing proof of identity, claimants may pick up their information at the WCB office. The WCB should obtain an acknowledgement of receipt.
   b. Claimants who live in a city or a town may receive their information by courier.
c. Claimants who do not live in a city or town may receive their information by express post. This will ensure that there is a record of the envelope. In addition, the envelope may be traced if it does not arrive as anticipated.

38. There will be no charge in the first instance, but any subsequent request for the same copies shall be subject to an administration fee of $50.00 plus a charge of $0.25 per page.

39. Updated copies of documents later received on a claim should be provided with the next written explanation of any decision on the claim, or can be provided on request, without the completion of a new form.

Employers and Representatives

40. To request copies of claim documents, an employer must use an Employer's Request for Photocopy of Relevant Records in File(s) form. No formal appeal is prerequisite, but the issue in dispute must be clearly identified and must concern a decision made on the claim or a pending appeal.

41. To request copies of claim documents, an employer's representative must submit an Employer Authorization Letter of Representation (EREP) in addition to the Employer's Request for Photocopy of Relevant Records in File(s) form.

42. Where the employer requests copies of claim documents:
   a. The decision maker (Claims Entitlement Specialist, Case Manager, Appeals Officer, etc.) will identify which documents are relevant to the decision in question. Copies are made only of those claim documents that are identified as relevant to the decision on the claim. Copies may be redacted to block out non-relevant information.
   b. After identification by the decision maker, the selected copies will be compiled by Operations staff. These will be provided to the worker by the means described in Point 37, along with a letter of notification that they have 15 business days from receipt of the letter to request a reconsideration of the copies to be provided to the employer. Any objections raised by the worker must be related to specific documents and be provided in writing with reasons given.

43. Staff will not send copies to the employer prior to the expiration of the 15 business days, or the time it takes the WCB to consider the objections of the worker, whichever is longer.

44. If no objections have been received, copies will be provided to the employer by the means of a double-envelope system. This includes:
   a. An outside envelope with the name and address of the employer, including a specific contact person, and
Procedure Manual

b. An interior envelope with a bold notice to the effect: “THIS DOCUMENT IS CONFIDENTIAL AND IS TO BE OPENED ONLY BY [EMPLOYER CONTACT NAME].”

45. The claim documents may be delivered by one of the following methods:
   a. Employers who have a business address in a city or a town may receive their information by courier.
   b. Employers who do not have a business address in a city or town may receive their information by express post. This will ensure that there is a record of the envelope. In addition, the envelope may be traced if it does not arrive as anticipated.

46. Any objections received will be considered by the staff responsible for the claim, and any changes in the selected copies will be explained to the worker in writing, with notification that a further 15 business days is allowed for final objections.

47. If no further objections are received, the requested copies will be sent to the employer as outlined under Points 44 and 45.

48. Where further objections have been received, they will be considered by the staff responsible for the claim, and the final selection of copies will be explained to the worker in writing. Copies will then be sent to the employer.

49. An employer may request that the WCB reconsider the decision regarding the copies of documents within 15 business days of the date of the decision.

Accuracy of Information

50. After reviewing copies of documents, workers or employers may submit to the WCB a written explanation of any matter they believe is in need of correction, or submit additional related information to be included in the claim or employer account.

51. Where the correction required involves markup or removal of claim documents, the number of documents and reason will be recorded in a memo on the claim, without revealing the information removed.

FOIPP Access Requests

52. Any application for access to information which cites The Freedom of Information and Protection of Privacy Act (FOIPP) will be sent directly to the Privacy Officer.

Office of the Worker’s Advocate

53. The Office of the Worker’s Advocate will be provided with electronic access to claims, subject to a confidentiality agreement. In some cases, they will require
copies of claim documents, which will be double-enveloped and delivered via suitable means of assured delivery.

File Information

54. The following types of documents do not properly form part of the claim or employer account. Copies of these documents should not be provided:
   a. Legal opinions.
   b. Comments or advice concerning specific courses of action recommended by the Corporate Solicitor, Legal Services and/or the Privacy Officer.
   d. Working papers or notes taken by Board Appeal Tribunal members during the course of a hearing or deliberation.
   e. Internal Audit investigation reports.
   f. The working papers or notes of a fraud investigator of Internal Audit, or
   g. Documents related to the WCB Security Policy.

55. Copies of documents identifying the source of information adversely affecting entitlement to benefits may be copied and sent, unless there is evidence that the security of that source may be at risk as a result. One criterion for judging this would be whether the security of WCB staff has been in question on this claim.

56. Copies of documents containing medical information considered harmful to the worker or any other person will not be sent directly to the worker. Instead, Medical Services will provide a report to the primary care provider with a covering letter of explanation. When staff members are unsure, the advice of Medical Services is to be sought.

57. Copies of documents on other claims of the same worker should be provided, where they are relevant to the issue(s) in dispute on the claim just decided.

Effective Date 01 January 2014
Amended References updated in accordance with The Workers’ Compensation Act, 2013.
Application All requests for disclosure of information.
Supersedes PRO 04/2008 Authority for Disclosure
Complements POL 15/2013 Privacy of Information
PRO 16/2013 Information from Inquiries
PRO 18/2013 Records Management
PRO 19/2013 Information Complaints
POL 21/2013 Appeals – Claims
POL 22/2013  Appeals – Board Appeal Tribunal
POL 20/2013  Appeals – Employer Accounts
POL 08/2013  Interjurisdictional Agreement on Workers’ Compensation (IJA)
10.4 Records Management (PRO 18/2013)

Document Date 18 December 2013

Purpose To establish guidelines for the storage, archiving, and destruction of information.

DEFINITION

Transitory records means records of temporary usefulness that are needed only for a limited period of time to complete a routine task or prepare an ongoing document. These records are not required to meet statutory obligations or to sustain administrative or operational functions. These records should be destroyed once they have served their purpose.

BACKGROUND

1. POL 15/2013, Privacy of Information, has been approved, providing guidelines for staff concerning the access, collection, and release of information within the control of the Workers’ Compensation Board (WCB).

2. The following procedure provides staff with specific guidance with respect to the storage, archiving or destruction of information in compliance with legislative requirements.

PROCEDURE

1. All information that is collected for the purposes of decision making on worker or employer files will be stored on the worker claim record or the employer account file.

2. In order to maintain the integrity of the claim record or the employer account file, information collected must be stored on the file in its complete form without the removal or redaction of information.

3. Redaction or removal of information may occur when the file is provided to the worker or employer if it is required to protect the worker or third parties (PRO 17/2013, Authority for Disclosure). Specifically, the WCB will not disclose information that is harmful to personal privacy or individual safety.

4. Information that is collected for purposes other than decision making on worker claim or employer account files will be stored by the respective department that is responsible for actions related to that information. For example, information relating to security incidents are stored in an appropriate file in Facilities.
5. According to *The Electronic Information and Documents Act, 2000* (EID), in the absence of a paper copy of a document, an electronic copy of that document is considered to be a legal original.

6. Email correspondence with a client in the course of business is also considered to be a WCB record, and shall be retained as part of the client file.

7. WCB encourages the scanning, microfilming, and imaging of all paper records in order to improve service and reduce costs.

8. To meet the requirements of *The Archives Act* (AA), the WCB will use the Administrative Records Management System, 2014 (ARMS 2014), a provincial government classification system for common administrative records (the ARMS 2014 Manual is available from Facilities). The Saskatchewan Archives Board will also provide the necessary assistance for the development of an Operational Records System (ORS) to manage the records specific to the operations of the WCB.

9. Each director, manager or other department head is responsible for compliance with this procedure and shall designate a Records Manager (RM) to identify the types of records in their department so that they may be categorized as either administrative or operational records.

10. After such identification has occurred the RM will develop a records retention schedule (RRS) stipulated by ARMS 2014 or ORS for the storage, archiving and destruction of information. This will include selection of non-current documents of historical interest for transfer to the Archives.

11. Records stored in-house will be kept in a clean, dry location with adequate security for the type of information stored. Electronic records will be stored in containers that provide environmental and magnetic protection with a fire rating of at least one hour. Records will not be stored in areas subject to water damage, mold or infestation.

12. Off-site private or public storage agencies will be contracted for the long-term storage of records not required on a regular basis, but which may be needed from time to time for reference purposes. In compliance with *The Health Information Protection Act* (HIPA), the agency must sign an agreement including, but not limited to, the following conditions:

   a. WCB records will be kept in a clean, dry location with adequate security for the type of information stored.

   b. Electronic records will be stored in containers that provide environmental and magnetic protection with a fire rating of at least one hour.

   c. Records will not be stored in areas subject to water damage, mold or infestation.
d. The integrity, accuracy, and confidentiality of the information is protected against any reasonably anticipated threat, loss or hazard, and

e. The information is to be stored in a manner that is consistent with the ARMS 2014 classification system and for easy retrieval by WCB staff when necessary.

13. The Privacy Officer will be responsible for arranging for the storage and destruction of documents no longer needed by departments.

14. Records scheduled for destruction in accordance with the RRS will be destroyed under controlled conditions and in a manner that protects the privacy of individual clients and the WCB. Records may be destroyed by shredding, pulverizing, disintegrating or burning of paper, tapes, disks or any other media. Electronic media may also be destroyed by deleting it from the WCB’s storage systems.

15. RMs will maintain a log of records disposed, using the form developed under the Saskatchewan Archives Board’s “Records Disposition System” (RDS) for quarterly review by the Privacy Officer.

16. The Privacy Officer will ensure ongoing training is provided to RMs as necessary.

17. RMs will:

   a. Consult with the Privacy Officer regarding the development of an ORS/RRS for their department or unit.
   
   b. Obtain approvals (manager, vice-president) for the disposition of all expired records listed in the ORS/RRS schedule, and

   c. Maintain and be accountable for control logs showing the disposition of all board records, electronic and paper. Logs will include a description of the records, the date range and volume of records and the date, method and agency responsible for destruction.

18. WCB staff will not keep transitory records. Upon the completion of a final work product, the creator of a transitory record will place the record in a secured disposal bin.

Act Sec #  20, 21, 22, 25, 140, 172, 173, 174; The Health Information Protection Act; The Archives Act; The Electronic Information and Documents Act, 2000, Administrative Records Management System, 2014.

Effective Date  01 January 2014

Amended  References updated in accordance with The Workers’ Compensation Act, 2013.

Application  All information stored by the WCB.

Supersedes  PRO 06/2008 Storage of Information

Complements  POL 15/2013 Privacy of Information
PRO 16/2013  Information from Inquiries  
PRO 17/2013  Authority for Disclosure  
PRO 19/2013  Information Complaints
10.5 Information Complaints (PRO 19/2013)

Document Date 18 December 2013

Purpose To provide an avenue for privacy inquiries and complaints.

BACKGROUND

1. POL 15/2013 – Privacy of Information has been approved, providing guidelines for staff concerning the access, collection and release of information within the control of the Workers' Compensation Board (WCB).

2. POL 15/2013 has incorporated the provincial government’s privacy principles (under the Privacy Framework) to safeguard and regulate the confidentiality of information collected, stored or released to third parties. It also provides an avenue for access requests under The Freedom of Information and Protection of Privacy Act (FOIPP).

3. Any person may challenge WCB compliance with its privacy policies and procedures or about its information practices; including accuracy of information collected, recorded, stored or disclosed. The following procedure provides guidelines for such concerns.

PROCEDURE

1. Persons with complaints should be encouraged to first contact the WCB staff member most closely involved with the circumstances. Responses at this level may be oral or written.

2. If a complaint or concern is received, WCB staff will:
   a. Respond to the best of their ability, and record on the claim file or employer account, the steps taken to rectify the complaint, including an apology where needed, or
   b. Refer issues they cannot resolve to their supervisor.

3. When complaints are not resolved by a supervisor, the person will be advised to send a written complaint to the Privacy Officer or by e-mail to privacyoffice@wcbsask.com.

4. The Privacy Officer will:
   a. Log the complaint, including the date it was received and any details necessary to investigate.
   b. Acknowledge the complaint and inform the individual of the steps that will be taken by the WCB to follow up, including when a response can be expected.
c. Investigate the complaint received in a confidential manner.
d. Access all relevant records and staff, as needed to complete the investigation.
e. Recommend appropriate measures to rectify the situation at hand and notify the complainant of the following as appropriate:
   i. Steps to be taken to comply with WCB policies and procedures, or
f. Explain to the supervisor any variance from WCB policies and procedures.
g. Record all decisions and actions taken, and
h. Follow up to ensure the appropriate steps have been taken.

5. A complainant may appeal a decision of the Privacy Officer to the Board Appeal Tribunal.

**Act Sec #**


**Effective Date**

01 January 2014

**Amended**

References updated in accordance with The Workers’ Compensation Act, 2013.

**Application**

All stakeholders.

**Supersedes**

PRO 07/2008 Information Complaints

**Complements**

POL 15/2013 Privacy of Information

PRO 16/2013 Information from Inquiries

PRO 17/2013 Authority for Disclosure

PRO 18/2013 Records Management

POL 22/2013 Appeals – Board Appeal Tribunal