WORKER'S COMP FOR DUMMIES:

A Primer for practice before the W.S. & I.B.

Robert A. McGill
Barrister & Solicitor
100 Fullarton Street
London, Ontario
N6A 1K1

&

Michael J. Pretsell
Pretsell Cavanaugh
Barristers
161 Front Street
Belleville, Ontario
K8N 2Y6

Note: The authors extend their thanks for permission to reprint portions of No Need to Dive Under the Carpet: A Primer on WSIB Practice, March 2000, by David Little of Hastings & Prince Edward Legal Services

"A WSIB PRIMER"
Ontario Trial Lawyers Conference – Fall 2003

PART I – THE GENERAL SCHEME

The Worker's Compensation scheme began in 1914 as an historic trade-off: Workers hurt in the course of their employment were entitled to benefits under the statutory scheme regardless of fault, and in return gave up any right to sue their employers. Historically, the schemes have included wage loss benefits, permanent disability benefits, healthcare benefits, survivors' benefits, and assistance in returning to work.

While the healthcare and survivors' benefits have been relatively constant, the other parts of the scheme have not.

There are, roughly speaking, the following three systems in place:

1. Pre 1990

Injured workers were paid for periods of "**temporary disability**" at a full benefit rate (if they were fully cooperative in their rehabilitation process), until they reached **"maximum medical rehabilitation"**. If they had a **"permanent functional impairment"**, they were awarded a **pension**, expressed as a percentage of total disability, payable for life. The pension rating was done according to a rating schedule (known by advocates as the "meat chart"), which was applied indiscriminately and without regard for actual wage loss. Some **pension supplements** were available, the most important of which was the full supplement which workers received when they were cooperating in Board sponsored vocational rehabilitation efforts to return them to work.

2. January 2, 1990 to December 1997

This period was known as the Bill 162 era. Workers were still paid for periods of "**temporary disability**", however this was only payable until the disability ended, or 12 to 18 months after the date of accident. At that point, the Board projected the worker's estimated income loss and paid the difference between what the worker earned before he

was hurt and what the Board deemed the worker capable of earning in suitable and available employment after his injuries. The **"Future Economic Loss"** (FEL) was established with an initial determination date (the "D1" date), and then was reviewed, firstly, two years after the initial projection (the "R1" date), and again three years after that (the "R2" date). In addition, permanently impaired workers received money for their **"Non-Economic Loss"** (NEL), which is roughly equated with pain and suffering. NEL benefits were paid as a percentage of total disability according to the AMA guidelines, another 'meat chart' approach. The FEL and NEL approach to permanent injuries was known as the **dual award approach**.

3. January 1998 and Ongoing

This is known as the Bill 99 era. There is no longer a concept of temporary disability or future economic loss. Instead, there is simply one category of "**Loss of Earnings**" (LOE). By eliminating the period of temporary disability, the Board has opened the way for employers to offer suitable work even the day after an accident. NEL benefits are still payable for permanently impaired workers under the Bill 99 scheme.

In every case, no matter which regime a claim may fall under, the Board establishes a **Date of Accident** (DOA) for each and every claim. This is straight forward for accidents which are "chance events" but more problematic with claims established on the basis of a "disablement".

A worker's rights are generally determined by the Act in place at the time of his or her injury. However the applicable regime may be the subject of a dispute with the Board where, for instance, a worker has previous claims involving a similar area of injury; the Board must determine whether a certain injury is a new injury or a recurrence of an old injury. Further, there are transitional rules applicable to old claims being adjudicated upon under the current system. These rules can become quite complicated and are beyond the scope of this paper.

PART II – RESOURCES

Law, Policy and Jurisprudence

The primary resource is the applicable Act and Regulations. Referring to these upon the initial review of a file is not very helpful. Reference to the Act and Regulations is more useful in sophisticated Appeals Tribunal advocacy, where the provisions of the Act are applied more strictly. For proceedings before the Board, familiarity with Board policy and procedures is critical for case preparation.

There are four main sources of the Board's Policy, which govern the decision making process. Generally, the policy in force at the time the Board rendered the decision in dispute applies. However, one must be cognizant of updated policies more advantageous to the worker's claim, or new policies express approved in place of old ones.

The first set of policies is contained in the old **Claims Adjudication Branch** manuals, which include old policy statements up to about 1989. These policies are only applicable to pre-1990 matters and are therefore not often used. However, to calculate a pension for a permanent disability suffered prior to 1990, you would consult this policy manual.

The **Operational Policy Manual** is the primary reference resource and consists of two parts. The first binder contains all policies in place before Bill 99 (pre-1998). These policies are still relevant as many of the appeals currently on stream concern Board decisions to which the pre-1998 policies apply.

The second binder, released in October 1999, contains policies relevant to decisions made by the Board after Bill 99 including many policies that affect Bill 162 workers given the changes brought about by Bill 99.

These binders are must-haves for practice in this area. They constitute the guidelines by which W.S.& I.B. Claims Adjudicators are directed to rule on claims. To order the Operational Policy Binders, contact the Toronto office of the W.S.& I.B. The one-time purchase price for the Operational Policy Documents is approximately $200.00 plus G.S.T. and subscriptions to receive ongoing Policy Updates cost about $80.00 per year.

The Board will delete old policies and release new or updated Policies to be included in the Manual about 6 times per year, therefore it is crucial to keep your Operational Policy Manual up-to-date (note: Deleted Policies should always be kept should issues involving old decisions arise). With a subscription to this service you will also receive a copy of "Policy Report", a W.S.& I.B. publication, which summarizes the Board's updates to its policies and procedures. "Policy Report" is published about 4 times per year and helps in determining trends in the Board's approach to interpretation of the legislation and it's adjudication on various issues.

The final set of "policies" can be found in Discussion Papers, the Board's informal practices, FOI requests, and by simply learning the way the W.S.& I.B. does things. While not always found in the actual manuals, familiarity with Board practices can be used to advantage in dealing with Claims Adjudicators.

Jurisprudence in this area is very well developed, at least at the Tribunal level. The WSIAT digests all of its decisions into the **Decision Digest Service** (DDS), which is available from the Tribunal. A range of important decisions are also published in the **WSIAT Reporter** published quarterly. Full text decisions are available off Quicklaw or from the WSIAT website located at www.wsiat.on.ca. Follow the link "Researching Decisions" to the "Decision Summary Search". This research facility also boasts an excellent "Keyword Directory" of just about every conceivable topic.

The secondary sources are also very good.

The best source is Workers' Compensation in Ontario Service by Garth Dee, the late Nick McCombie and Gary Newhouse, a loose-leaf service published by Butterworth's. These authors recently published a Workers' Compensation in Ontario Handbook, though this is comparatively inferior. Carswell's The Practical Guide to Workers' Compensation in Ontario is good for your first hearing, but rather elementary after that.

The Industrial Accident Victims' Group of Ontario (IAVGO) publishes The IAVGO Reporting Service, comprising articles contributed on a quarterly basis, as well as a useful newsletter outlining current topics of concern. Unfortunately, there is no good index.

Workers' Compensation: A Manual for Workers' Advocates, a co-production of IAVGO and Community Legal Education Ontario (CLEO) both of which are funded by Legal Aid Ontario, is a very useful and thorough review of pre-1998 claims procedure and jurisprudence. Unfortunately, it has not been updated for Bill 99 law.

Annotated Ontario Workplace Safety and Insurance Act by David Starkman, published by Edmond Montgomery, is also an excellent resource. Sections of the *Workplace Safety & Insurance Act* (ie. Bill 99) are set out followed by references to applicable Operational Policy Documents and, in some cases, leading W.S. & I.A. Tribunal decisions. There is also a table of concordance between the *Workplace Safety & Insurance Act* and the *Worker's Compensation Act*.

Non-Legal Resources

WSIAT has commissioned a number of medical-legal reports which are available from the Tribunal. These reports cover a variety of issues, including:

- Asthma and the Workplace
- Back Pain
- Carpal Tunnel Syndrome
- Chronic Obstructive Lung Disease
- Diabetes Mellitus
- Dizziness
- Double Crush Syndrome
- Dupuytren's Contracture
- Heamorrhoids
- Headache
- Hernias
- Industrial Dust Exposure and Chronic Obstructive Airway Disease
- Interstitial Lung Disease and Beryllium-Related Disease
- Limping and Back Pain
- Neck and Arm Pain and Related Symptoms
- Cervical Disc Disease

- Osteoarthritis
- Pes Plantus
- Plantar Fasciitis
- Post-Traumatic Stress Disorder
- Reflex Sympathetic Dystrophy
- Shoulder Injury and Disability
- Symptoms in the Opposite or Uninjured Arm
- Symptoms in the Opposite or Uninjured Leg, and
- Thoracic Outlet Syndrome.

Tribunal Vice-Chairs (the decision-makers at WSIAT) will often refer to these reports at hearings, particularly where causation is at issue. Thus, familiarity with these reports will help in understanding the decision-makers mindset when approaching the causal connection between an accident and an injury.

Useful Labour Market Information - which can be used to attack the Board's estimation of post-injury earnings capacity - can be found at the Human Resourced Development Canada website, http://www.hrdc-drhc.gc.ca.

Independent Vocational Rehabilitation Counsellors provide helpful reports to counter the minimalist approach to rehabilitation usually devised by the WSIB.

PART III – THE DECISION MAKING PROCESS AT THE BOARD

The Adjudication Model

The Board has teams of decision makers which are divided by industry sector and also divided regionally.

All complex case files are adjudicated out of Toronto. Complex cases involve the very severely injured (Complex Case Unit – Injuries) or Occupational Disease (Complex Case Unit – Diseases).

Almost all decisions concerning entitlement are made by a Claims Adjudicator.

Pre-1990 claims are dealt with by one team since these Adjudicators administer a radically different Act than the other Adjudicators. The other Adjudicators are divided by sector.

If you have a complaint about a certain Claims Adjudicator, contact his/her **Team Manager**, whose intervention is usually effective in getting action. The Manager's boss is the **Director** of that industry sector, who is usually located in Toronto (the exception is the Director for Small Business, who is located in Ottawa). You should only contact the Director in the more unusual cases. Keep in mind the Adjudicators make the initial decisions, not the Managers. You may need to contact the Manager if you are unhappy about the administrative process (i.e. delays, rudeness) or if the Adjudicator's decision is obviously outrageous.

Nurse Case Managers are liaisons between the Board and the injured worker's healthcare providers. As Registered Nurses, they are obviously familiar with medical terminology and can assist with requests for payment approval of recommended prescriptions, physiotherapy, etc. Nurse Case Managers provide some input into adjudicative decisions; however, all decisions on entitlement are ultimately made by the Adjudicator.

Board doctors, referred to variously as **Unit Medical Advisors** ("U.M.A." in Toronto) **Regional Medical Advisors** ("R.M.A." in Regional Offices) or, now, **Medical Consultants** ("M.C." in Regional Offices), act as consultants to the Claims Adjudicators. They do not make adjudicative decisions, but rarely does the Adjudicator's decision deviate from the Board doctor's opinion. It is inappropriate and unprofessional practice to contact a Board doctor directly.

All **Labour Market Re-entry** (LMR) services (i.e. arranging retraining, formal education, and psychological assessments) are out-sourced to service providers. Many of these service providers are former WSIB **Vocational Rehabilitation (V.R.) Caseworkers** who were guaranteed a certain amount of referral work as part of their termination packages when the Board started out-sourcing these services. The Board still

has some **Ergonomic Specialists** and **Return to Work Mediators** on staff to assist with Return to Work issues.

The "supporting cast" includes, **Access Specialists**, **Hearings Schedulers, and Hearings Administrators.**

The Access Specialist photocopies the Claims File and sends an Objection Form to the worker or his or her representative. Generally, File Access is received in 4 – 8 weeks from the date a request is received.

The Hearings Schedulers schedule oral hearings. A successful appeal can adversely affect the Accident Employer's Claims history and, in turn, premium payments to the Accident Fund. Employers are, therefore, parties to the Appeals process and are entitled to submit documentary evidence and attend hearings to lead oral evidence from witnesses and make submissions. Once the hearings notices are sent out, the role of the Scheduler is complete.

Hearings Administrators arrange witness summonses, arrange accommodations if necessary, deal with postponement requests, and generally all the administrative tasks associated with a hearing. Pre-hearing disclosure (evidence you want considered at the Hearing) should be sent to the Hearings Administrator 14 days in advance of the hearing. Many representatives will send additional documentary evidence directly to the **Appeals Resolution Officer** (ARO) assigned to hear the matter whom typically have no objection to this practice.

APPEALS

1. At the Board

A worker can only appeal a decision that is in the form of a letter concerning his or her benefit or service entitlement. The Board practice is to require that a letter be sent to the worker prior to any termination of benefits, however, in practice many workers are bewildered by a benefit termination without written notification until several weeks later. Since the enactment of Bill 99, worker's have six months to object to any decision regarding his or her entitlement, except with regards to Labour Market Re-entry Plans,

for which there is a 30-day appeal period. The Board's current practice is to advise the worker of the limitation period in an adverse letter. Objections must, at a minimum, be in writing. The threshold for what constitutes a valid "notice of objection" is low; it is usually sufficient that the worker/representative merely indicate, even without reasons, the desire to object. However, section 120(2) of the Act provides that *"(t)he notice of objection must be in writing and must indicate why the decision is incorrect or why it should be changed".* While the Board does not currently enforce the second part of the requirements of s. 120(2), it is recommended that solicitors assert, at a minimum, some grounds in support of the objection.

If you are drafting the notice of objection for the worker, you will typically include the worker's executed Consent Letter authorizing you to represent worker in her dealings with the W.S.& I.B. along with release of a copy of the Claims File to your office. Upon receipt of the notice of objection, the Adjudicator who made the adverse decision refers the file to the Access Department which photocopies the file, adds an **Objection Form** and sends it to you.

Oftentimes, forwarding Access and Objection forms is low on a Claims Adjudicator's priority list, therefore it's wise to diarize a follow up with the Access Department if the file has not been received within 4 – 6 weeks.

Once you have notified the Board of the intention to appeal in writing, there is no time limit to return the Objection Form.

When you are ready to submit your appeal, you must complete the Objection Form, identify the issues you are appealing and what Order you want the Board to make. It is usually wise to forward the Objection with a supporting submission (perhaps one to two pages) making reference to any additional medical reports or other evidence filed in support of your Objection, as well as any Board policies (ie. law) upon which you also rely.

The hierarchy of the Appeals procedure dictates that the Objection must first be ruled on by the Adjudicator who made the original adverse decision. Adjudicators rarely overturn their initial decision without fresh evidence that was unavailable or not submitted at the

time of the original adverse decision. Even with significant new evidence submitted, Adjudicators will often "stand pat" and uphold their decision. The Adjudicator will also review requests for adjudication on new issues as set out on the "Other Matters" portion of the Objection form. Often there is a Manager's review of the file and, if Claims does not reverse itself, the file is sent to the **Appeals Branch** in Toronto, where it is assigned to an **Appeals Resolution Officer** (ARO).

There are competing views on whether to include "new evidence" in the Objection Form. The Adjudicators seldom change their minds even with new evidence. Some practitioners view the appeal before the Claims Adjudicator as perfunctory, submit little or no new evidence with the Objection and concentrate their efforts at winning at the next level of appeal before the ARO. Another view holds that, by not submitting any new evidence, the Adjudicator will certainly not change the decision, and therefore, one appeal level is effectively lost. You will have to determine on a case-by-case basis whether an appeal has a realistic chance of success in the early stages of the process.

A similar school of thought holds that giving the Appeals Branch something new may permit the ARO to change the decision, whereas without new evidence the chance the ARO will overturn the Adjudicator is weak.

Ensure you specify in the Objection form exactly which decision you disagree with, identify the legal test involved (quote the applicable Operational Policy Document if possible) and state the remedy sought. Many times Claims Adjudicators will draw conclusions easily identified as unsupportable on the facts. You may then spend considerable effort attacking that conclusion as wrong only to later discover Claims was relying upon the wrong section of the Act or the wrong Operational Policy Document. Keep in mind, a decision-maker at the Appeals Branch or WSIAT cannot overturn a decision which has not first been clearly identified as an issue under appeal in the Objection and reconsidered by the Claims Adjudicator

When the Appeals Branch receives the file there is a delay before it is assigned to the ARO. During that delay, the Appeals Branch generates a **"60-day election"** letter. This gives the worker the option of receiving an appeal decision within 60 days of filing that letter, **based only on a review of the documentary evidence in the claim file when the**

Appeals Resolution Officer reviews it. There will be no contact with the worker, no investigation, no dialogue and certainly no hearing. This is therefore not usually recommended.

If the 60-day election is not taken, the file is assigned to an ARO for the purpose of conducting a Hearing. The ARO's are divided by sector.

The ARO will contact you to determine whether you want an oral hearing, or if written submissions only will suffice. You have to use your discretion on this since, while generally you have a better chance of success via an oral hearing, some cases can clearly be conducted without the benefit of client testimony. Matters where practitioners may wish to proceed on written submissions without an oral hearing include: strictly medical/causation decisions (i.e. whether exposure to a toxic substance is responsible for a respiratory disability, and there is no dispute as to the nature and level of the exposure); Earnings basis objections when there are no facts in dispute or disagreement about earnings capacity, and the main source of contention is the labour market information; and, matters proceeding unopposed (ie. where the Employer is not participating and, therefore, submitting no evidence or argument contrary to that submitted by the worker's solicitor) where creditability is not an issue.

After conducting some hearings and learning the methods of each individual ARO, you will discover some are amenable to essentially "settling" a case without a hearing. Usually available only in unopposed matters, some ARO's are happy to discuss the terms of a potential Order on the phone without a hearing.

When, however, the issue in dispute turns on: the nature of a job (i.e. whether a certain job caused a certain injury or recurrence); whether modified duties offered by an employer to an injured worker were physically suitable; or whether an accident actually occurred at work, a hearing will usually be required to hear first-hand the evidence of the injured worker and witnesses to the incident.

Solicitors are often tempted to use WSIAT jurisprudence at the Board level, on the *stare decisis* principle. Relying upon WSIAT cases in proceedings before the Appeals Branch can have a negative effect, as the ARO's take the view they are bound by Board policy

and their role is to make a decision that is a **final decision of the Board**. Historically, the WSIAT's view of an issue often differed from the Board's. WSIAT took the position it was not bound by Board Operational Policies and would simply disregard those policies where it concluded they conflicted with the Act. Although Bill 99 includes a new provision dictating that WSIAT is now also bound to apply Board policy, a lingering discord between WSIAT and the Board remains (there is a procedure whereby WSIAT can refer back to the Board, for further adjudication, issues arising out of Board Policies WSIAT feels may violate the Act; those proceedings are beyond the scope of this paper). It is better to use the logic of an Appeals Tribunal decision, even parroting the wording if need be.

As the ARO's are strictly bound by Board policy they will seldom deviate from those guidelines. The ARO's also have access to medical input from the Unit Medical Advisor, and will typically accept those opinions unless you submit a report from, say, a treating Specialist with a well-grounded contrary opinion.

At the Workplace Safety & Insurance Appeals Tribunal

The decision of the ARO becomes a "final decision of the Board", which the worker has the right to appeal to the Appeals Tribunal. There is a six-month time limitation for filing of the **Notice of Appeal**. This, and all WSIAT forms, can be found on-line at www.wsiat.on.ca. Appeals to WSIAT are not appeals in the civil litigation sense in that you must, for instance, show some error of law. Proceedings before WSIAT are, rather, ***hearings de novo***.

When initiating a WSIAT Appeal, it is important to:

1) Ensure all issues you want to appeal to the Tribunal have been addressed in a final decision of the Board; and

2) Begin collecting the evidence you may want to obtain from the Appeals Tribunal.

Given that WSIAT proceedings are *hearings de* novo, it is tempting to view proceedings before the ARO as a dry run for the Appeals Tribunal, and to simply view the Tribunal as

a repeat of your performance at the Appeals Branch. Solicitors are advised to completely review the file in light of the ARO's findings before the Notice of Appeal is filed in order to determine the weaknesses of the case.

Hearings before the Tribunal are conducted by either a single Vice-Chair or a panel of three, made up of an Employer member, a Worker member and a Panel Chair. Generally, proceedings before the Appeals Tribunal are far more sophisticated and juristic.

Prior to conducting a hearing before WSIAT, it is recommended you read the nine **Practice Directions.**

PART IV – INTAKE AND FILE ORGANIZATION

Ensure you have all claim numbers for matters in issue and you obtain claim numbers for prior claims established for injury to the same body part as the claim the worker brings to your office. You will often see workers with a number of injury claims (some of which may be accepted and some which may be denied) for, say, a low back injury. Clarify whether the Board is adjudicating the matter as a new claim or a recurrence of a previous injury and that you have file access to all applicable Claims Files.

PART V – THE CLAIM FILE

The Claims File from the Board will be divided into the following sections:

1. **To be Filed** - correspondence received but not, as yet, placed in the proper sub-file. This is a brief section and usually contains only the worker's objection letter. When reviewing and summarizing the Medical reports on file, be sure to check this section for stray medical reports recently submitted to file;

2. **Memoranda** - notes to file from various Board decision makers and other personnel, filed in reverse chronological order, detailing such things as calls to the Worker, calls to the Accident Employer, and queries posed from Adjudicators to the Board doctor;

3. **Forms** - containing, obviously, forms filed by the Worker to initiate a claim (Form 6); the Employer to report an accident (Form 7) or to document a claimed recurrence; the Worker's physician to report an injury (Form 8) or a Recurrence (REO); and, later, by the Employer regarding returns to work;

4. **Medicals** - containing all the medical reports from outside treating professionals, filed in reverse chronological order;

5. **Correspondence** - containing all correspondence written by or to the Board filed in reverse chronological order. Usually the Board will re-file any enclosed medical reports attached with correspondence from treating doctors and file them under "Medicals". As per paragraph 1, ensure you review this section for any stray medical reports when reviewing and summarizing the medical reports;

6. **Vocational Rehabilitation** (now called **Labour Market Re-Entry**) - contains all of the reports and memos concerning the Board's or Service Providers' attempts to return the worker to employment;

7. **NEL**, and

8. **Other** - If there have been previous Appeals decisions there will be a separate section for **Appeals**; if there has been a field investigation there will be a separate category for **Investigations**.

It is best to keep the file in the order in which it's received.

You will receive updates to the file in the course of your advocacy. These should be collated into the file upon receipt to avoid confusion and ensure your copy of the file builds parallel to the Board's copy.

For WSIAT appeals, the Tribunal produces a **Case Record**, which will become Exhibit 1 at the hearing. Subsequent documents are compiled in Addenda to the Case Record. The Tribunal often sends information request forms to the worker's representative and generally employs other procedural practices to identify all relevant information before the hearing. The most important of these is the **"three week rule**" which requires the production of all new documents and evidence to the Tribunal, and to the opposing party, three weeks before the hearing date.

PART VI- UNDERSTANDING THE SUBSTANTIVE ISSUES

The Historic Trade-Off

In return for the worker being eligible for benefits, the worker shall not sue

- his or her employer;
- the employer of another worker covered by the Act who may have caused the accident;
- another worker covered by the Act;

No dependent or survivor shall sue any of the above.

A worker may still sue any other not identified above, provided he or she has filed an election to receive benefits under the Act. If this has happened, then the worker's claim will be subrogated to the Board.

Decisions about who can sue whom are referred directly to WSIAT through an application by either party. These are referred to as **Section 31 Applications**.

Workers hurt after 1998 in circumstances where they could sue a third party, must file an election to receive WSIB benefits within three months of the date of the accident. Otherwise, they will be deemed to have elected to sue the third party.

The foregoing is an introductory view of the coverage issue; there is, of course, a significant body of WSIAT jurisprudence dealing with "right to sue" issues which is beyond the scope of this paper.

Coverage

Who is a "Worker"?

Only workers in certain specified industries, suffering accidents in certain places are covered.

Workers employed in any business or undertaking outlined in **Schedule 1** to the Regulations are automatically covered. Workers in other industries (most notably office workers) are not automatically covered; however, their employers can buy coverage for their workers as can self-employed individuals. There are noticeable gaps in coverage (e.g. bank workers). Executive officers of a company cannot be covered, except if they elect to do so.

Workers in **Schedule 2** industries are also covered. The difference between Schedule 1 and Schedule 2 employers is that the latter pay the cost of all claims directly, with a 15% administrative fee.

Workers in Federal undertakings have coverage under the authority of the *Government Employees Compensation Act*. That Act reflects an agreement between the Federal government and WSIB whereby the WSIB administers the Act to Federal workers and the Federal government is treated as a Schedule 2 employer.

To differentiate a "worker" from an "independent contractor", Board Policy dictates us of the **"Organizational Test"**. There is extensive WSIAT jurisprudence on this subject. This area is very problematic for taxi drivers, timber workers, and truck drivers.

The term "worker" is inclusionary – meaning unless you can find a provision that says that the employer's business is covered, it is not.

Included workers consist of:

- Any worker in an industry included in Schedule 1 or Schedule 2 (self-insured business);
- Workers in non-scheduled business whose employers opt for coverage;
- Sole proprietors, partners, independent operators and executive officers who opt for coverage;
- Federal government workers and workers in Federal Crown Corporations whose coverage is traced to the *Government Employees Compensation Act*;
- Volunteer firefighters, ambulance workers, emergency workers (special rules);
- Outworkers who do piecework in their homes;
- "Learners" and "Students";
- Full-time Domestics (24+ hours per week);
- "Workfare" participants in covered industries.

Persons excluded from coverage consist of:

- Casual workers;
- Independent contractors (be mindful of the rules concerning owner operator truckers, construction workers and loggers) – the Board uses specialized questionnaires, but the general principles are established by Common Law. (The "organizational test" and the "business reality" test).

Practice Concerns

The fact an employer may not be up to date with its contributions to the Accident Fund does not disentitle an injured worker to benefits. For the injured party, the only concern is whether the type of business is covered and whether he or she is a "worker" as defined by the legislation.

Most disputes involve whether the injured party was a "worker" or an "independent contractor". Board policies on this issue closely parallel common law principles.

What Do They Have Coverage For?

A worker receives LOE and Health Care benefits, as well as other services under the Act, when they have sustained a **"personal injury by accident arising out of and in the course of the worker's employment".** (*WCA* Section 4, *WSIA* Section 13).

Injuries accepted for coverage can be organic (physical) or psychiatric. The principles of adjudication for entitlement are the same, however, pre-1990 pensions and post-1990 non-economic loss awards on account of permanent impairments are assessed differently.

A prior similar condition does not defeat a claim. If the prior condition was symptomatic, then the new injury will be compensable for the acute phase only and the Board will grant entitlement on **"an aggravation basis"** only. If the prior condition was asymptomatic, then the claim should not be allowed on an aggravation basis. These claims, of course, offer fertile ground for dispute.

Prior compensable conditions, for which the Worker already has an approved WSIB claim, may be further aggravated by work in the ordinary course. Without evidence of any new accident, further entitlement may be granted under the old claim number on the basis of a **"reccurrence"**. If there was a new accident, the matter should be adjudicated as a new claim.

The legislation and Board policies define "accident" to include both "chance events" (eg. falling off a ladder) and "disablements" (eg. repetitive strain injuries from production line work). The two-part causation test dictates the accident: i) must occur in the course of employment and ii) must arise out of employment. There must be a link between the employment and the injury. There is a presumption that if an injury by "**chance event**" arose out of the employment, it must have also have occurred in the course of employment, and vice versa.

This presumption does not apply to cases where there is no "chance event". These are known as **"disablement"** claims. In a disablement claim, the onset of pain/injury is gradual and may well occur both at home and at work. In this case, the worker must prove, on the balance of probabilities, that the injury is work-related or that the work was

a significant contributing factor to the injury. Disablement claims are, for obvious reasons, more likely to be denied as compared to chance event claims.

There are many fascinating cases around the "arising out of and in the course of" issues. Cases involving drunk workers; fighting and horseplay; intentional acts causing injury; pop machines falling on workers as they tip them trying to get their quarter out; parking lot accidents; and so on. These cases are fascinating to research and great to argue, though relatively rare in the overall scheme of things.

However, the typical dispute over disablement is whether a given industrial process caused a certain injury. The repetitive strain injury experienced by a production line worker is a classic example; whether a healthcare worker was infected by Hepatitis C at work would be a more unusual one.

The Board recognizes Permanent Impairments pursuant to its policy on **"Chronic Pain Disability"**, which straddles both the organic and psychiatric types of injury. This is a difficult area of practice. To establish recognition of a Permanent Impairment pursuant to the Board's Chronic Pain Disability policy (CPD), see Operational Policy Document #03-03-05, the following criteria must be met:

- A work related injury occurs;
- Chronic pain is caused by the injury;
- The pain persists 6 or more months beyond the usual healing time of the injury (Note: Board Policy ascribes a "usual healing time" to all injuries);
- The degree of pain is inconsistent with organic findings; and
- The chronic pain impairs earning capacity.

The Board's test for entitlement as per the above policy this does not mesh exactly with Tribunal jurisprudence on point. The key feature is that pain out of proportion to the organic findings results from the original compensable injury and ultimately impairs earnings capacity. Typically a Psychologist's report drawing the causal connection between pain, loss of function and, in turn, impairment of earning capacity assists in establishing entitlement. Recognition of a Permanent Impairment on account of the CPD

policy entitles the worker to a holistic assessment of the impairment which generally leads to a higher award than a mere assessment of the area of organic injury.

If Chronic Pain Disability reasonably arises as an issue in your review of the claim file, ensure the matter of entitlement is adjudicated as a final decision of the Board. If it is not, and the Tribunal sees it as an issue in dealing with the "whole person" then the WSIAT appeal will likely be put into inactive status until you get a final decision of the Board on this issue.

Chronic stress has been expressly ruled out as an injury that will attract benefits by virtue of Bill 99, however, WSIAT interpretation of this provision is by no means settled.

Healthcare Benefits

The authorizing section in the Act is extremely wide; see Section 52 of the *WCA* and Section 33 of the *WSIA*.

However, the Board has developed a fairly extensive practice, fraught, of course, with difficulties.

On the relatively non-contentious issues, things proceed in a fairly straightforward manner. The employer has to arrange for transportation to the hospital, if necessary, and must pay a full days' wages on the Date Of Accident.

The Board authorizes an early physiotherapy treatment at a "community clinic" contracted for that purpose. This referral is usually made at the outset, even before a thorough adjudication of the claim, on the theory that it's best not to waste valuable rehabilitation time while the Board determines particulars of entitlement. Usually, the physio treatment is in a six-week block, but the Board can extend this on the recommendation of a physiotherapist.

The physiotherapist files minimal paperwork with the Board, usually a summary of the initial assessment and a discharge report, and sometimes sends secondary letters to the

family doctor. In some cases, you will want to obtain the full clinical notes and records from the physiotherapist.

In cases where the worker's condition does not appear to be improving in accordance with the usual healing time prescribe by Board policy, the Board will often refer the worker to a **Regional Evaluation Centre (R.E.C.)** where the worker will be evaluated by a physiatrist and either a physical therapist or an occupational therapist. A referral to the R.E.C. is the Board's attempt to obtain a comprehensive medical picture of the disease process and the worker's functional capabilities at that point. Problems arise with a R.E.C. report prognosis that a worker will likely recover in a certain number of weeks. Adjudicators will generally accept these predictions and, where appropriate, terminate benefits unless you provide contrary medical evidence that the worker has not, in fact, progressed in accordance with the R.E.C. prognosis.

Chiropractic treatment is also available through the Board, and is usually allowed in six-week blocks. The worker or the chiropractor requests coverage and the Claims Adjudicator, in consultation with the Nurse Case Manager, adjudicates on the request. Typically the Board denies coverage for "maintenance" treatments, approving payment only for treatment of the acute injury. There is no such limitation in the Act or Operational Policy. So if the worker takes physiotherapy or chiropractic treatment that is not covered by the Board, payment for services becomes an issue in dispute and appealed in the normal course.

To avoid problems with coverage for these services, remember that the Board will typically only approve active treatments (physiotherapy, chiropractic, massage therapy) in blocks of treatments (ie. say, 12 treatment sessions). To extend treatment beyond the approved block, the Board will want an opinion from the family doctor or the care provider that further treatment will likely benefit the compensable injury.

Of course, the worker can take OHIP sponsored physiotherapy or chiropractic treatments; however, in the case of physiotherapy the waiting list is long and in cases of chiropractic treatment the coverage is incomplete.

Another contentious healthcare issue is payment for medications. In the "common sense days" the Board has significantly restricted what they will pay for. The Board routinely denies coverage for secondary conditions, for example ulcer medication caused by excessive painkiller consumption. It has also restricted approval of narcotic medications in standard back injury cases, as well as some of the more expensive anti-inflammatories.

A report from the prescribing physician establishing the requirement for the treatment will trigger Board approval.

Mileage expenses also fall under the category of healthcare expenses, even when expenses are incurred in the course of a Labour Market Re-entry Plan. These payments have also been restricted. The Board will only pay for mileage that is in excess of what the worker traveled before he or she was injured. So, if the worker lived in Oshawa and traveled to work every day in Toronto, and post-injury injury traveled to Toronto every day to participate in schooling, the Board will not pay mileage.

The Board also has a policy on clothing allowance, which has been tightened up considerably in the past several years.

Earnings Basis

The worker's benefit rate is determined by what he or she earned before the injury. These rules are very complex, potentially very rewarding for the client, with considerable downside risk, and differ radically by the three different Acts. For the purpose of this paper, we only deal with Bill 162 and Bill 99 workers. A simple case, about which there is no dispute, is set out below to demonstrate how the earnings basis is calculated.

The worker is a single person who pays tax as a single person. He makes $10.00 per hour times 40 hours per week and has no benefits. He never works overtime and is hurt on a given date. His earnings basis is as follows:

Step A: $80.00 per day or $400.00 per week. This is the earnings basis.
To get from here to the benefit rate:

Step B: Refer to Net Average Earnings Tables, 1999, NEC code 01 (single person) resulting in net average earnings of $314.54.

Step C: His benefit rate is 90% of this, if he is a pre-Bill 99 worker, or 85% of this if he is a Bill 99 worker.

In reality, many injured workers do not have such simple earnings profiles. There are many part-time workers, casual workers, apprentices, learners, workers working lots of overtime, seasonal workers, commission workers, workers with complex benefits packages, workers employed at more than one job, and so on. Not surprisingly, the Claims Adjudicators tend to default to a minimalist review of earnings, and injured workers on benefits are shortchanged. The Board is supposed to include any benefit that can be calculated in terms of money. They often just accept what the employer records on the Form 7 Report of Accident which many times does not, for instance, include overtime. The effect on benefits paid to the worker is considerable, especially when permanent injuries are involved.

The earnings basis calculation under Bill 162 and under Bill 99 differs considerably for anything other than the simplest of cases.

For Bill 162 workers (and for the most part pre-Bill 162 workers), the outline is as follows:

1. The starting point is always the daily or hourly rate as is best calculated to give the rate per week of pay – this is called the nominal rate; and

2. If this method does not fairly represent the average earnings of the worker, then the worker or the employer can ask for the worker's earnings to be determined by referring to the gross pay in the one year prior to the accident, or such lesser period that the worker was employed immediately before the injury. This is often called the YEAW method under section 40(1)(b) of the 90-98 Act.

These calculations are often contentious.

Firstly, if the period of employment before the injury is less than three months, the Board will not use the YEAW method.

Secondly, even though the section clearly provides the worker or the employer may apply for this recalculation, the Board often does it on its initiative and this has received some support from the WSIAT jurisprudence.

Thirdly, things get very contentious where there is a period of lay-off. The classic example is the seasonal landscaper who has been employed for eight years during the good weather months but who is regularly laid off in the winter.

If the intention of the worker and the employer is for the employment relationship to resume after the period of lay-off, then the worker's earnings basis will be greatly reduced, as follows:

> Instead of $10.00 per hour times 40 hours per week = $400.00,
> It will be reduced to, say, $400 per week times 30 weeks = $1200.00, divided by 52 (weeks in a year), which equals $231 per week: a considerable reduction.

There will therefore be many disputes about whether the worker and the employer intended to resume the employment relationship, or whether a new relationship was formed in the second season.

A further complication arises in that a lay-off of more than three months is deemed to be a termination under Employment Standards legislation.

Often the Board will not factor into earnings basis Employment Insurance Benefits which the worker regularly obtained as part of a seasonal employment relationship. However, the general drift of the WSIAT jurisprudence on this point is that Employment Insurance earnings are earnings for the purpose of a "yearly" calculation.

Finally, the Board is supposed to factor out any periods of absence due to non-work issues, most notably periods of sickness. A common mistake made by Adjudicators and Payment Specialists is to factor out a week of sickness as five days, when in fact it should be factored out as seven.

By and large there is a wide discrepancy between the Board's approach (which is to use this YEAW approach as far as possible to minimize the earnings basis of workers) and the WSIAT jurisprudence which sees the main goal as using method that is "best calculated to give the rate per week that the worker was remunerated at".

The one-year method of calculation can also work to the benefit of the worker. There are workers who regularly work overtime, as overtime will not be calculated in the nominal rate unless it was regularly scheduled as part of the employment relationship, however it will be in the yearly rate. Also, a worker who does not take the full holiday allotment may also benefit.

In a YEAW calculation, all of the worker's pay in the one year prior to the accident is calculated and spread out over the number of work days, except for work which the worker missed because of sickness.

In practice, many workers will think that they work considerable overtime and that a yearly calculation is to their benefit. You should ensure a request for a recalculation will be to the worker's benefit prior to requesting this recalculation from the Board. If you correctly identify that the yearly rate will produce increased benefits for the worker, the new change in the benefit rate will be retroactive to the date of the accident. However, if you have incorrectly calculated the yearly earnings and the worker's earnings basis is reduced, the worker will be stuck with the new benefit rate as of the day he or she requested it. You cannot change then ask the Board to return to the initial earnings basis because you're dissatisfied with the recalculated rate. The Board's practice of not making the downside risk retroactive to the date of the accident is not legislated; in theory, the Board could change its practice at any point for any given worker.

There is a legislated maximum earnings wage (175% of the Average Industrial Wage in the province). There are no hard minimums; however, the worker earning below a soft

minimum will not be subject to the 90% benefit calculation, but simply 100%. The maximums and minimums are set out in the Operational Policy manual.

There are many separate rules for apprentices, learners, volunteer fire fighters, workers who get room and board as part of their pay package, and so on.

BILL 99 WORKERS

The rules are radically different for post-1998 workers and there is relatively little jurisprudence on this topic. A rough outline of the method for setting the earnings basis, as prescribed by the Operational Policies not the Act, is as follows:

Short-Term Earnings Basis: For the first 12 weeks after the injury, the worker is paid pursuant to the so-called "short-term average earnings rate", which includes all times that are paid regularly (such as the hourly rate, shift pay, mandatory overtime, voluntary overtime) in the four weeks prior to the Date of Accident.

Long-Term Earnings Basis: If the worker is still entitled to receive Loss of Earnings beyond 12 weeks from the Date Of Accident, the "long-term average earnings rate" is used. There is a distinction between workers in permanent regular employment (for whom the long-term will be the same as the short-term rate) and workers in non-permanent or irregular employment. For these workers, their benefit rate will generally be discounted for the periods of irregular earnings or unemployment in the 24 months before their accidents; however, the Board will include employment insurance benefits paid for periods of lay-off or termination.

PART VII- GETTING BACK TO WORK

Section 41 - Employers' Obligation to Re-Employ

Workers employed for more than a year before the accident, where the employer regularly employs more than 20 workers, may benefit from the employer's obligation to re-employ under Section 41.

These employers are obliged to return the worker to her pre-accident job (assuming she is able to do the essential duties of that job) or to provide the worker with comparable work when it becomes available. The obligation continues for, at most, two years from the date of the accident. If an employer re-employs a worker after an injury and then terminates the worker within six months, there is a presumption that the termination violates the employer's obligation to re-employ. Given the foregoing presumption in the Act, a "section 41 complaint" is often an easy way to secure ongoing Loss of Earnings benefits for a terminated worker as the Board typically penalizes employers up to one year's worth of Loss of Earnings benefits, which will usually be paid over to the worker.

Early and Safe Return to Work (ESRTW) and Labour Market Re-Entry Assessments (LMR)

The Board's hierarchy of objectives to return in injured worker to employment is as follows: 1) return the worker to the pre-accident job, 2) return the worker to the pre-accident job, modified according to the needs of the worker; or 3) return the worker to the pre-accident employer, in suitable, alternative work. This mandate is referred to as **Early and Safe Return to Work (ESRTW)** processes.

If this procedure fails, the goal is to return the worker to another employer in a comparable job. If this fails, the Board may consider re-training or re-education to return the worker to the workforce. This process is known as **Labour Market Re-entry (LMR)** and usually starts with a **Labour Market Re-Entry Assessment (LMRA)**, followed by a one-shot **Labour Market Re-entry Plan (LMRP)**, culminating with the Board determining the injured worker's residual earning capacity by a "deeming of wages" at the end of the Plan.

With the proclamation of Bill 99 in January 1998, the Board radically withdrew from active involvement in this whole process be establishing the ESRTW process. It legislated that the worker and the employer had to co-operate in the ESRTW process with the Board intervening only in the event of a dispute between the parties.

In practice, the Early and Safe Return to Work process is notoriously problematic. There are many disagreements as to what the return to work plan is; what the functional requirements of the modified job offered actually are; the worker's actual level of disability, and so on. Problems often arise when Claims Adjudicators simply accept employer's bald assertions that they can offer suitable modified work without really investigating the functional requirements of the job.

The Board has designed a Functional Abilities Form (FAF) to be completed by a worker's physician, although there are no guidelines as to how often these forms may be completed. The purpose of the FAF is to give both employer and worker guidance as to the worker's abilities and functional limitations. The form leaves no room for a doctor to assert a worker is totally disabled nor room to set limitations to function based solely on pain. It elicits comments only on functional abilities.

Similarly, with LMR Plans, there are many disputes. The worker often has little input as to what plan is adopted. The Board policy setting the criteria to be considered when offering a LMR Plan directs Claims to consider, for instance: the worker's education, training, experience, and the functional limitations imposed by any compensable permanent impairment; nowhere is the worker's wishes included as a criterion to be considered. The Board will often over-estimate the wages in the identified **Suitable Employment or Business (SEB)**, the area of re-employment targeted by the LMR Plan. LMR Plans often fail for a variety of reasons, including: a worker's intellectual inability to complete a course, recurrence of compensable disability, occurrence of a non-compensable event, and many other reasons. Many times an LMR Plan will fail with the Board terminating benefits and closing out the claim. The issues noted above often provide fodder for appeals.

PART VIII – BENEFITS

Pre-1990

Benefits were divided into **"temporary"** and **"permanent"** benefits.

Temporary Disability (ie. wage replacement) benefits were paid until the worker reached maximum medical rehabilitation, the point at which medical recovery plateaued. There was no time limit on temporary benefits.

Temporary benefits were paid at 90% of the worker's net income. (Workers injured before 1985 were paid at 75% of their gross income). The award of these benefits was based on whether the worker could perform his pre-accident job.

If the worker could not perform the pre-accident job, or indeed any other job, he received **"temporary total"** benefits, payable at the full rate. These are sometimes known as "Section 37" benefits under the *WCA.*

When the Board deemed the worker capable of some work, though not the pre-accident work, the worker would receive full benefits as long as he was co-operating in a Board-directed Vocational Rehabilitation Program. If he was not co-operating, he would generally only be paid 50% benefits (**"TP50" -** temporary partial benefits at 50%). There is no statutory authority for this practice; however, it has been accepted at all levels. If the worker returned to some other work but at a wage loss, the Board would pay 90% of the net (ie. after tax) loss between the pre-accident earnings and the post-accident earnings. These benefits were known as **"TPdiff"** benefits.

If the Board determined the worker was left with a Permanent Impairment, after the worker's condition plateaued, he was examined by the Board doctor for purposes of a **pension assessment**. The Board doctor compared the pre-accident medical history with the post-accident and assessed the residual compensable disability and associated range of motion statistics according to the "Ontario Rating Schedule" set out in the policy manual (better known as the "meat chart"). Workers with chronic pain, fibromyalgia, or

psychiatric entitlement, were rated according to a rating scale for **pyschotraumatic disability** guidelines.

The meat chart approach was an attempt to estimate the anticipated future loss of earnings a given Permanent Impairment would translate into for the worker's particular injury. The pre-1990 pensions awarded on account of a Permanent Impairment, however, often bore little resemblance to the actual impact of the impairment on the worker's ability to earn. For instance, an office worker (assuming coverage) with a back injury could receive a 20% pension even though that back injury may have no effect on her ability to earn an income. By contrast, a 55 year old construction worker without formal education or the ability to read or write English would receive the same proportion of his income for the same injury as the estimate of his earnings loss, regardless of the fact that a 20% back impairment might render him effectively unemployable.

There are 2 kinds of **pension supplements** for workers with permanent disability pensions:

Firstly, the **Section 147(2)** supplement, which tops the worker up to his full benefit rate so long as he is participating in a Board-approved Vocational Rehabilitation Plan aimed at returning him to work. So, for example, a worker with a 20% back injury attending community college to be retrained would receive his 20% pension along with a full supplement for the duration of the course, and generally for the job search period after the course. Thereafter, the benefits would revert to the pension only, regardless of whether the worker actually found work.

There are many cases at the Tribunal level of workers who claim further Section 147(2) benefits from the Board on the basis that they need further vocational rehabilitation assistance to get back to work.

Secondly, the **Section 147(4)** supplement is awarded to a worker:

- Who will not, in the Board's opinion, benefit from a Vocational Rehabilitation Program that would restore the worker's earnings capacity to his pre-accident earnings, when taking into account his pension; or

- Who, after a Vocational Rehabilitation Program, still does not have the earnings capacity that would allow him to approximate his pre-accident earnings, even taking into account his pension.

The supplement is currently about $400.00 per month, with an additional $212.00 payment after January 1, 1995. As these supplements are payable until age 65, they can significantly increase the value of a worker's claim and, consequently, there is a lot of WSIAT jurisprudence on the topic.

Issues and appeals regarding the denial of this benefit arise over: the worker's alleged non-cooperation with a Vocational Rehabilitation Plan that, if successful, would have resulted in an increased earnings capacity; whether the program offered by the Board would have restored the worker's earnings capacity; whether an "employment situation" led to the inability to restore earnings, where, for instance a worker is laid off following a post accident return to work; unrealistic estimations of the worker's deemed earnings capacity following of a Vocational Rehabilitation Plan.

Often Adjudicators make ill-considered decisions on entitlement to these benefits thereby creating many lucrative appeals opportunities considering the enormous long-term consequence of this benefit.

Survivors' Benefits

A dependant of a worker who dies as a result of an accident or as a result of a compensable injury is entitled to a lump sum pay-out, together with a permanent payment of the full benefit rate of the worker. Survivors are, in some instances, also potentially entitled to LMR Assessments and Plans if this will restore earnings lost by the death of the worker. There is a lot of WSIAT jurisprudence dealing with who is a "dependant" and how benefits are shared between various people claiming "dependant" status.

1990-1998

Bill 162 enacted the "dual award" system to workers with permanent impairments.

Temporary benefits (the scheme outlined above) are awarded for a maximum of 12 to 18 months. At that point, there was a transition to the dual award system: Future Economic Loss (FEL) and Non-Economic Loss (NEL).

The NEL benefit is awarded for, roughly speaking, pain and suffering, and is based on a percentage of permanent impairment according to the AMA (3rd Edition) guidelines for rating permanent impairment. The worker chooses a roster physician from a list sent to him, attends for an examination and the Board calculates the NEL benefit according to the range of motion statistics set out in the NEL assessment form executed by the examining physician.

FEL is the Board's projection of the income loss a worker is expected to experience as a result of the workplace injury. This benefit, if any, is awarded following the completion of the vocational rehabilitation program provided by the Board.

The FEL is calculated and reviewed according to the following schedule:

1. Initial Determination (D1) is 12 months, where possible, after the Date Of Accident;

2. First Review (R1) 2 years after the D1 date; and

3. Second Review (R2) another 3 years after the R1 date.

With the enactment of Bill 99, the FEL is reviewed after January 1998 if there is a material change (i.e. a change in the worker's income or health status that will affect the FEL decision).

After the R2 date, there are no changes to the FEL unless there was some misrepresentation before the R2 date.

Canada Pension Plan benefits will be deducted from any FEL payment, but only to the extent that those benefits are:

a) as a result of the workplace injury; or

b) only attributable to the worker and not to the worker's spouse or children.

The theory behind the FEL award is illustrated by the following example: an injured worker suffers a permanent impairment (NEL award) which precludes his return to work as a healthcare aide. The Board sponsors the worker in a retraining program to enable the worker to become a computer programmer. This new target occupation is the so-called **"Suitable Employment or Business" (SEB)** that the Board will use to establish the earnings the worker will be deemed capable of earning following completion of the re-training. Assuming the deemed earnings in the SEB are less than the pre-accident earnings, the FEL is calculated to reflect the shortfall in earnings. While the worker participates in the retraining program, he receives a supplement to top benefits up to his maximum 90% benefit rate. Upon completion of the retraining program, he's deemed capable of earning wages in the SEB of computer programmer at the "deemed wages" level, the supplemental benefits cease and he receives a permanent FEL benefit calculated at 90% of the difference between the pre-accident earnings and his deemed earnings as a computer programmer.

Typical problems giving rise to appeals of FEL decisions include the following:

- over-estimating deemed earnings in the SEB;

- inadequate vocational rehabilitation program which precludes a realistic opportunity for employment in the SEB;

- disagreement over the extent of worker's permanent impairment, such that the Board identifies SEB's for which the worker is not physically suited;

- disagreement over the extent of the worker's permanent impairment, such that the accident employer will, with Board approval, identify jobs allegedly within the worker's capacities for which the worker is not physically suited;

- recurrences of disability during the vocational rehabilitation program causing either a temporary or a permanent hiatus in the program ruled as "non-compensable" by the Board.

Retirement Benefits

The Board sets aside an amount equal to 10% of FEL payments (which are only payable to age 65) which is then paid out as a retirement pension after age 65.

1998 and Ongoing

With the enactment of Bill 99, the concept of Temporary Benefits and Future Economic Loss benefits has been abolished and replaced by **Loss of Earning (LOE)** benefits.

LOE is only paid at 85% of the pre-accident earnings. At the urging of the Employer lobby, Bill 99 does away with any concept of "total inability to work", therefore allowing an employer to offer suitable modified work immediately after the accident.

Workers now get full LOE benefit as long as they co-operate in medical rehabilitation, vocational rehabilitation (ie. ESRTW work activities), and/or LMR assessments and plans. The Board regularly terminates or reduces benefits based on the worker's alleged failure to cooperate in any of the foregoing.

The Act empowers the Board to review LOE whenever there is a material change. Generally the LOE benefits will be reviewed in roughly the same time periods as a FEL award.

Similar to the NEL and FEL dual award system, workers receive full LOE payment while participating in Early and Safe Return to Work or Labour Market Re-entry Plans. If, after an ESTRW or LMR Plan, the Board deems the worker capable of replacing only part of his pre-accident earnings, entitlement to a partial ongoing LOE will flow until age 65. If, after an ESTRW or LMR Plan, the Board deems the worker capable of earnings equal to or greater than the pre-accident earnings, LOE benefits will cease.

These decisions of course provide lucrative fodder for appeals.

PART IX – GENERAL PRACTICE TIPS – "stuff to look for"

Areas of Entitlement

When first reviewing a file ensure you clarify what parts of the body the worker claims to have injured and ensure these have been reported to the Board at an early stage, via the Worker's Report of Injury (Form 6), the Physicians Report of Injury (Form 8) or subsequent medical reports. You must clarify the "areas of entitlement" by ensuring all areas claimed to have been injured by the worker are recognized as such by the Board. This sounds straight forward, yet it is very common for benefits to be denied or terminated over misunderstandings over precisely what the claimant has entitlement for.

When the area of injury is localized (ie. amputation of a finger) these problems rarely arise. However, a worker suffering a "chance event" accident may claim injury to, say, the head, neck, upper and lower back only to have the Board rule on all areas of injury except, say, the neck. If, as the claim progresses, it appears the neck injury is keeping the worker from returning to work, benefits will cease if that area of entitlement has not been ruled upon. Much confusion can arise over the Board relying on assertions that "non-compensable" areas of injury are precluding the return to work.

If an area of injury has not been dealt with by the Board, write a letter and request the Adjudicator's ruling. If the symptomatic area of injury has been specifically denied that decision must be appealed.

Elections/Concurrent Entitlement

The rules governing an injured party's right to sue versus the obligation to accept WSIB benefits are set out in sections 26 to 31 of the *Act*. Civil courts award far greater damages for pain and suffering than does the W.S.& I.B. regime. Occasionally workers have the right to choose whether or not to pursue a civil action or accept benefits under the regime and in some very limited circumstances the worker can pursue both, subject to subrogated claims of either the Board or the Employer. With concurrent entitlements, the Board

should provide the worker with an Election Form and the worker must decide which route she wishes to take within 3 months of the Date Of Accident. Many times such injuries will be reported to the W.S.& I.B. and adjudicated upon as any other claim without the worker being provided the Election Form. Thus, in cases of concurrent entitlement, you are well advised to ensure the worker was provided the proper Election Form; if not, you may have grounds to request the matter be removed from the W.S.& I.B. regime.

Duty to Mitigate – "Self-Directed Vocational Rehabilitation Program"

As with any piece of civil litigation, there can be a considerable gap between the Date of Accident and the adjudication of an appeal seeking retroactive Loss of Earnings (LOE) benefits. While the appeal is pending, ensure you advise the client to document his mitigation efforts; what the Board refers to as a "self-directed program of vocational rehabilitation". If you are ultimately successful on appeal, the ARO or WSIAT Vice-Chair will typically only award full retroactive benefits where he or she has heard evidence the worker has pursued an appropriate self-directed program of vocational rehabilitation. This documentation (ie. job search lists, application/rejection letters, particulars of educational courses taken) can be submitted to Claims at any time during the appeals process.

If, while the appeal is pending, the worker returns to work with a new employer but at a rate below that enjoyed with the Accident Employer, ensure you advise the worker to keep all pay stubs evidencing these earnings. Should the appeal succeed, you will want the Board to consider retroactive payment of a partial LOE benefit. Even where a return to work with the Accident Employer is unlikely, it is important for the worker to maintain and document some regular contact with the employer to ensure he is, at all times, seen as eager to return to work within his physical capabilities.

Where the worker's ability to document mitigation efforts is questionable (ie. a low-functioning manual labourer with little education, minimal transferable skills and a severe back injury), you may consider commissioning a report from a vocational counselor, opining on the barriers to re-employment.

Although the Board's system may recognize you as the "solicitor of record", Claims Adjudicators and Nurse Case Managers will have regular phone contact with the worker. You may not be privy to the content of these discussions until you obtain and review updated File Access. Warn the client against making assertions of "total disability" to the Claims Adjudicators. Clients should be advised that their position vis. a viz. the W.S.& I.B. is, at all times, that "they agree to attempt to return to any suitable work that is within their physical restrictions". Keep in mind there may be disagreements over what constitutes "suitable work" and what the appropriate restrictions are. Many Claims Adjudicators will terminate a claim based on a brief phone conversation with a worker who tells them "my doctor says I can't work at all". The file will be closed on the basis of "non-compensable, self-imposed restrictions" with the client in the dark as to what has transpired.

If the Accident Employer indicates it has modified work, you should inquire if copies of a Job Description and a Physical Demands Analysis are available. If these are unavailable at the time of the offer, the worker should be advised to try the job. They should also be advised to document the particulars of the job's functional requirements and to attend with their physician to have symptoms charted should they flare up during the attempted return to work; this documentation will assist if you later have to argue the modified work was not suitable. **Workers help themselves immeasurably in the eyes of the W.S.& I.B. when they attempt a return to work**.

Attached in the appendices is a sample letter advising a client how to document his self-directed program of vocational rehabilitation.

Repayment Obligations

Many times clients attend at your office with a claim that has been denied or terminated many months or even years ago. After battling on their own, they seek your representation. Ensure you inquire about their income stream since the denial/cessation of benefits and check the Claims File for Repayment Authorizations to Employment Insurance, Social Assistance agencies, private LTD carriers, etc. As with any civil action seeking repayment for lost income, even a successful claims appeal may be subject to repayment of benefits to 3rd parties off the top of the award. If the worker has executed a

Direction to the WSIB authorizing repayment of these benefits, the Board will repay them directly to the 3rd party. If you are calculating fees based on sums recovered it is recommended you address with the issue of repayment to 3rd parties in your initial retainer agreement to avoid disputes over your fees.

Re-Assessment of Permanent Impairment awards

Many times clients will attend asking you to review old claims which have had no activity in many years. The starting point for a review of these claims is whether the Board has assessed a permanent impairment and awarded the appropriate benefit (pension for a pre-1990 claim, or a NEL benefit for a post-1990 claim). If there is evidence of a permanent impairment which has not been assessed, forward a request to the Board seeking the appropriate ruling.

If the client has had the permanent disability assessed, check the date of the assessment. If it is five or ten years old, it is very simple to obtain evidence that an orthopedic injury (low back, for instance) has deteriorated. Obtain updated medical evidence and request a re-assessment. This is a quick and often inexpensive way to generate additional benefits for the worker. If a permanent impairment is re-assessed on account of an unanticipated deterioration, you can then argue the Board should now review all its previous rulings on functional restrictions, the ability to earn income (ie. the deemed wages) as determined by the Board at the time of the initial assessment and, in turn, entitlement to FEL or LOE benefits.

Secondary Conditions

A worker with, for instance, a permanent impairment to a knee or a leg may develop a limp. If he walks with a limp long enough, he may develop problems in the hip, pelvis, low back or the opposite leg. If these secondary conditions then affect the worker's ability to earn income, you have a potentially valuable claim.

You must first obtain medical evidence suggesting a causal connection between the secondary condition and the original, compensable condition and obtain a ruling from the Board **expanding entitlement** to recognize the secondary conditions. You also want to

establish evidence of a permanent impairment in the area of the secondary conditions. Once this is done, you then have evidence to support the worker's assertion that the ability to earn income is affected by the compensable injuries.

Appendix

Workplace Safety and Insurance Board

Frequently used WSIB acronyms

WSIB intake form

Vocational Rehabilitation letter to client

WSIB consent to access claims file

WSIB office addresses

Workplace Safety and Insurance Appeals Tribunal

Appeal Procedure

Notice of Appeal form

Confirmation of Appeal

Frequently used WCB Acronyms

AE	Accident Employer
AMA	American Medical Association – their publication, guides to the Evaluation of Permanent Impairment, Third Edition (Revised), is used by the WCB as the permanent impairment-rating schedule.
CA	Claims Adjudicator
CC	Community Clinic – offers physical rehabilitation programs to injured workers designed to assist them in reaching full recovery as soon as possible.
CCUI	Complex Case Unit (Injuries)
CCUD	Complex Case Unit (Diseases)
CPD	Chronic Pain Disability – a method of assessing a Permanent Disability Benefit Entitlement.
DOA	Date of Accident
FAE	Functional Ability Evaluation – the assessment procedures used to identify an individual's functional abilities and limitations as they relate to a specific vocational objective or as a guide to selecting an appropriate vocational objective.
FEL	Future Economic Loss – the amount of compensation payable to a worker for future loss of earnings arising from their injury – **applicable to claims from 90-97**
ISU	Integrated Service Unit
IW	Injured Worker
LOE	Loss of Earnings Benefits
LMRA	Labour Market Re-entry Assessment
LMRP	Labour Market Re-entry Plan
MC	Medical Consultants – the Board doctor to whom the claims adjudicator will refer questions of entitlement, medical, compatibility etc.
MWPS	Modified Work Program Specialist – Encourages and assists employers to establish or enhance modified and transitional work programs.
NEL	Non-Economic Loss Benefit – benefit paid to a worker who has a

	permanent work-related impairment – **applicable to <u>all</u> claims from 1990 onward.**
OMA	Ontario Medical Association
PC	Personal Coverage – individuals who are not automatically considered to be "workers" under the Act may apply to the Workers' Compensation Board for personal coverage (i.e. Self-employed)
PD	Permanent Disability – a permanent loss of earnings capacity that results from an injury – relates to pre-Bill 162 cases only (ie.pre-1990 claims)
PI	Permanent Impairment – a physical or function abnormality or loss that results from an injury
Dual Award	the award created by Bill 162, which allows for payment for future loss of earnings (FEL) and for the permanent impairment (NEL)
REC	Regional Evaluation Center – centres which provide early access to specialist consultations, comprehensive assessments and diagnostic services- they offer assessment programs to injured workers whose recoveries are prolonged or who are unable to return to their pre-accident jobs
NEER	New Experimental Experience Rating Program – rates a firm based on its past record and predicts what its accident experience is likely to be for a certain year. The objective is to increase a firm's awareness of its safety record and offer an incentive for them to perform better than forecasted
WSIAT	Workplace Safety Insurance Appeals Tribunal – formerly known as "Workers Compensation Appeals Tribunal" external appeals tribunal that is the final (3rd) stage of objection to a WCB decision

W.S.I.B. CLIENT SERVICE INTAKE FORM File #_____

Date of Intake: ____/____/_____

Name: _____

Date of Birth:

_____

Present Age: _____

SIN _____

MAILING ADDRESS

Right handed [ ] Left handed [ ]

Street: _____

Employer (date of accident):

City/Town: _____

Province: _____

Date employment commenced:

Postal Code: _____

Phone# _____

Wage/Salary at DOA: _____

Weekly hours _____

O.T.? _____

Avg. Bonusing _____

Tips _____

Piece Work _____

Room & Board _____

Education: _____

_____

_____

_____

_____

Union/Rep: _____

Position/Title:_____

Duties: (functional requirements)

_____

_____

_____

WSIB Claim # (s): _____

Office: _____

D.O.A. ____/____/_____

_____/_____/_____

____/____/_____ _____/_____/_____

Area of Injury:

_____

Secondary Area(s) of Injury:

_____

Accident History (Re: compensable injury)

_____

_____

_____

Claim #'s: _____ Related to current Claim?

_____ Yes ____ No _____

P.I. Rating: _____%

Monthly Payment: _____ Lump Sum: _____

N.E.L Award Granted: _____ C.P.D.: _____

P.F. Award: _____ Psycho: _____

Other Benefits Received:

C.P.P.: _____ Date: ___/___/___ Social Assistance: _____

Case #: _____

L.T.D: _____ S.T.D.: _____

Physician:

Specialists:

ACTION PLAN

Decisions to be appealed

_____

_____

_____

_____

_____

_____

_____

Access: Appeal [ ]
F.O.I. [ ]

Info/documents to get from client:

_____
_____
_____
_____
_____
_____
_____

To Do:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Client V.R. letter? [ ] _____

October 29, 2014

Injured worker
Address

Dear :

Re: W.S. & I.B. - Claim #

I confirm our meeting of October 31, 2001 at which time we reviewed the above noted matter.

If the claim for further benefits is ultimately successful, we can claim for all retroactive benefits if we can show you have been pursuing a "self-directed program of Vocational Rehabilitation". If you search for work and take other steps to find employment while the appeal is pending we can claim for supplemental benefits during this period should we succeed at the appeal. It is crucial that you identify a realistic vocational objective that is achievable given your age, education, training, experience and your permanent impairment.

There are a number of agencies which may be of assistance to you in producing a vocational goal. Some of these are as follows:

1. Community Colleges - many offer programs in the areas of literacy, training and up-grading. Contact local colleges and obtain information regarding what programs are available. Many colleges will also administer vocational tests to help you determine what your aptitudes are; this will assist in determining career choices and appropriate training programs.

Unemployed Help Centre - is a private, non-profit organization funded through the United Way that assists injured workers in returning to the job force. This office is located at 114 Dundas Street, 2rd flr., London, phone #439-0501. This centre offers extensive employment and career counselling services. Specifically, they can administer aptitude tests, assist in preparing resumes, assist in job searches and provide you with access to their resource centre. I strongly urge you to contact this office and make an appointment to meet with an intake worker.

3. Canada Employment Centre - is located at 120 Queens Avenue, London. This office also offers extensive employment and career counselling services.

4. Leads Employment Services London Inc. - is located at 171 Queens Avenue, Suite 410, London. Leads is a non-profit organization that offers individuals employment and skill development services for people with disabilities (developmental, physical, learning, mental health issues) in London and Middlesex County starting from age 15. *Leads' Employment Services* match

the skills and abilities of each client to competitively paid employment positions in the community. On site support is proved by Employment Specialists (job coaches) until clients have mastered all requirements of the job. Follow up support ensures that both the employer and the client continue to be satisfied with the job match.

Once again, you must begin immediately taking steps to identify a vocational goal and search for appropriate work. Be sure to document specifically all efforts you make. That is, keep a daily journal of all steps you take, offices you contact, courses enrolled in, etc. to evidence your efforts at creating a vocational goal and obtaining employment within that goal. In the journal you will also record every potential employer you approach and the method used (ie. telephone call, correspondence, attended at offices, etc.), the person you contacted and details regarding the position you applied for. I want you to keep a copy of every newspaper ad you answer and make and retain copies of every letter of application you send and every letter of rejection you receive.

Please take a moment to re-read these instructions and follow my advice to the best of your abilities. **Please note, the above information is my standard instructions to injured workers who have not yet taken steps to re-train or seek re-employment.**

If you have any questions or concerns regarding the above noted please do not hesitate to call.

Yours truly,

Robert A. McGill

CONSENT LETTER

To: Workplace Safety and Insurance Board
148 Fullarton Street
London, Ontario
N6A 5P3

From: Injured worker

Re: Claim #

This letter shall serve as authorization for my lawyer, Robert A. McGill, to represent me in any dealings I may have with the Workplace Safety and Insurance Board. This letter shall be your good and sufficient authority for the release, upon request, of any and all documents you may have on file to Robert A. McGill and the provision of any related document or opinion in connection with this matter.

DATED

_____

Injured worker

WSIB Offices and Addresses

Office Location	Street Address	Phone/Fax
Guelph (deals with Agricultural sector only. For all other small business services in the area, see Kitchener.)	1 Stone Road West 4th floor, South Tower Guelph, ON N1G 4Y2	(519) 826-7490 1-888-259-4228 Fax: (519) 826-4678
Hamilton	120 King Street West Hamilton, ON L8N 4C5 **Mailing Address** P.O. Box 2099 Station LCD1 120 King Street West Hamilton, ON L8N 4C5	(905) 523-1800 1-800-263-8488 Fax: (905) 521-4502
Kingston	234 Concession Street Suite 304 Kingston, ON K7K 6W6	(613) 237-8840 1-800-267-9601 Fax: (613) 239-3321
Kitchener	55 King Street West 3rd Floor Kitchener, ON N2G 4W1	(519) 576-4130 1-800-265-2570 Fax: (519) 576-2667
London	148 Fullarton Street 7th Floor London, ON N6A 5P3	519) 663-2331 1-800-265-4752 Fax: (519) 663-2333
North Bay	128 McIntyre Street West North Bay, ON P1B 2Y6	(705) 472-5200 1-800-461-9521 Fax: (705) 472-9801
Ottawa	99 Metcalfe Street Suite 700 Ottawa, ON K1P 1E8	(613) 237-8840 1-800-267-9601 Fax: (613) 239-3321
Sault Ste. Marie	153 Great Northern Road Sault Ste. Marie, ON P6B 4Y9	(705) 942-3002 1-800-461-6005 Fax: (705) 942-7582
St. Catharines	301 St. Paul Street 8th Floor St. Catharines, ON L2R 7R4	(905) 687-8622 1-800-263-2484 Fax: (905) 687-7117
Sudbury	30 Cedar Street Sudbury, ON P3E 1A4	(705) 675-9301 1-800-461-3350 Fax: (705) 675-9367

Thunder Bay	1113 Jade Court Suite 200 Thunder Bay, ON P7B 6V3	(807) 343-1710 1-800-465-3934 Fax: (807) 343-1702
Timmins	119 Pine Street South Suite 310 Pine Plaza Timmins, ON P4N 2K3	(705) 267-6427 1-800-461-9856 Fax: (705) 264-9131
Toronto	200 Front Street West Toronto, ON M5V 3J1	(416) 344 -1007 1-800-387-0080 Fax: (416) 344-2707
Windsor	2485 Ouellette Avenue Windsor, ON N8X 1L5 **Mailing Address** P.O. Box 1617 Windsor, ON N9A 7B7	(519) 972-4254 1-800-265-7380 Fax: (519) 972-4181

Workplace Safety and Insurance Appeals Tribunal (WSIAT)
505 University Avenue, 2nd floor
Toronto, Ontario
M5G 2P2
Telephone: (416) 314-8800
Fax: (416) 326-5164
Toll free within Ontario: 1-800-618-8846
www.wsiat.on.ca

Workplace Safety and Insurance Board
www.wsib.on.ca

Appeal Procedures

The purpose of this document is to provide information about the Tribunal's process and procedures to those participating in an appeal. Please note that there have been some recent changes to the Tribunal's process, in particular the creation of a two-stage appeal form.

The Workplace Safety & Insurance Appeals Tribunal

The Workplace Safety and Insurance Appeals Tribunal ("the Tribunal") hears appeals of **final** decisions[1] of the Workplace Safety & Insurance Board ("the Board"). The jurisdiction or authority of the Tribunal is set out in section 123 of the Workplace Safety and Insurance Act.

Tribunal Expectations of Parties to the Appeal

The Tribunal receives thousands of appeals each year. An appeal will proceed more quickly if the parties are aware of the appropriate procedures, and follow them. In particular, parties to an appeal are expected to:

- Respond promptly to inquiries about the case;
- Provide all other parties with copies of any correspondence or submission to the Tribunal;
- Advise the Tribunal promptly of any changes including changes in representation;
- Complete the Confirmation of Appeal only when they are ready to proceed to a hearing date; and
- Agree to a hearing date on the understanding that the Tribunal does not grant adjournments except in exceptional circumstances. (Retaining a new representative is not considered an exceptional circumstance.)

The Tribunal has a Code of Conduct for representatives. You may obtain a copy of the Code of Conduct by contacting the Tribunal at 416-314-8800 or 1-888-618-8846 (toll-free in Ontario) or through the Tribunal's web site at www.wsiat.on.ca.

A Fair Appeal Process

The Appeals Tribunal requires parties to provide all witness information and new evidence needed for an appeal before the hearing is scheduled. This information is to be filed in full with the Confirmation of Appeal and the Response.

This disclosure is necessary because:

- The law requires that parties to an appeal must know what the case is about and have a full opportunity to prepare before the hearing

[1] Exceptions are right to sue cases, pursuant to s. 31 of the Act, and access to health records, pursuant to s. 59 of the Act.

- Where the evidence is filed, in full, well before the hearing, the Tribunal and the parties have a better chance to assess the case to see if there are opportunities for early resolution.

- Prior to hearing, the Tribunal can review the case and order any additional information that appears to be necessary for a complete adjudication at hearing. This will help the Tribunal avoid adjournments and post hearing investigations; and

- The Vice Chair or Panel needs to be able to prepare fully for the hearing.

Starting an Appeal: A Summary of the Steps

To File the Appeal

1. The appellant must complete and send to the Tribunal a **Notice of Appeal** (NOA) form **within 6 months of the date of the final Board decision**.

2. On receipt of the Notice of Appeal form, the Tribunal will give **notice of the appeal to any respondent** (usually the worker or employer) and to the Workplace Safety and Insurance Board.

3. The Tribunal will provide the appellant with a **Readiness Form**. This is to be returned to the Tribunal only when the appellant is ready to proceed.

Ready to Proceed

1. When the appellant is ready to go to hearing with the appeal, the Readiness Form is sent to the Tribunal.

2. On receipt of the Readiness Form, the Tribunal will provide the appellant with the **Confirmation of Appeal** (COA) form, as well as a copy of the Case Record.

3. The appellant must complete the **Confirmation of Appeal** form, and send it to the Tribunal and to any other party in the appeal.

4. When the Tribunal receives the Confirmation of Appeal form, it will assign a hearing date within four months unless there are exceptional reasons not to do so or the case is identified as complex.

5. The respondent will have two weeks to complete a **Response Form** following receipt of the Tribunal's confirmation that the appellant's Confirmation of Appeal form is complete.

To File the Appeal: The Notice of Appeal

An appeal must be made in writing. The appellant (the person starting the appeal) must indicate why the decision is incorrect and why it should be changed (*Workplace Safety and Insurance Act* s. 125(2)). The appellant must therefore provide written notice of appeal by completing the Notice of Appeal.

The purpose of the **Notice of Appeal** is to register the appeal, and to enable the Tribunal to confirm receipt of the appeal within the time limits (see below). The appeal will not be processed further until the appellant requests and completes the Confirmation of Appeal (see below). The appellant is instructed not to file the Readiness Form or the Confirmation of Appeal until he or she is ready to go to hearing.

To obtain a Notice of Appeal form: Telephone the Tribunal at 416-314-8800 or 1-888-618-8846 (toll-free in Ontario) or on the web site at www.wsiat.on.ca

The Notice of Appeal provides the Tribunal with the following information:

- **Name, address, telephone number and other contact information;**
- **The name of the representative;**
- **The decisions being appealed and the reasons for appeal; and**
- **Consent to release Board file information to other parties to the appeal.**

The Tribunal will confirm receipt of a completed Notice of Appeal form. At the same time, the Tribunal will provide the appellant with a Readiness Letter. This is to be sent to the Tribunal when the appellant is ready to proceed with the appeal.

Until the Tribunal receives the completed Confirmation of Appeal form, the appeal will remain on the Tribunal's Notice of Appeal list, and will not be processed. An appeal may remain on the Notice of Appeal List for up to two years at which time the Tribunal will determine if there is any good reason not to consider it abandoned.

Notice of the Appeal To Respondents and the Board

The Tribunal is required by the *Workplace Safety and Insurance Act* to provide prompt notice of the appeal and the issues to be decided, to the parties of record and to the Board (*Workplace Safety and Insurance Act,* s. 125(3)). The parties of record are those who were involved with the appeal at the Board. The law also requires notice of the appeal to any other party who has sufficient interest in the outcome of the appeal. Usually the parties to an appeal are the worker and the employer.

The Tribunal provides notice by forwarding a copy of the completed Notice of Appeal to the Workplace Safety and Insurance Board and the parties of record. The parties will be asked if they want to participate in the appeal. A copy of the response will be provided to the appellant.

Ready to Proceed: The Confirmation of Appeal

The Confirmation of Appeal form is to be completed only when the appellant is ready for hearing.

To obtain the Confirmation of Appeal form, the appellant must return the Readiness Form to the Tribunal**.**

On receipt of the Readiness Form, the Tribunal will provide the appellant with a copy of the Confirmation of Appeal form, together with a copy of the Case Record. The Tribunal will also provide a copy of the Case Record to any other parties to the appeal.

At this time, the appellant must file all the necessary information for scheduling and hearing the appeal, and certify that the information is complete. The Confirmation of Appeal is used to:

- **Request a hearing in writing;**
- **Request alternative dispute resolution (ADR) including mediation to address all or some of the issues;**
- **Identify other Tribunal appeals by the same appellant;**
- **Identify other claims, decisions and appeals (related to this worker) with the Board;**
- **File evidence to support the appeal;**
- **Identify witnesses to be called at the hearing, including what they will say, and if a summons is needed; and**
- **Identify any expert evidence (e.g. medical reports) you will rely on for your appeal.**

IMPORTANT: The completed Confirmation of Appeal form must be sent to the Tribunal and any other participating party. The Tribunal requires written proof of service that the form was sent to the respondent. Proof of service can include a fax confirmation or a courier slip.

How does the respondent participate? The Response

The respondent will be provided with a Response form together with the Case Record. This form is to be completed and returned to the Tribunal on receipt of the Tribunal's acknowledgement that the appellant's Confirmation of Appeal form is complete.

The respondent will have two weeks to complete this form and return it to the Tribunal. The form allows the respondent to identify issues on cross-appeal, witnesses and any new evidence being brought to the Tribunal.

Scheduling the Appeal

Once the Confirmation of Appeal is received at the Tribunal, the Tribunal will:

- **Schedule a hearing date within four months (unless, in the Tribunal's opinion, the case is not ready to proceed or there are other exceptional circumstances);**
- **Review the appeal documents to confirm whether any further information is required;**
- **Provide any additional materials necessary for the hearing in a Case Record Addendum;**
- **Confirm whether a written process is appropriate; and**
- **Confirm whether alternative dispute resolution (ADR), including mediation, is appropriate for the appeal. (Note that if a case is not resolved through alternative dispute resolution, it will be scheduled for a hearing.)**

What Happens at the Hearing

The appeal will be heard by a single Vice-Chair or a three-person Panel of the Tribunal. The Tribunal holds hearings in a number of locations throughout Ontario. (Please visit the Tribunal's web site at www.wsiat.on.ca for hearing locations.)

At the beginning of the hearing, each party will state what he or she wants the Vice-Chair or Panel to decide at the end of the hearing. Most oral hearings include testimony, usually by the

injured workers, and at times by other witnesses. (See Witnesses below.) At the conclusion of the oral testimony, the parties usually provide a summary of the case to explain why the Tribunal should decide the case in a particular way.

You may wish to make submissions at the hearing about the applicability of the Board policy documents, or whether the policy is inconsistent with or not authorized by the Act.

The Case Record

The Case Record is a copy of the relevant documents in the claim files or employer firm files of the Workplace Safety and Insurance Board, and includes copies of the Board policy provided to the Tribunal by the Board (*Workplace Safety and Insurance Act*, s. 126).

The Case Record is prepared by the Tribunal and sent to the appellant with the Confirmation of Appeal form and to the respondent with the Response form.

Parties are asked to review the Case Record and Addenda immediately, and to notify the Tribunal of any errors or omissions. (If you have identified problems with your Case Record, please call 416-314-8800 or 1-888-618-8846 (toll-free in Ontario) and ask to be transferred to the Registrar's Information Centre ("RIC").)

The Case Record will be referred to at the hearing, therefore, parties should bring their copy to the hearing.

Oral and Written Evidence

The Tribunal always considers documentary evidence, including the documents in the Board file. If there is an oral hearing, the Tribunal hears oral evidence in the form of testimony under oath at the hearing.

All new documents filed as evidence in the Tribunal appeal must be included with the appellant's Confirmation of Appeal form or with the respondent's Response form.

Any evidence (documents) sent to the Tribunal must also be sent to any other participating parties.

Evidence that is not reasonably available at the time the Confirmation of Appeal (or Response) is submitted should be sent to the Tribunal and to participating parties when it becomes available. This must happen no later than three weeks before the scheduled hearing. New evidence submitted after the three week deadline will not be placed before the Vice-Chair or Panel.

These rules do not apply to written submissions on law or policy. (If you are participating in a written hearing process, please refer to the documentation provided to you regarding the timing of submissions.)

Witnesses

The worker is expected to testify where there is an issue of entitlement.

Parties who intend to have witnesses, other than the worker, attend the hearing, should list the witness(es) on the Confirmation of Appeal form or the Response form, with a brief explanation of what each person will say.

Witnesses who were not listed on the Confirmation of Appeal or in the Response will not be allowed to testify without the permission of the Vice-Chair or Panel hearing the appeal.

In an employer appeal where the worker is not participating, the employer may request that the Tribunal summons the worker to attend at the hearing.

Expert Witnesses

Before an expert witness can be called, the Tribunal requires the following information be provided with the Confirmation of Appeal or the Response:

- With the Confirmation of Appeal, the party must provide a written report signed by the expert witness, summarizing the evidence that he or she will give;

- The party calling the witness must also file a copy of the letter asking for the report, including any specific questions put to the expert; and

- The party calling the witness must file a copy of the curriculum vitae of the expert detailing his or her qualifications.

The party calling the witness is responsible for paying the full cost of their fee. The Tribunal does not pay fees for an expert witness unless the Vice-Chair or Panel rules it will do so. This generally occurs only when the expert's report was requested by the Vice-Chair or Panel.

Please note that the Tribunal prefers to rely on written reports from expert witnesses. Oral testimony is seldom necessary, unless a report requires additional clarification.

Summonsing Witnesses

Where a party wants to summons a witness, the required information must be provided on the Confirmation of Appeal or the Response. Reasons for requiring the summons must be included.

The Tribunal has the discretion to decide whether to issue a summons, and any objections may be raised with the Vice-Chair or Panel hearing the appeal.

Using Board Transcripts

If a party wants to use part of the Board transcript at the Tribunal hearing, it is necessary to follow the process set out in the Tribunal's Practice Direction on Board Transcripts. This Practice Direction sets out how the Board transcript may be used at a Tribunal hearing. Board transcripts can be ordered by contacting the Board Appeals Branch, 200 Front Street West, 9th Floor, tel. (416) 344-3583. The Board will provide the name and address of the court reporter and you will be responsible for the full cost of the transcript.

Time Limits for Bringing an Appeal

Section 125 of the Workplace Safety and Insurance Act states that all appeals to the Tribunal must be made within six months after the Board's final decision. (See the Tribunal's Practice Direction on Time Extension Applications.)

Where a decision is received after the six-month limitation period, the Tribunal may, in limited circumstances, allow an extension of time.

An appellant who wants an extension of time to appeal will be asked to provide submissions or reasons for the extension in writing. If there is another party involved in the appeal, they will be provided with these submissions, and asked to respond in writing. On receipt of all the written submissions, the application will be referred to a Vice-Chair or Panel who will make a decision on whether the appeal should be allowed to proceed. An oral hearing will not be held for the extension request unless so ordered by the Vice-Chair or Panel.

Appearing with or without a Representative

A party can appeal without a representative. The Tribunal does not arrange or pay for representation.

The Tribunal recommends that all appellants seek the assistance of a knowledgeable representative because:

- The decisions of the Tribunal are final, and the law does not allow for any further right of appeal, and,
- The law, policy and medical issues in workplace safety and insurance appeals can be complicated.

Even if you do not have a representative for your hearing, reviewing your file with an experienced person can be very helpful. **The Tribunal cannot give you advice or assistance on how to argue your case.**

The Tribunal will provide a list of representatives available in the area in which the appeal is to be heard. Please contact the Tribunal at 416-314-8800 or 1-888-618-8846 (toll-free in Ontario) or access the Tribunal's web site at www.wsiat.on.ca.

Tribunal Practice Directions

The Tribunal has Practice Directions on a number of topics that govern the hearing process. These are available from the Tribunal's Publications Department or the Internet

at http://www.wsiat.on.ca. There are Practice Directions on the following topics of general application:

- Access to Workers' Files
- Determining the Tribunal's Right to Hear An Appeal of a Board Decision
- Fees and Expenses
- Inactive Files
- Post-hearing Procedure
- Summonses
- Transcripts of Tribunal Hearings
- Transcripts of Board Hearings
- Withdrawals and Adjournments
- Code of Conduct for Representatives
- Reconsiderations
- Applications Concerning Right to Sue
- Applications for Leave to Appeal
- Time Extension Applications

Fees and Expenses

There is no fee charged for appeals. However, an appellant or a respondent may incur costs because some representatives charge for their services.

The Tribunal pays expenses as set out in the Practice Direction on Fees and Expenses:

- Travel expenses for hearing attendance for the worker or witnesses in certain circumstances
- Witness fees

Please see the Practice Direction: Fees and Expenses for details. Expense forms are available at the hearing.

For more information about the Tribunal or its process please refer to the web site at www.wsiat.on.ca.

Ce document est aussi disponible en français. Pour en obtenir copie, prière de communiquer avec le Centre d'information du greffe au 416-314- 8800 ou au numéro sans frais en Ontario 1-888-618-8846.

Ontario

Notice of Appeal

WSIAT Notice of Appeal Number

Workplace Safety and Insurance Appeals Tribunal (WSIAT)
505 University Avenue, 2nd Floor,
Toronto ON M5G 2P2
Telephone: (416) 314-8800
Fax: (416) 326-5164
Toll-free within Ontario: 1-888-618-8846
www.wsiat.on.ca

I would like the Tribunal to communicate with me in: ☐ English ☐ French

The purpose of this form is to register your appeal in order to meet the time limits of the Workplace Safety and Insurance Act. ("the Act").
Please complete each part of this form in full or it will be returned to you. You may print or type the information.

Appellant Information

Please note if you are an employer applicant, insert the Company Name in the "Last Name" space and the Company Contact Name in the "First Name" space.

Last Name	First Name	
Address (Street Number and Street)	Suite/Unit/Apartment Number	
City/Town	Province	Postal Code
Home Telephone Number ( )	Work Telephone Number ( )	
Fax Number ( )	E-mail Address	
Please notify us immediately if you change your address or telephone number.		

Place a check mark in the appropriate box. The address information in the following section must be completed in full so that the Tribunal can give notice of appeal. **Choose either Block A below, Block B or Block C on Page 2.**

Block A

☐ I am the worker. When I was injured, I was employed by:		
Company Name		
Address (Street Number and Street)	Suite/Unit/Apartment Number	
City/Town	Province	Postal Code
Telephone Number ( )	Fax Number ( )	E-mail Address
Note: If you think the injury or disease arose as a result of work with more than one employer, please name all employers on a separate page and attach to this form. Please check here if more pages are attached. ☐		

Block B

☐ I am the worker's survivor or dependent. The worker's name was		
Last Name	First Name	
At the time of the injury or disease, the worker was employed by: Company Name		
Company Address (Street Number and Street)	Suite/Unit/Apartment Number	
City/Town	Province	Postal Code
Telephone Number ( )	Fax Number ( )	E-mail Address
Note: If you think the injury or disease arose as a result of work with more than one employer, please name all employers on a separate page and attach to this form. Please check here if more pages are attached. ☐		

Block C

☐ I am the employer. The worker's name is (if applicable)		
Worker's Last Name	Worker's First Name	
Worker's Address (Street Number and Street)	Suite/Unit/Apartment Number	
City/Town	Province	Postal Code
Telephone Number ( )	My employer firm number is	

Representation

Place a check mark in the appropriate box. **Choose from either Block D or Block E**.

Block D

I have a representative whose name is:		
Company, Association or Organization Name		
Address (Street Number and Street)	Suite/Unit/Apartment Number	
City/Town	Province	Postal Code
Home Telephone Number ( )	Work Telephone Number ( )	
Fax Number ( )	E-mail Address	

Block E

☐ I will represent myself in this appeal.

Decisions Being Appealed

List the dates of decisions and claim numbers of the Workplace Safety and Insurance Board (WSIB) that you are appealing:

Decision Date (dd/mm/yy)	Claim Number

Note: You must enclose a copy of the decision(s) you are appealing with this form. Under section 125 of the Workplace Safety and Insurance Act, the notice of appeal must be filed within **6 months of the WSIB decision date** unless the Tribunal decides to permit a longer time

Issues in Decisions Being Appealed

Place a check mark in the appropriate box. **Choose from Block F or Block G**.

Block F

☐ I am appealing all issues decided against me in the attached decision(s).

Block G

I am appealing only the following issues:

Note: Additional pages may be attached. Please check here if more pages are attached ☐

Reasons for Appeal

Section 125(2) of the Act requires that the appellant provide reasons why the decision is incorrect or should be changed. **It is important to be as specific as possible about the reasons for appealing the decision(s).**
If there is not enough space below to explain, additional pages may be attached. Please check here if more pages are attached. ☐

(a) the WSIB decision is wrong or should be changed because:

(b) If I win this appeal, I want the Tribunal to do the following: *Please give as much detail as you can. For example: "I want the tribunal to award loss of earning benefits from July 6, 1999 to April 14, 2000."*

Release of Board File to Employer

This section applies to all worker applicants. **The *worker must choose* and *sign* either Block H or Block I.**

Block H

I AGREE that documents in my claim file or related claim files or any new information forwarded by me to the Tribunal may be released to employers who appear to the Tribunal to be interested parties. I do not need to review my claim file(s) before agreeing to release information.

Date (dd/mm/yy) Signature of Worker _____

Block I

I DO NOT AGREE that documents in my claim file or related claim files or any new information forwarded by me to the Tribunal may be released to employers who appear to the Tribunal to be interested parties. I understand that the processing of this appeal will be delayed until it is determined what may be released.
Note: You may review your file before agreeing to release information

Date (dd/mm/yy) Signature of Worker _____

Signature

The above information is correct and sets out all issues that I intend to raise in this appeal.

I understand that my right to appeal is subject to the time limits set by section 125 of the Workplace Safety and Insurance Act.

I understand that copies of this completed form and the attached decision(s) will be sent to persons who appear to the Tribunal to be interested parties.

Date (dd/mm/yy)	Signature of Appellant or Representative

NOTICE:: Information on this form is collected for the purpose of an appeal under the *Workplace Safety and Insurance Act, 1997,* S.O. 1997, c. 16, Schedule A. In some cases, it may be necessary for the Tribunal to collect additional information before the Tribunal can properly determine the appeal.
All information is collected pursuant to the *Workplace Safety and Insurance Act, 1997,* sections 102, 123(1), 124(1), 129, 132 and 134. Questions about the collection of information should be directed to:**, Workplace Safety and Insurance Appeals Tribunal, 505 University Avenue, Toronto ON M5G 2P2 (416) 314-8800**.

Confirmation of Appeal

WSIAT Number

Workplace Safety and Insurance Appeals Tribunal (WSIAT)
505 University Avenue, 2nd Floor,
Toronto ON M5G 2P2
Telephone: (416) 314-8800
Fax: (416) 326-5164
Toll-free within Ontario: 1-888-618-8846
www.wsiat.on.ca

Please complete this form when you are ready to proceed with your appeal. Please return this form and all requested attachments. You may print or type the information.

Appellant Information

Last Name	First Name	Contact Name *(if Employer Applicant)*

Hearing

I want my appeal to be heard in: ☐ English ☐ French

I need an interpreter for the hearing: ☐ No ☐ Yes, If yes, in what language? _____

Hearings in Writing

In order to speed-up the appeal process, the Tribunal may propose that some appeals be decided on the basis of written submissions instead of an oral hearing. **Choose either Block A or Block B.**

Block A

☐ I agree that the Tribunal may decide my appeal based on written submissions, without an oral hearing, if the Tribunal proposes this process.

Block B

☐ I request the Tribunal hold an oral hearing for my appeal.

Alternative Dispute Resolution

The Tribunal offers mediation services **for suitable appeals**. This process tries to reduce or eliminate the need for an oral hearing through Alternative Dispute Resolution (ADR). If the appeal is not resolved in the ADR stream, the appeal will be decided after a written or oral hearing by a Panel or a Vice-Chair. **Choose either Block C or Block D.**

Block C

☐ I wish to have my appeal dealt with in the ADR stream.

Block D

☐ I do **not** wish to have my appeal dealt with in the ADR stream.

Other Workplace Safety & Insurance Appeals Tribunal Appeals or Decisions

Please provide information about any **current or previous appeals** that you have made to the Workplace Safety & Insurance Appeals **Tribunal** ("the Tribunal"). **Choose either Block E or Block F.**

Block E

☐ I have had **no** other appeals or decisions at the Tribunal.

Block F

☐ I have had other appeals or decisions at the Tribunal.

WSIAT or WCAT Numbers

\- , - , -

\- , - , -

OR

Decision Numbers

/ , / , /

/ , / , /

Note: Employer applicants should only list claims involving the same worker.

Other Claims at the Workplace Safety & Insurance Board

You must confirm if you have additional claims at the Workplace Safety & Insurance **Board** ("the Board"). **Choose either Block G or Block H.**

Block G

☐ I have no other claims at the Board.

Block H

☐ I have the following other claims at the Board:

Claim Number _ _ _ _ _ _ _ _, _ _ _ _ _ _ _ _, _ _ _ _ _ _ _ _, _ _ _ _ _ _ _ _,

_ _ _ _ _ _ _ _, _ _ _ _ _ _ _ _, _ _ _ _ _ _ _ _, _ _ _ _ _ _ _ _,

Note: Employer applicants should only list claims involving the same worker.

Other Claims You Are Appealing at the Workplace Safety & Insurance Board

The Tribunal generally uses a "whole person" approach and decides related issues at the same time. If you have **other claims you are appealing** at the **Board** that are **related** to this appeal, it is likely that the Vice-Chair Registrar, or a Panel or Vice-Chair, will not be willing to proceed with this appeal until the Board appeals are finished.
Choose either Block I or Block J.

Block I

☐ I have **no** other claims I am appealing at the Board at this time.

Block J

Please list **claims you are appealing** at the Board so that the Tribunal can determine whether they are related to this appeal.

☐ I have other appeals that are in process at the Board at this time or there are decisions of the Board that I intend to appeal or there are other decisions for which I have reserved the right to appeal at the Board.

Date of Decision Under Appeal or That May Be Appealed (dd/mm/yy)	**Decision Maker**	**Claim Number**

I wish to choose the following option:

☐ I agree that the Tribunal will put this appeal into Inactive Status until the Board has decided my other related appeal(s). I understand that I will then be allowed to have any related issues arising from that Board decision scheduled together with this appeal without being placed on the Tribunal's waiting list. I will advise the Tribunal when I am ready to proceed.

OR

☐ My other appeal(s) are not related to this appeal. I want the Tribunal to schedule this appeal by itself. I will not be requesting that any additional issues from appeal(s) be heard with this appeal.

OR

☐ My other appeal(s) are related to this appeal but there are special circumstances why I want the Tribunal to schedule this appeal by itself. I will not be requesting that any additional issues from my other appeal be heard with this appeal.

If you choose this option you must attach a letter explaining the special circumstances.

☐ I have attached a letter explaining the special circumstances.

Evidence

You *must* submit all new evidence with this form. This replaces the Tribunal's former requirement for applicants to submit evidence at least three weeks before the hearing. Applicants may only submit evidence at the three-week date if it was not reasonably available or obtainable earlier. New evidence submitted after the three-week deadline will not be placed before the Vice-Chair or Panel.

If evidence is submitted after your appeal is scheduled, your hearing date may be adjourned while the evidence is reviewed, or the Vice-Chair Registrar or a Panel or Vice-Chair may refuse to accept the evidence or may adjourn the hearing.

Choose either Block K or Block L.

Block K

☐ I have **no** new medical or other evidence.

Block L

☐ I have **new medical evidence** that the Board did not have when it made its decision or that is not in the Case Record.

☐ I have **other new evidence** that the Board did not have when it made its decision or that is not in the Case Record.

☐ I have attached a copy of all new evidence that I intend to submit at the hearing.

If your evidence includes a report of a doctor or other expert that has been specifically prepared for your appeal, you must submit a copy of the curriculum vitae (qualifications) of the doctor or expert and a copy of the letter sent to the doctor or expert requesting the report.

☐ I have also attached a copy of any letters I sent requesting these reports and the curriculum vitae (qualifications) of the doctor or expert.

Witnesses

You must provide information about all your witnesses on this form. You will not be allowed to call any witnesses who are not listed here without the permission of the Vice-Chair Registrar, or the Panel or Vice-Chair hearing the appeal. The Panel or Vice-Chair may adjourn your hearing or may not allow the witnesses to testify, if you ask to call new witnesses at the hearing.

It is NOT the Tribunal's usual practice to call a doctor as a witness. In most cases a report from the doctor is sufficient. The Tribunal does NOT pay for medical witnesses called by parties or medical reports submitted by parties unless the Vice-Chair Registrar, or a Panel or Vice-Chair, orders this.

☐ I am the worker, I understand that I am expected to testify at my appeal.

Choose either Block M or Block N.

Block M

☐ I will be the only witness to testify at the hearing.

Block N

☐ I plan to have witnesses, other than myself, testify at the hearing.
Witness Name:
What this witness is expected to say:
☐ There are more witnesses than can be listed in this space. I have attached a list of additional witnesses and what each witness is expected to say.

Summons

If you think you need a summons, you must request it on this form. If you request the summons later, the Tribunal may not be able to serve it before the hearing. In accordance with the Tribunal's Practice Direction on Summonses, you must attach a letter explaining why a summons is needed for witnesses and why their testimony is necessary for the appeal.

A summons will not be issued for a doctor or expert witness without an order from the Vice-Chair Registrar or from a Panel or Vice-Chair.

Choose either Block O or Block P.

Block O

☐ I do not require a summons for my witness(es).

Block P

☐ I request a summons for my witness(es).
Witness No. 1 Name
Witness No. 2 Name
Witness No. 3 Name
☐ I have attached a letter explaining my request for summons for each of these witnesses and why the testimony of each is necessary for the appeal.

New Representative

Please choose either Block Q or Block R.

Block Q

☐	I understand that I must tell the Tribunal promptly if I change my representative or obtain a representative or if a representative stops representing me.
☐	I understand that if my new representative is not ready to proceed with my appeal and if I have not yet agreed to a hearing date, I may ask that my appeal be placed in Inactive status until my new representative is ready.
☐	I understand that any new representative should be ready and available to proceed on any hearing date that I or my prior representative have already agreed to.

Block R

☐	I am the representative. I have advised the appellant of their obligations regarding representation during the course of this appeal.

Certification

I certify that *all* issues under appeal remain as identified on the Notice of Appeal form.

I certify that I have provided the participating respondent(s) with a copy of this completed form and the attachments.

☐ Attached is proof of service (for example: *fax cover sheet or courier slip*)

I certify that I have read the Appeal Procedures and am ready to proceed with this appeal.

Date (dd/mm/yy)	Signature of Appellant or Representative

NOTICE: The information on this form is collected for the purpose of an appeal under the *Workplace Safety and Insurance Act, 1997,* S.O. 1997, c. 16, Schedule A. In some cases, it may be necessary for the Tribunal to collect additional information before the Tribunal can properly determine the appeal. All information is collected pursuant to the *Workplace Safety and Insurance Act, 1997,* sections 102, 123(1), 124(1), 129, 132 and 134. Questions about the collection of information should be directed to:,**Workplace Safety and Insurance Appeals Tribunal, 505 University Avenue, Toronto ON M5G 2P2 (416) 314-8800**