AWCBC INTERJURISDICTIONAL AGREEMENT COMMITTEE

Interjurisdictional Cost Reimbursement

A Best Practice Guide

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Version 2.3 (May 2015)

To assist Boards in reimbursing claim costs to another jurisdiction and requesting reimbursement of claim costs from another jurisdiction. Standardizing the information required to execute cost reimbursement and simplifying associated processes.

Change History

Version	Date	Section	Description of Change
2.1	March 28, 2014	3.5	Changes to reflect 2014 Maximum Annual Earnings Added change history section
2.2	April 3, 2014	3.6	Request from NL to amend/update their section of 3.6
2.3	May 15, 2015	2.4	Industry groups added to reflect addition of busing to AAP
		3.1	2014 Resolution added
		3.2	2014 Resolution added re: file documentation
		3.4	2013 Resolution added
		3.6	Added reference to dollar for dollar agreement between AB and YK
		3.7	Added 2014 note re: WSIB
		3.8	Employer Registration section added
		4.2	2014 Resolution added re: file documentation
		6.1.2	2014 Resolution added re: reimbursement overpayments
		6.1.4	Added reference to section 3.8
		7.1	2014 Resolution added re: no authority to appeal adjudication decisions Removed module related to statistics and reformatted document numbering Removed draft watermark

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Appendices

Module 1: Introduction

1.1 Purpose of the guide

The purpose of the guide is to provide information to assist Boards in both reimbursing claim costs to another jurisdiction and requesting reimbursement of claim costs from another jurisdiction.

The guide aims to standardize the information required to execute cost reimbursement and simplify the associated processes.

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Module 2: Key Sections of the Agreement

The following sections of the Interjurisdictional Agreement relate to cost reimbursement.

2.1 Section 7: Occupational Disease

7.3 No Reimbursement

There is no reimbursement for an interjurisdictional occupational disease claim if the claim would have been accepted by the Contributing Board for the full injurious result.

7.4 Partial Exposure with Contributing Board

If the Contributing Board cannot allow the claim pursuant to section 7.3 then they will adjudicate the claim if 30% of the total contributing exposure (calculated in months) occurred in that jurisdiction.

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If 30% of the exposure (calculated in months) was not in the jurisdiction of the Contributing Board then the Board can;

- adjudicate the claim; or
- refer the claim to the Board where the longest exposure occurred (if one or more Boards has 30% total contributing exposure); or
- refer the claim to the Board where the most recent exposure occurred (if the longest contributing exposures over 30% are equal).

7.5 Acceptance of Determination by Adjudicating Board

The contributing boards shall accept the allowance of the claim by the Adjudicating Board (no re-adjudication).

7.6 Contribution Request by Adjudicating Board

The Adjudicating Board (who has accepted the claim and paid full claim costs) can request reimbursement from another Contributing Board (where the claim was originally submitted) if that Board did not apply the rules under subsection 7.4 (less than 30% exposure in jurisdiction of Contributing Board).

7.7 Sharing of Costs

If subsection 7.4 applies, claim costs will be shared by Contributing Boards (once they have exceeded $5000.00) as follows;

- The adjudicating Board shall apportion claim cost among Contributing Boards based on duration of exposure.
- The adjudicating Board shall invoice quarterly for its share in the cost of the claim (not in advance).
- Contributing Boards will pay the invoice from the Adjudicating Board within 60 days subject only to statutory limitations.

7.11 Exclusions

- Occupational chronic stress
- Occupational chronic pain
- Occupational noise induced hearing loss.

7.12 No Election

If the Adjudicating Board allows a claim without an election being made, Contributing Boards are not responsible for any claim costs.

2.2 Section 8: Aggravation or Worsening of a Disability

8.1 Subsequent Employment

If a worker who is or has been in receipt of benefits from one jurisdiction begins employment in another jurisdiction; and claims the condition for which they are or were receiving benefits has recurred, worsened or been aggravated as a result of this employment in that jurisdiction, the Board in that jurisdiction shall;

a) adjudicate the claim and award additional benefits;
b) pay the full cost of such benefits as are provided for by Statutory Authority or policy; and
c) advise the other Board upon request.

8.2 Not from Subsequent Employment

If the Board where the worker is now employed determines that the recurrence, worsening or aggravation did not result from employment in that jurisdiction, that Board shall refer all pertinent information to the original adjudicating Board for adjudication and the provisions of the agreement in respect of administrative co-operation shall apply.

2.3 Section 9: General Cost Reimbursement

9.1 Accident Board Responsible

Claim costs will be borne by the Board in the jurisdiction where the injury occurred if the worker is eligible to claim in more than one jurisdiction.

9.2 Amount of Reimbursement

Reimbursement will be for the full amount subject only to the Reimbursing Boards policy or statutory limitations.

Capitalized Future Costs

The above includes capitalized future costs if this process is employed by both jurisdictions. Reimbursement of capitalized future costs will be limited to the extent that the Reimbursing Board would have capitalized the costs.

9.4 Effect of Limit on Participation

Where Statute or policy permits participation in a reimbursement process but limits the amount or nature of participation, similar limitations shall be deemed to apply to all other Boards when dealing with that Board.

9.5 Reimbursement Requests

Reimbursements shall be requested and paid either when the claim is closed or at a minimum of quarterly.

Action Commenced

When an action has been commenced, request for reimbursement will be deferred pending determination of net actual cost to the Adjudicating Board.

9.6 Capitalization

If capitalization is based on a limited number of years and further capitalization is expected at a later date, the Adjudicating Board shall advise the other Board(s) of this when initially requesting reimbursement.

9.7 Claims Re-opened

If a claim is re-opened and additional benefits provided, the additional costs incurred are subject to the general reimbursement provisions.

9.8 Costs not Subject to Reimbursement

Additional costs incurred as a result of statutory or policy changes are not subject to reimbursement. This restriction does not apply where capitalized costs contain provisions for cost of living adjustments.

9.9 Costs to Exceed $1000

These guidelines do not apply to claims in which the total costs do not exceed $1000.00.

9.10 Notice Within Two Years

An Adjudicating Board will notify a Reimbursing Board within two years of the date the claim is accepted. No reimbursement will be payable unless the Adjudicating Board has met this requirement.

2.4 Section 12: Alternative Assessment Procedure

Alternative Assessment Procedure (AAP) means the elective assessment procedure under which an Electing Participant pays all assessments for a calendar year in respect of a worker engaged in one of the following industries;

- Bulk Liquid Trucking
- Couriers, Messengers and Delivery
- Dry Bulk Materials Trucking
- Forest Products Trucking
- General Freight Trucking
- Specialized Freight Trucking
- Used Household and Office Goods Moving
- Interurban and Rural Bus Transportation
- Charter Bus Industry
- Land Scenic and Sightseeing Transportation

to one assessing Board.

Administration of AAP

12.9 If a worker elects to claim compensation from a Registering Board, that Board shall adjudicate the claim and pay benefits in accordance with its legislation. The Registering Board shall invoice the Assessing Board for the costs of the claim either when the claim is closed or at a minimum on a quarterly basis.

12.10 The Assessing Board will pay the total cost of the invoice as determined by the Registering Boards law and policy.

12.12 (e) Section 9 – General Cost Reimbursement Guidelines do not apply to an Electing Participant to which this section applies (transfer of assessments rather than cost reimbursement).

Module 3: General Cost Reimbursement

3.1 Communication prior to requesting reimbursement

When a request for reimbursement is anticipated in relation to a claim, best practice is to send a letter to the jurisdiction in which cost reimbursement may be sought, with the properly completed right of election from the adjudicating Board attached. This letter alerts the Board who may be responsible for costs that the worker has elected to claim benefits in your jurisdiction and that reimbursement may be sought at a later date. This letter should identify any reasons for a delay in the request for reimbursement being issued. For example, claim costs have not yet reached $1000.00 or there is a possible third party action. The following information should be included in this letter; workers full legal name, address, date of accident, injured body part and employer's full legal name.

Section 4.1 of the agreement should be the overriding principle of notification however, jurisdictions can reimburse without a signed right of election, but agree in to take on any inherent risk in doing so. If issues arise regarding reimbursement without a signed right of election, the issue should be referred to the IJA Coordinators to resolve (PPP 2014).

Notification best practice was agreed to be a copy of the election and a copy of the application. The Board receiving this information should initiate a claim and then suspend it until a reimbursement request is received (PPP 2014).

All jurisdictions are responsible for their own translation services and related costs (PPP 2014).

Sample letter – see Appendix A

3.2 Required information for making a request for reimbursement

When requesting reimbursement from another jurisdiction it is best practice to include the following identifying information either in the request letter or in the file information included with the request letter;

- Invoice number/invoice date
- workers full legal name
- workers address, telephone number, DOB, SIN and/or PHN
- workers job title and date of hire if possible
- claim number
- date and geographical location of accident
- body part injured; and
- employers full legal name and address

The letter should begin with a paragraph identifying that the purpose of the letter is to request cost reimbursement under the Interjurisdictional Agreement.

The total amount of reimbursement requested should be clearly identified and should be broken down into the following categories (as applicable);

- earnings loss benefits;
- pension costs; and
- medical aid benefits (should be categorized by benefit type).

Earnings loss information should include as much of the following information as is available to allow the reimbursing jurisdiction to calculate benefits as per their own legislation and policy;

- payment dates, to and from periods (benefit summary sheet)
- number of days paid in each payment period
- annual or weekly gross earnings
- number of days per week and hours per day
- type of benefits ie: temporary wage loss, extended wage loss; and
- TD (tax department) code.

File documentation to support your request should be enclosed, for example;

- claim cost printout
- information to enable wage loss benefit calculation
- decision letters; and
- information to support medical aid costs such as service provider reports/invoices
- Claim summaries are optional but it is crucial that complete file documentation, including all pertinent details are submitted with reimbursement requests (PPP 2014).

To avoid potential issues with protection of privacy, separate letters for each request/claim are required. As well, particular attention should be paid to protection of privacy when releasing file information.

Sample letter – see Appendix B

It is best practice to advise the Board of the status of the claim at the time of the request to indicate whether future reimbursement requests can be expected (ie: claim is now closed, claim remains open for earnings loss and medical aid benefits, claim remains open for medical aid benefits). A resolution in May 2010 (May 12&13, 2010, Committee Protocols, Practices and Procedures) states that Adjudicating Boards should make every effort to ensure that the Reimbursing Board is kept informed of costs being incurred on a claim file. Timely subsequent invoicing has been the subject of arbitration in the past *(see WCB Alberta and Yukon Workers Compensation Award of Arbitration -*

AWCBC IJA Committee information repository). That said; no invoice for reimbursement under $200 shall be sent after the initial reimbursement is made. If you have alerted the Reimbursing Board that the claim is still open it is assumed that further costs will be incurred. The Adjudicating Board is responsible for requesting reimbursement of claim costs over $200 in a timely manner, at a minimum quarterly basis. That said; reimbursement requests should not be made on a claim more than once every 90 days.

When requesting reimbursement for pension benefits, the requests should be based on actual costs issued. Similarly, when reimbursing pension benefits; actual costs should be reimbursed (PPP 2014).

3.3 Required information when denying or reimbursing a request

Upon receipt of a request for reimbursement, the process prescribed by your Board in determining whether the request will be accepted should be followed. It is best practice to establish processes which allow this determination to be made in as timely a way as possible. Best practice would be no longer than 90 days with the exception of claims undertaking negotiations through the dispute resolution process (Committee Protocols, practices and Procedures, April 19, 2004 resolution).

3.3.1 Reimbursement Denied

If a request is denied, it is best practice to send a letter to the requesting jurisdiction outlining the decision and providing a detailed rationale. Governing legislation and/or policy should be included to support the decision to deny reimbursement.

3.3.2 Partial Reimbursement

If partial reimbursement is being made, it is best practice to send a letter to the requesting jurisdiction outlining the decision and providing a detailed rationale for the shortfall. Governing legislation and/or policy should be included to support the decision to provide partial reimbursement.

3.3.3 Full Reimbursement

If full reimbursement is being made, it is best practice to send a letter to the requesting jurisdiction informing them that the request will be reimbursed in full noting no shortfall.

When responding to a reimbursement request it is best practice to provide the following information;

- workers full legal name,
- claim number of requesting jurisdiction and claim number of reimbursing jurisdiction,
- date of accident,
- Employer's name,
- Decision with rationale including supporting legislation and/or policy,

- If reimbursement is being made, total amount reimbursed,
- If applicable, rationale for shortfall with supporting legislation and/or policy, and
- Cheque representing reimbursed amount or details of when cheque can be expected.

If reimbursing multiple requests to a jurisdiction, to avoid potential issues with protection of privacy, it is best practice to send separate letters for each request.

If an overpayment occurs, the Reimbursing Board should not recover the monies by withholding payment from another IJA/AAP claim. Recovery of these monies should be left to individual jurisdictions to resolve (Committee Protocols, Practices and Procedures document, May 12&13, 2010 resolution).

Sample letter – see Appendix C

3.4 Third Party Action

The following agreed upon practices apply to claims in which an adjudicating Board seeks cost reimbursement on a claim for which it also receives a settlement for third party action;

- The decision of an adjudicating Board to pursue third party action is not open for reconsideration by the reimbursing Board.
- The IJA cannot be used as an instrument to bar third party litigation in other jurisdictions (PPP 2013)
- The adjudicating Board cannot seek reimbursement for third party claims costs that have been recovered from the third party. All remaining costs on the claim in excess of any settlement received can be requested.
- The right of action included in the Appendices of the Interjurisdictional Agreement refers to WCB Right of Action.

3.5 Jurisdictional Compensation Rates for Loss of Earnings

Jurisdiction	Compensation Rates	Maximum Annual Earnings (2015)	Wait Period*
Alberta	90% net	$92,300	No
British Columbia	90% net	$77,900	No
Manitoba	90% net	$74,960	No
New Brunswick	85% net	$60,100	3/5ths*
Newfoundland and Labrador	80% net	$60,760	No
Northwest Territories	90% net	$82,720	No

and Nunavut			
Nova Scotia	75% net for 26 weeks 85% thereafter	$56,000	2/5ths*
Ontario	85% net (post 1998 accidents) 90% net (pre 1998)	$84,100	No
Prince Edward Island	85%	$52,100	2/5ths*
Quebec	90% net	$69,000	No
Saskatchewan	90% net	$59,000	No
Yukon	75% gross	$83,501	No

*Refers to a period of time (ie: 3/5ths of a work week) following the date of accident that a worker is unpaid by their employer prior to earnings loss benefit commencement.

3.6 Jurisdictional Constraints in Reimbursing a Request

Jurisdiction	Constraint(s)
**Alberta	Section 28 (1) of the Alberta WC Act identifies the following conditions for a right of election to be offered for an out of province accident: If an accident happens while the worker is employed out of Alberta, the worker or the worker's dependents are entitled to compensation under this Act if (a) the worker (i) is a resident of Alberta, or (ii) has his or her usual place of employment in Alberta and the work out of Alberta is a continuation of the employment by the same employer or an employer that is related to that employer within the meaning of section 134 (b) the nature of the employment is such that, in the normal course of the employment, the work or service the worker performs is required to be performed both in and out of Alberta, and (c) subject to subsection (2), the employment out of Alberta has lasted less than 12 continuous months *The Alberta Board does not have any provisions in the WC Act to outline election requirements for in-province injuries for out-of-province workers. These workers are offered the right of election as long as the employer has an account in the province of Alberta or are required to have an account with the AB WCB, at the time of the worker's accident. Limits to Reimbursement: -Employer does not have coverage and was not required to at the time of the accident (not a mandatory industry, no optional coverage) -Accident employer is self-insured (Canada Post/Federal Government) -Wage loss benefit requests are subject to maximum annual earnings limitations -Reimbursement would not be possible if third party action was not resolved. -Reimbursement of partial wage loss requires gross income earnings post-accident -Permanent Functional Impairment award reimbursements are subject to maximums identified per year -Alberta legislation/policies do not have any provisions to pay interest on any benefit entitlement
British Columbia	Section 8 and 8.1 of the Act deal with **injuries outside BC** and provide authority for BC to enter into agreements. 8(1) states, where an injury of a worker occurs while the worker is working elsewhere than in the Province which would entitle the worker or the worker's dependants to compensation under this Part if it occurred in the Province, the Board must pay compensation under this Part if (a) a place of business of the employer is situate in the Province; (b) the residence and usual place of employment of the worker are in the Province; (c) the employment is such that the worker is required to work both in and out of the Province; and (d) the employment of the worker out of the Province has immediately followed the worker's employment by the same employer within the Province and has lasted less than 6 months,

	but not otherwise.
Manitoba	Limits to reimbursement: • Accident employer is self-insured • No interprovincial election form completed • Employer does not have coverage and was not required to at the time of the accident (not a mandatory industry, no optional coverage) • Worker has no right of election in Manitoba • Cannot reimburse partial wage loss unless other Board provides details of income earned post-accident • Cannot reimburse claims costs for benefits paid in advance ie: living allowances etc... • Pension cannot be paid past 48 months if worker is 61 or older at the time of the accident (section 39(3) WCA).
New Brunswick	**Section 8.1(1) (2) and (3) of the Act addresses the right to election:** **8.1**(1) Where a worker or his dependents are entitled to compensation or some other remedy in respect of an accident both in another jurisdiction and in New Brunswick, the worker or dependents shall elect *(a)* to claim compensation or the other remedy under the law of the other jurisdiction, or *(b)* to claim compensation under this Act, and shall give notice of that election to the Commission under subsection (2), but if there is in existence an agreement under subsection 8(3), the right of election is subject to the terms of the agreement. **8.1**(2) Notice of election shall be given to the Commission *(a)* by the worker within three months after the happening of the accident, or *(b)* if the accident results in death, by a dependent within three months after the death, and if notice of election is not given in accordance with this section, the worker or dependent is deemed to have elected not to claim compensation under this Act. **8.1**(3) The Commission may, on application either before or after the expiration of the three month period referred to in subsection (2), extend that period if, in the opinion of the Commission, the claim is a just one and ought to be allowed. **Reimbursement Limitations:** **1. Section 2(3) of the Act, Definition of a Worker, Exclusions:** **2**(3) Subject to sections 4 and 6, this Part does not apply to the following: *(a)* persons whose employment is of a casual nature and otherwise than for the purposes of the industry; *(a.1)* persons who play sports as their main source of income; *(b)* outworkers;; *(c)* members of the family of the employer residing with the employer who are under sixteen years of age; and *(d)* persons employed as domestic servants. 2. **Section 7(1), Conditions for Entitlement**: **7**(1) When personal injury or death is caused to a worker by accident arising out of and in the course of his employment in an industry within the scope of this Part, compensation shall be paid to that worker or his dependents, as the case may be, as hereinafter provided, unless the accident was, in the opinion of the Commission, intentionally caused by him, or was wholly or principally due to intoxication or serious or wilful misconduct on the part of the worker and did not result in the death or serious and permanent disability of the worker. **3. Section 38.11(14) (15), Loss of Earnings Benefits:** **38.11**(14) Compensation pursuant to this section is payable until the loss of earnings ceases or until the worker attains age sixty-five, whichever occurs first. **38.11**(15) Notwithstanding subsection (14), where a worker is sixty-three years of age or more at the commencement of the worker's loss of earnings resulting from the injury or recurrence of an injury, the Commission shall provide compensation pursuant to this section for a period not exceeding two years following the commencement of the worker's loss of earnings resulting from the injury or recurrence of the injury. **4. Employer does not have coverage and was not required to have mandatory coverage at the time of the accident (less than 3 employees)** **5. Accident employer is self-insured.**

	6. Loss of earnings requests are subject to the maximum annual earnings limitations and the 3 day wait. **7. Permanent Physical Impairment awards are subject to the maximum annual earnings limitations based on year of accident.**
Newfoundland and Labrador	WHSCC of Newfoundland and Labrador has the following limits to reimbursement: - Accident employer is self-insured - No election form completed - Wage loss benefit requests are subject to the prescribed maximum compensable and assessable earnings - Permanent Physical Impairment awards are subject to the prescribed maximum compensable and assessable earnings based on year of accident - Reimbursement is not provided until third party action resolved - Cannot reimburse partial wage loss until other board provides details of income earned post-accident - Employer does not have coverage and was not required at the time of the accident.
Northwest Territories and Nunavut	Nunavut and the Northwest Territories' Workers' Compensation Acts have a section which deals with injuries occurring outside of the Territories and provide authority for the WSCC to enter into agreements: **22.** (1) Compensation is payable in respect of a worker who suffers a personal injury, disease or death arising out of and during the course of employment while working outside the Northwest Territories, if (a) the worker's usual place of employment is in the Territories; (b) the worker's employment involves performing activities both inside and outside the Territories for the same employer; and (c) the period of work performed outside the Territories does not exceed six months. **23.** (1) If a person is entitled to compensation or some other remedy under both this Act and the law of another place where the personal injury, disease or death occurred, the person must elect whether (a) to claim compensation under this Act; or (b) to claim compensation or the other remedy under the law of that other place. **95.** The Commission may make agreements with a public body in another jurisdiction responsible for workers' safety or compensation, to ensure that (a) the workers' safety or compensation regimes in both places are efficiently administered; and (b) eligible claimants receive compensation either in conformity with this Act or in conformity with the laws of that jurisdiction. Policies 00.03 and 02.03 apply the above legislation. http://www.wscc.nt.ca/YourWSCC/WhoWeAre/Policies/Pages/Policymanual.aspx The amount of compensation we pay is limited to 90% of a legislated yearly maximum insurable remuneration (YMIR) amount (as defined in the Act and prescribed in the Regulations), which limits the amount the WSCC will reimburse. Sections 38 to 43 provide guidance on compensation for disability, section 48 provides instruction on the compensation to a surviving dependent spouse with section 50 containing limits on the compensation paid to the child of a deceased worker. Section 58 details how to determine a worker's annual remuneration. Section 21 requires the person to be entitled to compensation or other remedy both under the NT or NU Act as well as the law of another place before the IJA would apply. The general interpretation of this section is that the claim must meet the WSCC entitlement provisions. In addition, section 9.2 of the IJA requires full reimbursement subject to any policy or statutory limitations. For example, the limit on compensation to a child over the age of 19 who is no longer attending school. I have been advised that some examples of situations where the WSCC has denied reimbursement, in part or in full, are: • The worker was paid for days (on rotation) that the WSCC would not have considered working days; • The worker's referral to vocational rehabilitation were for reasons not permitted/included in the WSCC's policy; and • The diagnosis was not supported by evidence as required by WSCC policy.

Nova Scotia	In Nova Scotia, the major statutory limitation we face regarding requests for reimbursement relate to the "3 worker rule" which involves two parts: 1. Determining whether the employer/firm is considered within a mandatory industry for registration 2. Determining the residency of the worker, if necessary To summarize how this rule operates in very general terms: in order for a worker to be considered a worker under our *Act*, the employer must first be required to register (or be within a mandatory industry). When looking at whether an employer/firm must be registered, again generally speaking, the employer/firm must have 3 or more workers, working 5 or more days throughout the calendar year (residency component) in NS. **WCAct: s.3(2)(3) (Application of Part I)** **3 (1)** This Part applies to employers and workers engaged in, about or in connection with any industry prescribed by the Governor in Council by regulation. **(2)** The Governor in Council may, by regulation, exclude any employer, class of employer, or class of worker engaged in, about or in connection with any industry prescribed pursuant to subsection (1). **(3)** A class of employer prescribed pursuant to subsection (2) may include a class of employer employing fewer than the prescribed number of workers. **WCAct: s. 19-27 (Residency Rules)** **19** Subject to Sections 20 to 27 and Section 166, no compensation is payable to a worker pursuant to this Part unless (a) the place where the worker usually works for the employer is in the Province; and (b) the accident occurs in the Province. 1994-95, c. 10, s. 19. **Accident during absence from Province** **20 (1)** Where (a) a worker's residence is within the Province; (b) the place where the worker usually works for the employer is within the Province; (c) the place of business or chief place of business of the employer is within the Province; (d) an accident occurs while a worker is employed outside the Province; and (e) at the time of the accident the worker had been employed outside the Province for less than six months, the worker may claim compensation pursuant to this Part as if the accident had occurred in the Province. **(2)** Where (a) a worker's residence is within the Province; (b) the place where the worker usually works for the employer is within the Province; (c) the place of business or chief place of business of the employer is within the Province; and (d) the employment of the worker outside the Province lasts or is likely to last for six or more months, the worker's employer may apply to the Board to be assessed on the earnings of the worker. **(3)** Where (a) an application made pursuant to subsection (2) is approved by the Board; and (b) an accident occurs while the worker is employed outside the Province; the worker may claim compensation pursuant to this Part as if the accident had occurred in the Province. 1994-95, c. 10, s. 20. **Application by employer to be assessed** **21 (1)** Where (a) the residence of a worker is outside the Province; (b) the place where the worker usually works for the employer is outside the Province; and (c) the worker's employment within the Province lasts or is likely to last for more than five days, the worker's employer shall apply to the Board to be assessed on the earnings of the worker and the worker is a worker for the purpose of subsection 3(1). **Accident during temporary absence** **22** Where (a) the residence of a worker is outside the Province; (b) the place where the worker usually works for the employer is within the Province; (c) the place of business or chief place of business of the employer is within the Province; (d) an accident occurs while the worker is outside the Province; and (e) at the time of the accident the worker was outside the Province merely for some temporary purpose connected with the worker's employment within the Province,

	the worker may claim compensation pursuant to this Part as if the accident had occurred in the Province. 1994-95, c. 10, s. 22. **Compensation where entitlement outside Province** **23** Where (a) an accident occurs while a worker is outside the Province; (b) the place of business or chief place of business of the employer is outside the Province; and (c) the worker is entitled to compensation pursuant to the law of the place where the accident occurred, the worker may not claim compensation pursuant to this Part, whether the worker's residence is within or outside the Province, unless (d) the place where the worker usually works for the employer is within the Province; and (e) at the time of the accident the worker was outside the Province merely for some temporary purpose connected with the worker's employment within the Province. 1994-95, c. 10, s. 23. **Accident outside Province in transportation industry** **24** Where (a) an accident occurs outside the Province in connection with the operation of (i) a ship, boat or other vessel, or (ii) an aircraft, train, truck, bus or other vehicle used to transport goods or passengers; (b) the worker's residence is within the Province; and (c) the work or service performed by the worker is required to be performed both within and outside the Province, the worker may claim compensation pursuant to this Part as if the accident had occurred in the Province. 1994-95, c. 10, s. 24. **Assessment of employer** **25** Where a worker is employed outside the Province and the circumstances of (a) the place of business or chief place of business of the worker's employer; (b) the residence of the worker; and (c) the worker's usual place of employment, are such that, if an accident occurred while the worker was outside the Province, the worker could claim compensation as if the accident had occurred in the Province, the worker's employer shall declare and be assessed on the earnings of the worker in the same way and in the same amounts as though the worker was employed within the Province. 1994-95, c. 10, s. 25. **Liability of employer where earnings not reported** **26 (1)** Where (a) compensation is payable for an injury that occurred outside the Province; and (b) the worker's employer has not reported the full earnings of the worker to whom the injury occurred, the employer is liable, unless relieved by the Board, for the full amount of compensation and other expenditures made by the Board. **(2)** The Board may collect the amount for which the employer is liable pursuant to subsection (1) in the same manner as the collection of an assessment. 1994-95, c. 10, s. 26.
Ontario	**A) <u>Employer not obligated to register</u>** • Employers who are in industries that are not listed in Schedules 1 or 2 of O. Reg. 175/98 are not required to register. Such employers would only have coverage by application. Therefore, Ontario could not reimburse if the employer is in a by-application industry and has not obtained by-application coverage from the WSIB. (see s. 11(1) of the Act and O. Reg. 175/98) o O. Reg. 175/98 can be found at the following link: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_980175_e.htm **B) <u>Worker not covered (even if employer is registered/obligated to register)</u>** • A worker who is not a resident of Ontario must have a "substantial connection" with Ontario in order to come within the scope of the *Workplace Safety and Insurance Act, 1997*. Policy 12-04-12 outlines the factors that will be considered in determining if there is a substantial connection. Each case must be decided on its own facts; however, generally speaking a worker who works in Ontario for 11 or more days in the course of a year usually has a substantial connection with Ontario. o Policy 12-04-12 can be found at the following link:

	http://www.wsib.on.ca/en/community/WSIB/OPMDetail?vgnextoid=d2e3fcea9bfc7210VgnVCM100000449c710aRCRD • There are certain workers who are excluded from coverage due to the nature of their employment (e.g.: casual work/piecework). (see s. 11(1) of the Act). • In all industries except construction, all independent operators, sole proprietors, partners, and executive officers are excluded from coverage unless they have optional insurance with the WSIB. (see ss. 11(2) and 12 of the Act) • In the construction industry, since January 1, 2013, compulsory coverage has been expanded to include most independent operators, sole proprietors, partners, and executive officers in the construction industry. However, there are two exemptions from compulsory coverage: (i) for exempt home renovation work; and (ii) an exemption for 1 partner from each partnership and 1 executive officer from each corporation who does not perform "construction work" (as defined in WSIB policy) if the individual fills out the required declaration form. (see ss. 12.1 and 12.2 of the Act, O. Reg. 47/09 and Policy 12-01-06) o O. Reg. 47/09 can be found at the following link: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_090047_e.htm o Policy 12-01-06 can be found at the following link: http://www.wsib.on.ca/en/community/WSIB/OPMDetail?vgnextoid=309346e7324f6310VgnVCM100000469c710aRCRD
Prince Edward Island	For **accidents within PEI** causing injury to workers residing or employed outside of PEI, there are no statutory limitations to cost reimbursement. Section 7 of the Act speaks to **accidents outside PEI** and the following are statutory limitations to cost reimbursement; 7(2) The employer business is within PEI; the residence of worker is within PEI. The employment out of province is lasting or likely to last more than 6 months. The employer **may** register with WCB PEI and if so, the worker would be entitled to benefits in PEI. If worker elects injury jurisdiction and cost reimbursement is requested but the employer is not registered in PEI, PEI may not reimburse claim costs as it is not mandatory that the employer is registered in PEI. 7(4) The employer business is outside PEI; the residence of the worker is within PEI; the worker is entitled to benefits outside PEI. The worker is not entitled to benefits in PEI unless usual place of employment is within PEI. If worker elected injury jurisdiction and cost reimbursement was requested, PEI would not reimburse claim costs unless the usual place of employment of the worker is within PEI. 7(5) PEI would not reimburse claim costs related to an accident outside the province in connection with any vehicle used in the transportation of passengers, goods or substance unless the following criteria are met; • work or service is required to be performed both within and outside the province; and • the residence of the worker is within the province.
Quebec	**Employer must have establishment in Quebec:** **7.** This Act applies to every worker to whom an industrial accident happens in Québec or who contracts an occupational disease in Québec and whose employer, when the accident happens or the disease is contracted, has an establishment in Québec (note: a PO Box is NOT considered an establishment in Québec – see definition below). **For accident outside Quebec, worker must have domicile in Quebec:** **8.** This Act applies to a worker who is the victim of an industrial accident outside Québec or who suffers from an occupational disease contracted outside Québec if, when the accident occurs or the disease is contracted, the worker has his domicile in Québec and his employer has an establishment in Québec. **Exception to above:** Worker's domicile outside Québec. However, where the worker's domicile is not in Québec, this Act applies where the worker had his domicile in Québec at the time of his assignment outside Québec, the work outside Québec is for a duration of not more than five years when the accident occurs or the disease is contracted, and his employer has an establishment in Québec. **Agreement**. **8.1**. An agreement made under the first paragraph of section 170 of the Act respecting occupational health and

	safety (chapter S-2.1) may provide for exceptions to sections 7 and 8, on such conditions and to such extent as it determines. **Definition of establishment:** **"*establishment*"** means all the installations and equipment grouped on one site and organized under the authority of one person or of related persons in view of producing or distributing goods or services, except a construction site; this word includes, in particular, a school, a construction enterprise and the lodging, eating or recreational facilities put at the disposal of workers by the employer, excepting, however, private lodging facilities;
Saskatchewan	Denials would only be on the basis of the employer not being required to or not being eligible for coverage within Saskatchewan. A temporary denial would occur if the requesting Board had not addressed possible Third Party action. **1.2.1 Coverage Within Saskatchewan – Out of Province Employers (POL 07/2002) Document Date 29 July 2002** Purpose: To establish guidelines for out-of-province employers (incidental incursions). **DEFINITIONS** "Incidental" means out-of-province workers come into Saskatchewan two or less times per year or for a duration of four or less consecutive days. "Principal" means the employer in a mandatory industry in Saskatchewan who contracts for service with an out-of-province employer (contractor). **BACKGROUND** 1. When employers based outside of Saskatchewan require their employees to travel into Saskatchewan, either as part of the employer's operations in another province or solely for the purpose of operating a portion of their business activities in Saskatchewan, clarification is needed as to when or in what circumstances the employer and their employees become subject to The Workers' Compensation Act, 1979 (the Act) of Saskatchewan. 2. The Saskatchewan Workers' Compensation Board (the WCB) has exclusive jurisdiction under Section 22 of the Act to determine all matters and questions arising under the Act, including under 22(1)(h) whether any industry is within the scope of the Act and under 22(1)(i) whether any worker is within the scope of the Act. 3. "Industry" is defined in Section 2(j) as "an industry to which this Act applies and includes establishment, undertaking, trade and business." 4. Section 3(1) makes application of the Act mandatory to all "employers and workers engaged in, about or in connection with any industry in Saskatchewan", except industries that are specifically excluded. It is necessary for assessment and injury coverage purposes, to determine whether an out-of-province employer is carrying on business in a mandatory Saskatchewan industry and therefore, is required to register and pay premiums to the WCB. 6. Employers required to register with the WCB who are in default of submitting a statement of payroll or paying assessments to the Board, shall be subject to the penalties set out under Section 153 of the Act, and Sections 3, 4, 5 and 8 of The Workers' Compensation General Regulations, 1985 (the "General Regulations"). **Mandatory Coverage** 1. Where an out-of-province employer is awarded a contract for work to be carried out in a mandatory Saskatchewan industry, registration with the WCB is required if the employer: a. has established a place of business in Saskatchewan, or b. employs Saskatchewan resident workers. 2. Where neither of the above is true, out-of-province employers performing work for a principal in a mandatory Saskatchewan industry will be required to register if: a. the employer comes into the province 3 or more times per year, or b. the employer comes into the province 5 or more consecutive days per year. 3. Where an employer has both a Saskatchewan base of operations (in a mandatory Saskatchewan industry) and a non-Saskatchewan base of operations, coverage will only be extended to workers who are engaged in activities that are part of the Saskatchewan base of operations. Workers employed in the employer's non-Saskatchewan base of operations will not be covered if they are engaged in activities that are not part of the Saskatchewan base of operations, even when working in Saskatchewan. **Voluntary Coverage**

	4. Where the work performed by an out-of-province employer is incidental, registration with the Board is not required and the workers of the out-of-province employer will not be considered workers under the Saskatchewan Act. The Saskatchewan principal may be liable for any legal action commenced by an out-of-province worker in the event of a work injury, unless: a. the Saskatchewan principal becomes responsible for the premiums payable to the Board, or, b. the out-of-province employer elects voluntary coverage with the WCB. **Exceptions** 5. The Independent Worker policy (POL 15/2000), will be considered in conjunction with this policy, as registration criteria vary from the provisions contained here. 6. Any other exceptions to the policy outlined above will be forwarded to the Director of Revenue and Employer Accounts for consideration. **Payroll Reporting and Payment of Premiums** 7. When it has been determined that an out-of-province employer is required to register with the WCB, a statement of the employer's payroll must be submitted within 30 days of the commencement of business and premiums paid accordingly. 8. Where a registered out-of-province employer defaults on premiums payable with respect to the work being carried out in a Saskatchewan industry, the principal will be personally liable to pay the premium on the labour portion of that contract. Act Sec # 002(f)(j), 003(1), 022, 028, 124, 132, 133, 153, 157(1)
**Yukon	In order to apply the IJA, the worker's employer must be registered with the board. The employer must belong to an industry required to register. The employer must register if doing business in the Yukon for more than 10 days in a year. The injured worker must be a "worker" as defined in the legislation. Section 7 of the Yukon's Workers' Compensation Act sets out rules for worker's injured outside of Yukon. If the worker is working outside the Yukon then compensation is only payable if the worker was working outside of Yukon for less than 12 months, the worker is a resident or usually employed in the Yukon and the employment outside Yukon is a continuation of the Yukon employment. Compensation for loss of earnings is limited to 75% of the gross average pre-injury earnings of an injured worker. This is subject to the maximum wage rate that is defined in the legislation. Sections 23-31 govern the basis of calculating compensation benefits for loss of earnings. The worker is entitled by virtue of section 31 to an annuity at the age entitled under the Old Age Security Act. Compensation for a surviving spouse and dependents is subject to the limits in sections 43 to 48. Spousal compensation is equal to 3.125% of the maximum wage rate for the year. **Work-related injury caused outside of the Yukon** **7**(1) If a worker is working outside of Canada and is required by the laws of the foreign jurisdiction to have coverage, and the worker suffers a work-related injury, if the worker is covered by that foreign jurisdiction, the worker is not covered in the Yukon under this *Act*. (2) If a work-related injury is caused while a worker is employed outside of the Yukon, compensation is payable only if; (a) the worker was outside of the Yukon in connection with that employment for less than 12 consecutive months immediately before the cause of the work-related injury arising; (b) the worker is either a resident of the Yukon or is usually employed in the Yukon; (c) the worker's employment outside of the Yukon is a continuation of the employment by the same employer in the Yukon; and (d) where a worker is working outside of Canada, the board has received written confirmation that the worker is in compliance with paragraphs 7(2)(a) to (c). (3) The board may extend the 12 month period in subsection (2) on the application of the employer. (4) A worker or the worker's dependent must notify the board within 30 days of the date the worker's work-related injury arose of their intention to claim compensation under this section. (5) Subject to an interjurisdictional agreement, if compensation is claimed in the jurisdiction where the work-

	related injury was caused, compensation shall not be paid in respect of that work-related injury. (6) Compensation is deemed to have been claimed in the jurisdiction where the worker's work-related injury was caused if notice under this section is not provided to the board within 30 days

** Effective January 1, 2014, Alberta entered into new dollar-for-dollar reimbursement agreement with Yukon.

3.7 Cost Relief

The Reimbursing Board is responsible to determine entitlement to cost relief for the amount reimbursed to the Adjudicating Board based on its own policies/procedures. The decision regarding cost relief to an employer does not affect the amount reimbursed between Boards.

If there is a shortfall in the reimbursement amount received, the Adjudicating Board can decide if cost relief will be provided for the remaining claim costs.

Some Adjudicating Boards simply remove 100% of claim costs from the employer's firm experience regardless of the total claim costs reimbursed by the Reimbursing Board while other Adjudicating Boards remove only claim costs that are reimbursed.

Reference: 1997 and 2011 Meeting Minutes and the IJA
Committee Protocols Practices and Procedures document

WSIB will determine entitlement to cost relief in cases where it is the Adjudicating Board but any amounts that are subsequently reimbursed will be removed from the employers cost statement and would no longer apply (PPP 2014).

For some jurisdictions, shortfalls will remain and appear on employer's accident cost if the jurisdiction is not fully reimbursed.

3.8 Employer Registration

If it is determined that a worker is able to claim in the jurisdiction in which the injury occurred and the employer is in a mandatory industry, assessments can be backdated so the IJA can be applicable and reimbursement can occur (PPP 2014).

Module 4: Cost Reimbursement – Alternative Assessment Procedure

A Registering Board who accepts a claim from a worker injured in their jurisdiction may invoice the Assessing Board for the cost of the claim under the Interjurisdictional Agreement (AAP Section 12) at a minimum quarterly basis. The Assessing Board will pay the full amount of the invoice (subject to the applicable limits set out in Appendix A of the Interjurisdictional Agreement) as this is an assessment refund rather than claim cost reimbursement. In these cases, Section 9 of the Interjurisdictional Agreement does not

apply. The $1000 minimum request and subsequent request minimum of $200 does not apply to assessment refund invoicing under the AAP.

4.1 Communication prior to requesting reimbursement

When a request for assessment transfer is anticipated in relation to an AAP claim, best practice is to send a letter to the jurisdiction in which transfer of assessment may be sought, with the properly completed and signed right of election from the adjudicating Board attached. This letter alerts the Board who may be responsible for costs that the worker has elected to claim benefits in your jurisdiction and that reimbursement may be sought at a later date. This letter should identify any reasons for a delay in the request for reimbursement being issued. For example, claim costs have not yet reached $1000.00 or there is a possible third party action. The following information should be included in this letter; workers full legal name, address, date of accident, injured body part and employer's full legal name.

Sample letter – see Appendix A

4.2 Required Information for Invoicing an Assessing Board

When invoicing an Assessing Board it is best practice to include the following identifying information;

- Invoice number/invoice date
- workers full legal name
- workers address, telephone number, DOB, SIN and/or PHN
- workers job title and date of hire if possible
- claim number
- date and geographical location of accident
- body part injured; and
- employers full legal name and address

The letter should begin with a paragraph identifying that the purpose of the letter is to invoice the cost of the claim under the Alternative Assessment Procedure of the Interjurisdictional Agreement.

The total amount being invoiced should be clearly identified and should be broken down into the following categories;

- earnings loss benefits (benefit summary sheet);
- pension costs; and
- medical aid benefits (should be categorized by benefit type).

Earnings loss information should include as much of the following information as is available to allow the Assessing Board to determine the amount payable (restrictions subject only to the applicable limits set out in Appendix A of the Interjurisdictional Agreement);

- payment dates, to and from periods
- number of days paid in each payment period
- annual or weekly gross earnings
- number of days per week and hours per day
- type of benefits ie: temporary wage loss, extended wage loss; and
- TD code.

File documentation to support your invoice should be enclosed in your request to allow the Assessing Board to determine the amount payable subject to the applicable limits set out in Appendix A of the Interjurisdictional Agreement. For example;

- claim cost printout
- information to enable wage loss benefit calculation
- decision letters; and
- information to support medical aid costs such as service provider reports/invoices
- Claim summaries are optional but it is crucial that complete file documentation, including all pertinent details are submitted with reimbursement requests (PPP 2014).

To avoid potential issues with protection of privacy, separate letters for each request/claim are required. As well, particular attention should be paid to protection of privacy when releasing file information.

It is best practice to advise the Assessing Board of the status of the claim at the time of invoicing to indicate whether future invoices can be expected (ie: claim is now closed, claim remains open for earnings loss and medical aid benefits, claim remains open for medical aid benefits). A resolution in May 2010 (May 12&13, 2010, Committee Protocols, Practices and Procedures) states that Adjudicating Boards should make every effort to ensure that the Reimbursing Board is kept informed of costs being incurred on a claim file. Timely invoicing has been the subject of arbitration in the past. *(see WCB Alberta and Yukon Workers Compensation Award of Arbitration, February 16, 2010).* If you have alerted the Reimbursing Board that the claim is still open it is assumed that further costs will be incurred and therefore further refund of assessments will be required. The Adjudicating Board is responsible for requesting assessment refunds in a timely manner, at a minimum quarterly basis.

Request for Transfer of Assessments – See Appendix D

4.3 Required Information when Paying or Denying an Invoice from an Assessing Board

Upon receipt of an invoice (request for assessment refund) from a Registering Board, the process prescribed by your Board in determining whether the invoice can be paid should be followed. It is best practice to establish processes which allow this

determination to be made in as timely a way as possible. Best practice would be no longer than 90 days with the exception of claims undertaking negotiations through the dispute resolution process or where a third party action has been commenced (April 2004 - resolution passed that accounts would be paid within 90 days of billing - Protocols, Practices and Procedure document).

4.3.1 Invoice Payment Denied

If invoice payment is denied, it is best practice to send a letter to the invoicing jurisdiction outlining the decision and providing a detailed rationale (employer does not participate in AAP at the Reimbursing Board).

4.3.2 Invoice Payment Approved

The invoice is to be paid in full. It is best practice to send a letter to the invoicing jurisdiction informing them of this including a cheque for the invoiced amount or an indication of when a cheque can be expected.

When responding to an invoice from a Registering Board, the Assessing Board should provide the following information;

- workers full legal name,
- claim number of invoicing jurisdiction and claim number of reimbursing jurisdiction if known,
- date of accident,
- Employer's name,
- If denying invoice payment, provide rationale (employer does not participate in AAP)
- If invoice is being paid, total amount paid (should be paid in full)
- Cheque representing reimbursed amount or details of when cheque can be expected.

If reimbursing multiple invoices to a jurisdiction, to avoid potential issues with protection of privacy, it is best practice to send separate letters in response to each request.

Module 5: Troubleshooting

5.1 Typical Issues and Potential Solutions

5.1.1 Full vs. Limited Reimbursement

The amount of reimbursement appears to be dependent on the reimbursing Boards interpretation of whether the policy and statutory limitations refer to reimbursement or payment of compensation. A paper was presented by William Ostapek on this issue at the 2010 Committee Meeting. This document reviewed section 9 of the IJA. The Committee agreed that the limits imposed on full reimbursement are sufficiently broad and unclear and that they significantly undermine full reimbursement as a governing principle. The IJA does not provide detail or guidance related to when it is appropriate to apply limitations with the exception of capitalized future costs. It was suggested at the 2010 meeting that Section 9.2 of the agreement be redrafted but there was no appetite by Committee members to take on this piece of work. This was further discussed at the 2013 Committee Meeting and it was again determined that no redraft was required. That said, all members were in agreement that if a Board is able to reimburse, then full reimbursement should be the guiding principle.

5.1.2 Re-adjudication

Section 9.2 of the IJA states that reimbursement shall either cover the full amount of all payments made by the adjudicating Board on a claim, or the portion of that full amount requested by the adjudicating Board for reimbursement subject only to any policy or statutory limitations. This clause is open to interpretation and appears to be dependent on the level of scrutiny applied in relation to claim review in consideration of reimbursement.

A discussion paper presented to the IJA Committee by Doug Mah (Alberta) in 2004 suggests an interpretation. He suggested that “policy” refers to policy that has the force of law, is binding on all decision makers within the system and is enacted by the governing body of a Board and does not refer to practices and procedures. He suggests a principle of ‘minimal adjudication’ which means the reimbursing jurisdiction is only allowed to adjudicate on the issue of legality of payment rather than generally re-adjudicating the claim.

A further paper presented in 2008 suggests that there are four levels of re-adjudication, with only type 1 being acceptable:

Type 1: Where the Reimbursing Board concludes that to make full payment of the request would cause the Reimbursing Board to breach its own law or policy, and thus the Reimbursing Board is legally compelled to deny or reduce the amount of reimbursement.

Type 2: Where it is not illegal for the Reimbursing Board to make full payment but its law or policy confers discretion. The Reimbursing Board decides to exercise discretion by denying or reducing the amount of reimbursement.

Type 3: Where it is not illegal for the Reimbursing Board to make full payment, but because its methodologies, customs or practices

differ from the Adjudicating Board's, the Reimbursing Board denies or reduces the amount of reimbursement.

Type 4: Where the Reimbursing Board disagrees with the Adjudicating Boards interpretation of the evidence and denies, ceases or reduces the amount of reimbursement.

The paper provides a number of helpful scenarios for which re-adjudication may or may not be appropriate, with an outcome;

Scenario 1

The Adjudicating Board does not employ any in-house medical advisors. It has outsourced this function to a number of community physicians who work as part time contractors. The Adjudicating Board is charged a fee by the contractor for every file review / medical opinion. These costs do not come from the Adjudicating Boards administrative budget but are charged as a claims cost and are ultimately passed on to employers. The Reimbursing Board has in-house physicians to discharge this function. Because the Reimbursing Board does not use contractors, it denies reimbursement for these costs.

Resolution:

The Reimbursing Boards denial is type 3 re-adjudication (as above) and is not permitted under the IJA.

Scenario 2

The worker has reached medical and vocational plateau and is being assessed for permanent clinical impairment (PCI). The Adjudicating Boards rating schedule is different than the Reimbursing Boards, resulting in a percentage of whole person that is higher than the Reimbursing Boards would have been. The Reimbursing Board has received a medical opinion regarding PCI from its own physician, which of course is lower. The Reimbursing Board reduces the payment accordingly.

Resolution:

This again is type 3 re-adjudication and is not permissible under the IJA.

Scenario 3

While driving in the Reimbursing Boards jurisdiction in 1994, the worker pinches his calf and develops deep vein thrombosis (DVT). The Adjudicating Board accepts the claim for DVT. By 2007, the Adjudicating Board has determined that the worker's leg problem is permanent and assesses for permanent disability. The Reimbursing Board denies the payment request related to permanent disability in its entirety, stating that it is responsible only for the acute period following the 1994 incident and that the worker's longer term problems are the result of "general job duties".

Resolution:

This is type 4 re-adjudication and is not permissible under the IJA.

Scenario 4

The Reimbursing Board has rigid rules pertaining to the calculation of compensation rates, resulting from both legislation and policy. The Adjudicating Boards methodology for calculating compensation rates results in a more generous long term rate. The Reimbursing Board applies its methodology, resulting in a significantly lower long term rate and thereby reducing the Adjudicating Boards reimbursement request considerably.

Resolution:

This could be type 1 re-adjudication (permissible), depending on whether or not there is legal compulsion to apply the Reimbursing Boards methodology. Otherwise, it might be type 2 or type 3, or a combination, and therefore not permissible.

Scenario 5

The Reimbursing Board, based on its own in-house medical advice, does not believe that a certain prescription paid for by the Adjudicating Board relates to the work injury. The Adjudicating Board, on the other hand, has a medical memo that says the prescription is indicated. The Reimbursing Board denies reimbursement for the prescription.

Resolution:

This is type 4 re-adjudication and is not permitted under the IJA.

Scenario 6

The Adjudicating Boards policy requires referral for Permanent Clinical Impairment (PCI) upon the happening of a certain event. A PCI was established under the Adjudicating Boards methodology. The Reimbursing Board purported to deny reimbursement for permanent disability on the basis that, in its medical opinion, it was too early to do a proper PCI assessment.

Resolution:

This is type 4 re-adjudication and would not be allowed under the IJA.

Scenario 7

The worker was diagnosed with minor residual psychological symptoms and awarded a 10% permanent disability by the Adjudicating Board. The Reimbursing Board formed the opinion, following review of the file, that the evidence was not reliable enough to confirm a diagnosis of PTSD (Post Traumatic Stress Disorder) under the DSMIV (Diagnostic and Statistical Manual of Mental Disorders). On the Adjudicating Boards file, there were differing opinions from treating providers as to whether or not the worker had PTSD.

Resolution:

This is a question of sufficiency of evidence. Once the Adjudicating Board found that the worker suffered from a permanent psychological disability and in view

of the fact that there is some evidence on the file as to PTSD, it was likely that the Reimbursing Board engaged in type 4 re-adjudication.

Mah's 2004 discussion paper also provides examples of scenarios encountered related to re-adjudication for consideration:

1. The maximum insurable earnings in the Adjudicating Boards jurisdiction is $70k. In the Reimbursing Boards jurisdiction this is $58k. The Adjudicating Board submits a claim to the Reimbursing Board for one year of TTD (Temporary Total Disability) at the Adjudicating Boards maximum. The Reimbursing Board is entitled to reimburse at its own maximum, not the Adjudicating Boards maximum.
2. Chronic stress is acceptable in the Adjudicating Board but is specifically de-insured by legislation in the Reimbursing Board. The Adjudicating Board submits a reimbursement claim to the Reimbursing Board for a chronic stress claim. The Reimbursing Board is entitled to not pay claim.
3. A surviving spouse under age 40 in the Adjudicating Boards jurisdiction is entitled to a lifetime pension based on the deceased worker's earnings; but in the Reimbursing Boards jurisdiction a surviving spouse under 40 is only entitled to a single lump sum benefit equal to two years times the deceased worker's annual earnings. The Adjudicating Board submits for reimbursement, the capitalized cost of the fatality claim to the Reimbursing Board. The Reimbursing Board is only required to reimburse two years' worth of benefits.
4. The Adjudicating Board determines that a worker is 50% disabled based on a medical opinion on file. The Adjudicating Board submits a claim to the Reimbursing Board for the capitalized cost of the pension. The Reimbursing Board, upon reviewing medical evidence, believes the worker is only 10% disabled. The Reimbursing Board gets a medical opinion from its own medical advisor supporting a 10% disability. In these circumstances the Reimbursing Board has re-adjudicated the Adjudicating Boards finding of 50%, which is not permitted and constitutes Type 4 re-adjudication. The Reimbursing Board must still reimburse the Adjudicating Board based on the 50%.
5. The Adjudicating Board funds a two year academic program for an injured worker and submits a claim to the Reimbursing Board. The Reimbursing Board, upon reviewing the file, concludes that it would have given that worker 12 weeks of re-employment assistance under local practice but not a two year program. In this case, the Reimbursing Board has re-adjudicated the Adjudicating Board's discretion to grant the two year program, which is not permitted and constitutes Type 3 re-adjudication. The Reimbursing Board must still reimburse the Adjudicating Board for the full cost of the program.

6. The Adjudicating Board accepts a worker's mental disorder as compensable in the absence of a diagnosis under the DSM (Diagnostic and Statistical Manual of Mental Disorders). The Adjudicating Board submits a reimbursement claim to the Reimbursing Board. Under the Reimbursement Board's policy, there must be a diagnosis of a recognized disorder under the DSM before a claim for mental disorder is acceptable. The Reimbursing Board is entitled to withhold payment until such time as a diagnosis under the DSM is obtained by the Adjudicating Board.

A resolution in the IJA Committee Protocols, Practices and Procedures document dated May 2008 states that there is only one type of case in which re-adjudication is appropriate and that is where the injured individual is determined not to be a worker in the reimbursing jurisdiction. Despite this, re-adjudication continues to be an issue in the application of the IJA.

Resolution:
At the 2013 Committee Meeting it was decided that where the Reimbursing Board has discretion, reimbursement should be made and the only acceptable type of re-adjudication is Type 1 (as described on page 29). The guiding principle should be full reimbursement wherever possible.

Reimbursement Overpayments Resolution: At the 2014 Committee Meeting jurisdictions agreed that in situations where an Adjudicating Board experiences a change in the decision (ie: as a result of an appeal), it should be reflected in the reimbursement requests made to the Assessing Board. Determination of an error in this case would not be considered re-adjudication. Jurisdictions should act in good faith to deal with these claims as they do not occur often (PPP 2014).

5.1.3 Disputed IJA Application

These cases differ from “re-adjudication” cases in that in the latter, the application of the IJA is not disputed. In re-adjudication cases, it is accepted that the IJA applies and what is disputed is the amount of reimbursement.

Here are some sample scenarios of purported non-application drawn from real experience to illustrate the nature of the issue.

Scenario 1
The worker lives in the Adjudicating Board and during the months of March, April and May was engaged in delivering refrigerators (weighing 200 to 300 lbs.) for the same employer. The worker performed his work in the Reimbursing Board from March 27 to March 30. The worker reports the following information to the Adjudicating Board in June:

Date	Location	Symptom
March 28	Reimbursing Board	Sharp pain in groin.
April 15	Adjudicating Board	Twinges in groin.
May 10	Adjudicating Board	Developed hernia.

The worker did not seek medical treatment for the March 28 incident and described the pain as going away. The Adjudicating Board accepts the claim for a hernia and has made a reimbursement request to the Reimbursing board on the basis of the March 28 incident as the precipitating incident, which the Reimbursing Board has denied. The Reimbursing Board says the accident occurred in the Adjudicating Board when the hernia surfaced on May 10 and therefore the IJA does not apply.

Scenario 2

The worker was employed as a laborer erecting metal sheds and was required to lift heavy poles and gauge metal. The worker had done the same work for 11 years, five years with the same employer. The employer carries out work throughout Alberta, Saskatchewan, Manitoba, Ontario and British Columbia. On November 28, the worker reported a back strain to the Adjudicating Board that occurred on August 24 (while in the Reimbursing Board), although the worker continued to work for some months. The employer's report submitted on December 1 to the Adjudicating Board noted that the worker had injured his back as a result of general lifting requirements over the past year, and did not mention a specific work incident. Medical reporting on the Adjudicating Board's file indicates that the injury was progressive in nature. The Adjudicating Board has made a reimbursement request to the Reimbursing Board, which has been denied on the basis that it is not an IJA claim.

Scenario 3

The worker reported that he fell in the Reimbursing Board's jurisdiction while unloading equipment. He then drove 8.5 hours home on a logging road back to his home in the Adjudicating Board's jurisdiction. The employer went to the worker's home to pick up the company truck and found the worker lying on the ground. The worker indicated that he had fallen again while unloading articles from the truck. The employer took the worker to hospital for medical treatment. The worker was diagnosed with a low back injury and the Adjudicating Board accepted the claim. The Adjudicating Board's reimbursement request to the Reimbursing Board was denied.

Scenario 4

The Adjudicating Board and the Reimbursing Board are in adjacent provinces. The worker was employed as a truck driver in the Adjudicating Board, sometimes traveling into the Reimbursing Board. The worker had been experiencing back

pain for some time. There were apparently ergonomic problems with the driver's seating. The worker crossed over into the Reimbursing Board's jurisdiction, parked his vehicle and slept for 8 hours. When he woke up, he experienced severe back pain. The Adjudicating Board accepted the back claim and submitted a reimbursement request to the Reimbursing Board on the basis that the worker was physically located in the Reimbursing Board when the severe pain started. The Reimbursing Board denied reimbursement.

Resolution to scenarios described above:
All of these cases share the common feature that the Reimbursing Board is denying reimbursement on the basis that the IJA does not apply. The injuries are either progressive in nature and developing in more than one jurisdiction, or it is uncertain as to exactly where the injury occurred. In any case, if the Boards disagree with the reimbursement, it is proposed that the following occur:

a) the Adjudicating Board submit the dispute for dispute resolution under the IJA (see Section 6.3); or
b) the IJA Coordinators develop a methodology for apportioning costs between the jurisdictions.

The Practices, Policies and Procedures document notes a resolution on May 14&15, 2008 which states that whatever happens, the worker should not be "left hanging" and that third party dispute resolution is the recommended avenue if adjudicators and coordinators could not come to an agreement in the first instance.

Scenario 5
Requesting Board requests reimbursement for costs to the Board for Internal assessment or medical report that does not show as a claim cost but is a cost to the Board for a service provided.

Resolution:
Costs should only be requested from the reimbursing jurisdiction if costs were billed to an employer and are thereby charged to the claim file.

(Scenarios are as per Doug Mah's discussion paper, May 2008)

5.1.4 Non-registered employer vs. employer that "should have been" registered:

An employer not being registered in the reimbursing jurisdiction is not, in itself, a bar to reimbursement. A resolution passed at the 2008 Committee meeting states that the reimbursing jurisdiction must determine whether the employer **should have been** registered in their jurisdiction at the time of the accident (see section 3.8 Employer Registration).

Resolution:

IJA:

If it is determined that an employer should have been registered with a Board then reimbursement is appropriate under Section 9 of the IJA. The Reimbursing Board should determine the time period which the employer should have been registered and paying assessments in that jurisdiction and can collect retroactive assessments.

AAP:

If an employer is registered in AAP with one jurisdiction and has failed to advise a jurisdiction in which it has resident workers, appropriate measures need to be taken to "back-date" participation. Full reimbursement would then occur, under the AAP based on the jurisdiction of residence and the jurisdiction that collected premiums accordingly.

As per the April 6&7, 1998 resolution documented in the Committee Protocols, Practices and Procedures document, the reimbursing Board is obliged to honor the reimbursement if the employer was in a compulsory industry at the time of the accident even if the employer was not registered at the time of the accident.

5.2 Other Case Studies and Resolutions

The following are case studies discussed at previous IJA Committee meetings with either questions raised by the case or where possible, resolution to the issues described.

5.2.1 2010 IJA Committee Meeting Resolutions

5.2.1.1 Capitalization Clarification (Section 9.2/9.6)

The Adjudicating Board requests reimbursement from the Assessing Board for pension costs (aka ELP costs). The Assessing Board reimburses the Adjudicating Board. However, at the time of first reimbursement, the Reimbursing (assessing) Board employs a process of capitalizing future costs based on the Assessing Board's assumptions for earnings loss capability. As reimbursement requests continue over the months/years from the adjudicating province, the Reimbursing Board eventually limits/ends reimbursement to continued pension requests once they reach their total capitalized figure (aka pension reserve) suggesting that if they were adjudicating this claim, this would be the limit of the worker's entitlement?

Some provinces take this one step further and actually have reviewed their past claims where pension costs have been reimbursed to the Adjudicating Board and create overpayments, suggesting that reimbursement was made in error, in excess of the pension reserve calculated. In turn, the Reimbursing Board are requesting reimbursement back from the Adjudicating Board.

RESOLUTION:
The Reimbursing Board should not be capitalizing or limiting reimbursement under IJA as per the May 12&13, 2010 resolution documented in the Committee Protocols, Practices and Procedures document. At the 2011 Committee Meeting it was recommended that jurisdictions resolve this issue with the opposing Board (May 10&11, 2011 Committee Protocols, Practices and Procedures document).

5.2.1.2 Clarification on Application of the IJA/ITA with 2 different employers charged

A worker has a work accident in AB but resides in SK. As a result, he chooses to elect benefits from AB, where the work accident occurs. AB establishes the claim along with charging and determines that employer A is the appropriate employer charged (who happens to participate in the AAP). However, since it is an AAP employer, costs are recoverable from the province of residency (in this case, SK). Therefore, AB requests reimbursement back from SK as they assume that they are collecting premiums from employer A, for their worker who resides in SK. SK establishes a claim and is prepared to issue reimbursement to AB. However, SK has determined that the employer responsible in their province is actually Employer B, based on their legislative provisions and indicated that Employer A is actually NOT required to have an account in their province. Employer B participates in the AAP in SK and in AB. However, the AB Board has determined that Employer B is **NOT** the appropriately charged employer for this claim due to their own legislative rules.

This raises the following questions:
1. Is it appropriate for SK to reimburse AB when AB has determined that it is a *different employer charged?* OR In order for reimbursement to occur should the employers charged be the same? Does one province's rule take precedence over another in cases like this? When this request for reimbursement is received, should SK even consider a different employer--or should they simply review the AB's Board's decision regarding the Employer A being charged and then advise that this employer is not required to have an account in their province, and subsequently deny the reimbursement request. Would it be considered re-adjudication by the SK Board to determine Employer B is the appropriate employer being charged?

2. Is it reasonable to have *2 separate employers being charged for the same claim*, dependent on where the worker chooses to elect benefits? It is possible that if the worker was to choose to elect benefits in SK, the employer charged would be different then if he chose to elect benefits in AB.

3. Does this create any *FOIP issues* regarding access to information? Employer A or Employer B? Specifically, if Employer B requested a copy of this file from AB (in order to obtain up-to-date file info) after AB received reimbursement from SK (knowing that they are the employer being faced with the costs of the claim), AB would not necessarily release a copy of the file as the AB Board would not consider Employer B to be the employer charged in AB.

4. *Claims management issues* are created when we have 2 different employers being charged with the claim. Under the IJA, the AB Board has 2 full years to request reimbursement. So, it is very possible that this claim could be accepted, managed and closed without Employer B ever being aware that they would be the employer responsible for this claim until they receive their costs statements from the SK Board. This can create concerns for Employer B particularly if they are proactive in their disability management practices and have never had an opportunity to become involved in the case management of the file (as in AB, the claim is charged to Employer A, who the SK Board has determined is not required to have an account).

This creates issues with respect to simple things like establishing a worker's compensation rate to more complex things like disagreeing with benefits being paid to the worker and/or having the ability to offer modified duties to the worker in an attempt to reduce the claims costs incurred as the AB Board would not even consider to involve Employer B in these discussions. If we follow the same logic, then it also begs the question whether it is even appropriate to provide Employer A the "right" to appeal case management issues on the claim when truly they are never going to be the employer responsible for the costs of the claim and there would be no true ties to the claim.

Resolution:
All jurisdictions agreed the same employer is not required in order to accept a request for reimbursement. If the employer has an account and the worker was able to elect with another jurisdiction, reimbursement is reasonable in accordance with the IJA. The Board can releive all costs to the employer once reimbursement is received (May 16&17, 2012 resolution documented in the Committee Protocols, Practices and Procedures document).

5.2.2 Case Studies

Case Study #1

Adjudicating Board is seeking reimbursement for pension costs. BC, the Reimbursing Board, has paid to the capitalized value of the claim; its legislation does not permit payment beyond the capitalized value. Is this practice fair? Is it

in accordance with section 9.2 and 9.6 of the IJA? Alberta does not capitalize the value of a claim. Is it appropriate for the Assessing Board to do so and to revisit its payments and to create an overpayment if the claim has reached its capitalized value?

YK advised it does not capitalize. They do pay 75% of gross earnings for older claims. If a jurisdiction is doing what it normally does pursuant to their policy, then one must accept that. However, if it is not, then it is contrary to the IJA.

AB advised they used to estimate future costs by capitalizing costs. Such estimates should not be used to cap reimbursement if a board can actually pay more under its legislation.

MB stated older claims should only be revisited if there is change in legislation. Capitalizing and reserving are used to estimate the cost of the claim going forward. It is not a method to cap benefits to another jurisdiction and therefore should continue to pay the claim if respective legislation allows it.

In BC, payment is made to the maximum of the cap value of the claim. Workers have an opportunity for commutation and BC pays only to the reserve amount.

AB stated it used to request full amount for capitalized value but now pays out as costs are incurred. AB tweaks any IJA requests it makes so that other boards can pay (such as to MB which cannot pay into the future, so it only makes requests once the entitlement period to payment has passed. It breaks lump sums into smaller amounts and requests reimbursement periodically).

SK advised they do use caps internally for insurance purposes only, not for reimbursing on an IJA basis. A special agreement occurred between ON and SK for one case involving survivor benefits.

BC advised that one board may say a 15% cap value is worth $50,000 and the other says it is valued to $80,000. One board pays to age 65; other pays for life of the claim. Boards need to capitalize for insurance purposes; however, this should not be indicative of the actual payment of the claim as this is dependent on many factors including actual life span of the worker.

AB thought there should be equivalency and agreement between boards about how to cap costs.

ON advised that caps come into play for old claims. Ontario will pay monthly amount up to legislative limits.

MB does not pay cap costs. Their jurisdiction can only pay monthly until the worker reaches 65 years of age. MB cannot pay benefits into the future. NB, YK and QC do not cap for reimbursement purposes. NS does not believe they are capping for reimbursement purposes. NWT does cap its claims.

Jurisdictions discussed the benefits/drawbacks of which approach should be taken: A board pays until benefits stop or, if there is a cap value; benefits are only paid to that cap value in one lump sum or month-by-month. Payments month-by-month may or may not exceed the capitalized value of the claim.

Resolution:
The general consensus is that reimbursement should not be limited on the basis of capitalized costs calculated by the Reimbursing Board, however a recommendation at the 2011 Committee meeting was that the two Boards involved should resolve this issue amongst themselves (May 10&11, 2011 resolution documented in the Committee Protocols, Practices and Procedures document).

Case Study #2:
Alberta believes that if a board made an error in paying a claim, it should not be allowed to recover monies by withholding payment on another IJA/AAP claim. YK is in agreement with AB. Limitation of actions is six years under YK provincial legislation.

QC asked if a Reimbursing Board had paid in excess of the invoiced amounts, should the Adjudicating Board reimburse the overpayment. Committee agreed that the Reimbursing Board should be reimbursed the overpayment.

Resolution:
Re-adjudication & Overpayments: In situations where an Adjudicating Board experiences a change in a decision because of an appeal, it should be reflected in the payments of the Reimbursing Board. Determination of an error is not re-adjudication. Jurisdictions should act in good faith to deal with these claims as they do not occur often (2010 IJA Committee Meeting).

Case Study #3a:
Leased operator hired another leasing operator. In SK, leasing operator is not an employer. In AB, leasing operator can be an employer. SK determined that the leased operator was part of the larger transport company and therefore a worker. The larger company had never been involved in the adjudication of the claim (modified duties etc.). Can two different employers be charged for the cost of the same claim? Is it re-adjudication because one jurisdiction has determined that a different employer is to be charged with the cost of the claim? Does one jurisdiction take precedence over another for employer charging?

In AB, Company “A” was found to be employer of the injured worker. As Company “A” was participating in the AAP, and the worker was a resident of SK, AB requested reimbursement under the AAP. The accident happened in AB. In SK, the worker was found to work for Company “B”, but Company “B” did not participate in the AAP.

The Committee concluded that because of individual legislation there could be two different employers for the same individual. Though Company "A" participated in the AAP, the injured worker did not qualify for the AAP for that employer in Saskatchewan. There would be no reimbursement under the AAP. SK needs to deny the request.

This case illustrated that the AAP operates at the worker level, and that not all workers of an employer may be covered under the AAP. The jurisdiction that receives all the assessments/premiums for a worker must be able to cover that worker in all jurisdictions. Situations such as this could be avoided if more communication was occurring between the Assessing/Registering Board(s) to ensure employers were properly registering in the AAP.

Resolution:
More effective communication between assessing and registering Boards is required (2010 IJA Committee Meeting).

Case Study #3b:
SK trucking employer hired a NS worker who is injured in U.S.A. The injured person was not considered a worker in SK because there is no substantial connection to SK's jurisdiction; NS stated that in its jurisdiction, to be an employer, one must have more than three workers in NS in order for WCB coverage to be considered. In this case, the worker would not have had coverage in NS because there were fewer than three employees working for the employer in NS.

There was mention that the worker may have travelled through ON. ON indicated that if the worker had a substantial employment connection and regularly worked in ON, the worker could claim in ON (assuming he/she was not an independent operator). ON also indicated that in such a case, the employer would have been required to pay premiums in ON.

Resolution:
Employers should check with every jurisdiction's Board that workers travel through to determine appropriate coverage (2010 IJA Committee Meeting).

Module 6: Dispute Resolution

An IJA Dispute Resolution Best Practices Training Guide was prepared by Douglas R. Mah, Secretary and General Counsel at the Workers Compensation Board of Alberta in 2010.

6.1 Principles

1. All participants in the IJA will act in good faith and use best efforts to comply with the spirit and intent of the IJA. In particular, this means making efforts to ensure that no worker goes without a remedy.
2. The interpretation of the IJA is not static and is ever evolving.
3. Participants will take a collaborative and consultative approach to interpretation. That is why the IJA Coordinators meetings are useful as they achieve documented protocols, practices and procedures with respect to IJA administration.
4. As an overarching rule, a reimbursing jurisdiction is not allowed to "re-adjudicate" the decision of an adjudicating jurisdiction. The amount of reimbursement is governed by section 9.2 of the IJA and is limited only by statute or policy enacted by the jurisdiction's governing body. The reimbursing jurisdiction should not substitute its own discretion or purport to make a different decision where the original decision is within the reimbursing jurisdiction's authority. Section 9.2 reads as follows:

   > Reimbursements shall either cover the full amount of all payments made by the adjudicating Board on a claim, or the portion of that full amount requested by the adjudicating Board for reimbursement subject only to any policy or statutory limitations. This includes the capitalized costs established on a claim, where both the adjudicating and reimbursing Boards employ a process of capitalizing future costs. Reimbursement in such cases shall be limited to the extent that the reimbursing Board would have itself capitalized the costs had it administered the claim.

5. The reimbursing jurisdiction does not have authority to appeal any adjudicative decisions through the adjudicating jurisdictions appeal system (PPP 2014)

6.2 Process

Disputes under the IJA invariably involve either nonpayment or reduced payment by a reimbursing jurisdiction subsequent to a request for payment by an adjudicating jurisdiction. In determining whether to pursue the payment, the adjudicating jurisdiction must make a business decision. The following factors (the list is not intended to be exclusive) may be relevant:

- amount in dispute
- effort required to secure the payment
- relationship with reimbursing jurisdiction
- the effect of not receiving payment on the employer in the adjudicating jurisdiction
- whether or not the worker "falls through the cracks"

- length of time required to resolve the dispute (where anecdotal experience indicates the average period of time to resolve a dispute is two years)

7. The adjudicating jurisdiction should seek clarification from the reimbursing jurisdiction as to the reasons why there has been nonpayment or reduced payment. First, the two jurisdictions must reach consensus on the facts of the case. Second, the adjudicating jurisdiction must receive an explanation in writing from the reimbursing jurisdiction as to the legislation and policy being relied upon for the decision.
8. The claim handler/case manager in the adjudicating jurisdiction may wish to seek legal advice and/or input from his or her supervisor at this stage.
9. The claim handler/case manager in the adjudicating jurisdiction should attempt a negotiation with his or her counterpart in the reimbursing jurisdiction. If resolution is not reached, the adjudicating jurisdiction may wish to escalate the issue to the two IJA Coordinators for further discussion.
10. If discussions between the IJA Coordinators does not result in a resolution, then the adjudicating jurisdiction may initiate one or more of the following dispute resolution mechanisms:
    - submission of the case on an anonymized basis to the annual meeting of the IJA Coordinators as a case study
    - pursuing the statutory review or appeal process in the reimbursing jurisdiction, where permitted by law
    - pursuing mediation under section 16 of the IJA

6.3 Exclusive Jurisdiction of Adjudicating Board

Each Adjudicating Board has the exclusive jurisdiction to determine all matters arising under its Statutory Authority and the action or decision of the Adjudicating Board on such matters is final and conclusive. This decision-making authority cannot be delegated to any other Board.

6.4 Goal of Dispute Resolution

In the event of a dispute arising between jurisdictions, the Boards in disputes shall undertake negotiations in good faith to reach a decision. Such negotiations shall originally be conducted by the staff involved by correspondence and telephone. Failing an agreement, senior representatives of each Board shall address the issues, with the goal of reaching a fair and reasonable conclusion.

6.5 Referral to IJA Coordinator

Should the dispute remain unresolved, each Board shall refer the dispute to the Interjurisdictional Coordinator appointed by their respective Boards for further review and discussion. If the coordinators fail to resolve the issues to their mutual satisfaction, they may agree to the

appointment of one or more coordinators from other Boards to mediate the dispute.

7.5.1 Information for Mediators

The mediators may request any additional information as is necessary for the understanding and determination of the dispute and may conduct an oral hearing on the dispute at such time and place agreeable to the Boards involved in the dispute. All evidence, whether written or oral, shall be treated with the utmost confidentiality.

7.5.2 Recommendations

The recommendations of the coordinator who acts as mediator is not binding on the parties, however, it is agreed that Boards shall act in utmost good faith and make every bona fide effort to carry out the mediator's recommendations.

7.5.3 Costs Shared

Any reasonable costs incurred by any coordinator who acts as mediator shall be paid equally by the Boards in dispute.

6.6 Pursuing Consensual Arbitration (Steps)

1. Identify and agree upon the issue for arbitration.
2. Identify and agree upon the arbitrator.
3. Prepare and execute the arbitration agreement. Points to consider;
    - both sides should agree to pay one-half of the arbitrator's fee regardless of outcome
    - arbitration agreement should be signed by the parties and the arbitrator
    - arbitration agreement should provide that arbitrator has exclusive jurisdiction to determine process
    - arbitration agreement should stipulate that arbitration is non-binding as board/commission likely not able to delegate decision-making authority
4. Prepare and sign an Agreed Statement of Facts (if facts can be agreed upon)
    - consider what, if any, further evidence needs to be submitted, either in Affidavit form or through witnesses
5. Determine whether examination on affidavit required.
6. Prepare and submit written briefs to the arbitrator.
7. Oral hearing if requested by one of the parties or required by the arbitrator.
8. Receive decision.
9. Pay arbitrator's invoice.

6.7 Principle of Good Faith

It should be noted that except in the case of statutory review and/or appeal, the other remedies noted above are not necessarily binding upon the reimbursing jurisdiction. However, if the outcome is within the legal discretion and authority of the reimbursing jurisdiction (which it should be), then the reimbursing jurisdiction may wish to implement the outcome based on the principle of good faith.

6.8 Timeframe

In general, dispute resolution in the form of mediation or arbitration should be commenced within two years of the dispute arising. For certainty, the dispute is deemed to have arisen on the date the reimbursing jurisdiction declines, in writing, to make the payment requested.

Appendix A - Template letter – Communication prior to reimbursement or transfer of assessment request

[Name and address of recipient]

[Date]

Dear [name of recipient],

RE: [Workers full legal name and address] WCB XXX Case ID # [case ID number], Date of Accident [DOA], Injured Body Part [body part]

Please find enclosed, a completed and signed copy of an interjurisdictional election form submitted by the above named worker following an accident in [accident jurisdiction] on [date of accident].

Option 1 – notice only
The worker has elected to claim benefits in [jurisdiction elected] but could equally open an application for benefits in your jurisdiction, therefore, I am forwarding this copy to you for information purposes in compliance with the [Interjurisdictional Agreement and/ or the Alternative Assessment Procedure].

If applicable, a [request for reimbursement or transfer of assessments] of claim costs may follow.

Option 2 - possible third party action
As this has been identified to be a third party claim, the worker has been requested to elect to claim benefits with [jurisdiction elected] or elect take action against the third party in their own right. Should the worker elect to claim benefits from [jurisdiction elected] they subrogate their right of action to [jurisdiction elected]. Should the worker elect to claim benefits with [jurisdiction elected] and the Board opts not to proceed with an action or a settlement is reached and there are remaining claim costs, a request for reimbursement of claim costs or transfer of assessments may follow.

If you have any questions or concerns related to this correspondence, please do not hesitate to contact me at [phone number].

Sincerely,

[Name]
[Title]

Encl.

Appendix B - Template letter – Request for reimbursement

[Name and address of recipient}

[Date] [Invoice #]

Dear [name of recipient];

RE: [Workers name] WCB XXX Case ID#: [case ID number]

The purpose of this correspondence is to request reimbursement of claim costs/transfer of assessments under the Interjurisdictional Agreement further to our [original letter advising of the above named workers election to claim] OR [previous request for cost reimbursement] dated [date of letter with copy of election or previous request for reimbursement].

Option 1 - initial request
[Workers full legal name] was injured in [injury jurisdiction] on [date of accident] while employed with [full legal name of employer].

Please note this worker's employer information is as follows:
[Complete employer information including contact person name and number]

The total amount of reimbursement requested is [total $ amount requested].

[Type of loss of earnings benefits] were calculated using the following information:

- [annual or weekly gross earnings]
- [number of days per week and hours per day]
- TD code.

Option 2 - subsequent reimbursement request
Since our previous request, additional benefits have been paid and therefore additional costs incurred. As such, I am requesting further reimbursement as follows.
[note any changes to benefit calculation since initial request if applicable].

Loss of earnings for [period paid from and to and total # of days paid]	**[Total LOE $]**
[Type of medical aid]	[Total $]
[Type of medical aid]	[Total $]
Medical Aid total	**[Total MA $]**
Total Reimbursement Requested	**[Total $]**

Please note this claim [is now closed] **OR** [remains open and therefore further reimbursement may be requested at a later date]. Please find enclosed file documentation to support this request.

If you have any questions in relation to this request, please feel free to contact me at [phone number].

Sincerely,

[Name and title]

Encl.

Appendix C - Template letter – Denial, partial or full reimbursement

[Name and address of recipient]

[Date]

Dear [name of recipient],

RE: Your invoice #: [invoice #] [Workers full legal name] WCB XXX case ID#: [case ID number] Date of accident: [date of accident]

The purpose of this correspondence is to provide a decision in response to your request for reimbursement of costs/transfer of assessments under the Interjurisdictional Agreement dated [date of invoice] for the above claim for [workers full legal name] who is employed by [employer's full legal name].

Option 1
I am pleased to inform you that your request for reimbursement has been approved noting no shortfall. A cheque for [total reimbursed amount] is enclosed.

Option 2
Your reimbursement request has been approved noting a shortfall of [total shortfall amount]. [Add complete rationale for shortfall with supporting legislation and/or policy statements]. A cheque for [total reimbursed amount] is enclosed. **OR** Your request has been forwarded to our [department responsible for payment] for processing and you can expect payment [date or timeframe in which payment can be expected ie: within 2 weeks].

Option 3
Unfortunately, your request for reimbursement is denied. [Add complete rationale for shortfall with supporting legislation and/or policy statements].

If you have any questions or concerns related in relation to this decision, please do not hesitate to contact me at [phone number].

If you disagree with the above decision, please submit a request for reconsideration outlining the facts which support a change in my decision. I would happy to review your request upon receipt.

Sincerely,

[Name and title]

Appendix D – Alternative Assessment Procedure Request for Transfer of Assessment

ALTERNATIVE ASSESSMENT PROCEDURE (AAP) FOR INTERJURISDICTIONAL TRUCKING AND TRANSPORT REQUEST FOR ASSESSMENT TRANSFER

A. Identification of the worker

Surname			Sex M F
First name			
Address			
	City	Province or Territory	Postal code
Date of birth		Social Insurance Number	
Claim number			

B. Identification of the employer			
Name of Employer			
Establishment Address			
	City	Province or territory	Postal code
Contact person			
Phone number		Employer #	

C. Description of time and place of the occurrence		
Place of occurrence	City	Province or territory
Date of accident		

D. Description of the occurrence and nature of the work-related injury (injury location)

E. Benefit category

Gross weekly earnings _____

	Amount	**Payment period**
- short term	_____	_____
- long term	_____	_____
- health care	_____	_____
- rehabilitation	_____	_____
- survivor benefits	_____	_____
- other _____	_____	_____

Total _____

First request ☐ Interim request ☐ Final request ☐

For subsequent assessment transfer requests, please provide claim number in section A and complete section E.

F Further disbursements expected Yes ☐ No ☐

Signature of authorized representative

_____ _____ _____

Name of Representative Phone Number Date