**WCAT Decision Number:** WCAT-2008-02333
**WCAT Decision Date:** August 06, 2008
**Panel:** Hélène Beauchesne, Vice Chair

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## Introduction

The worker, a magnetic resonance imaging (MRI) technologist, had an occupational exposure to fumes in 1995, which has resulted in permanent functional impairment. In August 2006, the Board granted her a permanent partial disability (pension) award of 2.5%.

The worker appeals a decision of the Review Division of the Workers' Compensation Board, operating as WorkSafeBC (Board), dated January 29, 2007. In that decision, a review officer denied the worker's request for review, confirming the Board's pension decision of August 1, 2006. The review officer found that the Board's decision to grant the worker a functional award of 2.5% was consistent with the facts, the law and the policy. He agreed the worker was not entitled to a loss-of-earnings award.

This appeal was filed with the Workers' Compensation Appeal Tribunal (WCAT) under section 239(1) of the *Workers Compensation Act* (Act). An oral hearing was held on September 24, 2007 with respect to the appeal. The worker attended with a representative from the Workers' Advisers Office. The employer participated in the appeal and was represented at the hearing.

In a memorandum dated February 5, 2008, I referred the worker's claim back to the Board for further investigation under section 246(2)(d) of the Act to reassess the worker's permanent functional impairment based on new evidence and findings.

The Board internal medicine consultant provided a memorandum dated February 25, 2008 and the disability awards officer reviewed the worker's permanent functional impairment on February 27, 2008 in response to the referral. The memoranda were provided to the parties, along with updated disclosure of the worker's file.

The worker provided a written submission dated May 12, 2008, which was provided to the employer's representative. The employer provided a submission dated May 28, 2008. The worker's representative advised the worker would not provide a rebuttal.

## Issue(s)

The issue arising from the appeal is whether the worker's permanent partial disability award was properly determined, including whether the worker was entitled to an award on a loss-of-earnings basis.


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**Background and Evidence**

The worker filed a claim for compensation for multiple skin and airway irritations which developed in February 1995 as a result of occupational exposure to film processing fumes. She and five other MRI technologists had complained of symptoms including headaches, nausea, dry skin, sore eyes, hives, chest tightness, and shortness of breath. Investigation revealed that an x-ray developing machine had not been installed according to the manufacturer's recommendations. The worker's claim was originally accepted as a temporary aggravation of a pre-existing allergy.

In *WCAT Decision #2006-01164-RB* dated March 10, 2006, a panel addressed the compensability of the worker's condition in September 1998. The panel stated the conditions of fibromyalgia and chronic fatigue syndrome were not before her. The panel found that by September 1998, the worker had developed a permanent sensitivity to film processing chemicals that resulted in recurring respiratory and skin irritations, rhinitis, headaches and gastrointestinal symptoms. The worker did not have occupationally-induced asthma, nor did her occupational exposure have causative significance with respect to tinnitus, nystagmus or mild balance problems. The worker's occupational exposure did not cause or significantly aggravate her musculoskeletal symptoms prior to September 1998. The worker was entitled to temporary disability benefits for the period February 7, 1997 to April 7, 1997. The panel found that the worker did not have the disorder of "multiple chemical sensitivities" due to occupational exposures, although the worker did have some sensitivity to film processing chemicals due to occupational exposures.

A case manager implemented *WCAT Decision #2006-01164-RB* in a decision dated June 6, 2006. The case manager referred the worker's claim to the Board's Disability Awards Department for assessment of a potential permanent functional impairment. The case manager determined the worker's wage rate for the period of temporary disability determined by WCAT and also set the worker's long-term wage rate.

An internal medicine consultant provided a memorandum to the disability awards officer dated July 4, 2006. The internal medicine consultant reviewed the medical evidence on the worker's file. He relied extensively on a medical-legal opinion from Dr. Stark, a specialist in internal medicine and clinical immunology and allergy, dated January 6, 2005 that provided a summary of the worker's consultation and follow-up visits from August 1995 to November 2004. The internal medicine consultant applied the criteria from the American Medical Association *Guides to the Evaluation of Permanent Impairment, 5th Edition* (AMA Guides) to calculate the permanent functional impairment. He concluded that overall, the worker qualified for a Class I – 2.5% impairment for her combined symptoms. She did not qualify for an impairment award as a result of her respiratory symptoms or her rhinitis symptoms, nor, apparently, for her skin symptoms. She did qualify for a 1% award for her gastrointestinal symptoms and a 1.5% award for

her headache symptoms. The total permanent functional impairment was 2.5% of total disability.

In the August 1, 2006 pension decision, the disability awards officer accepted the internal medicine consultant's opinion and awarded the worker 2.5% of total disability. The effective date of the award was April 8, 1997, the date following the termination of temporary disability benefits. The long-term wage rate was $695.17 per week, or $3,020.68 per month. The disability awards officer stated a loss-of-earnings award was not applicable as the worker was capable of returning to her pre-injury employment as a result of workplace modifications implemented by the employer. The award was paid as a lump sum payment.

In a decision dated August 31, 2007, the worker's long-term gross weekly wage rate was increased to $771.81, or a monthly pension wage rate of $3,353.70. The increase resulted in an additional lump sum payment.

The representative from the Workers' Advisors Office supplied the following new evidence on September 19, 2007: consult reports from Dr. Stark dated August 23, 1995, October 2, 2006, March 13, 2007 and June 20, 2007; a December 3, 1998 consult report from Dr. Lindley, ophthalmologist; a September 9, 2006 letter from a co-supervisor of the employer's MRI department documenting the worker's use of Ventolin and Flonase at work; an August 7, 2007 letter from the employer's occupational hygienist; and an August 28, 2007 medical-legal opinion from Dr. Blaxland, the worker's regular physician.

At the oral hearing on September 24, 2007, the worker described her ongoing symptoms since her occupational exposure. She provided records of the occurrences of those symptoms taken from sources where the symptoms had been formally documented. The worker's evidence and submissions were incorporated into the referral back to the Disability Awards Department for further investigation.

The internal medicine consultant reviewed the new evidence and provided the results of his further investigation in the February 25, 2008 memorandum. He stated that the worker did not exhibit findings that would justify a permanent functional impairment award for her respiratory, rhinitis, and skin symptoms. He stated that he had been unaware that the worker required a special diet for her irritable bowel syndrome. He opined that the worker qualified for an award of 6% of total disability for her gastrointestinal symptoms. He stated that the worker's headache pain was disproportionate to any associated objective physical impairment. He concluded that, other than the increased award for gastrointestinal symptoms, the assessment of the worker's permanent functional impairment remained unchanged.

The disability awards officer conducted a permanent functional impairment review on February 27, 2008. He concluded that he agreed with the increase of 5% of total

disability for gastrointestinal symptoms (to 6% from the 1% previously awarded). He stated that the worker was previously granted an award of 1.5% for headache complaints on a judgement basis. He noted that the worker's headache symptoms were not constant. He concluded that the 1.5% award granted was an appropriate assessment of her impairment from those complaints.

The worker provided a submission dated May 12, 2008, which included new medical evidence. The worker submitted that her bronchial hyper-responsiveness met the requirement for a permanent functional impairment award using the Board's criteria. She stated her rhinitis/upper airway condition was recurrent with past evidence of ulceration, and was only partially responsive to medication or withdrawal from exposure. She contended that her skin symptoms were intermittently but frequently present, had imposed severe employment restrictions, affected her performance of daily activities, and medication gave only limited relief. The worker submitted her ocular surface disease was related to her skin symptoms and exposure to fumes. She submitted that her eye condition limited her performance of daily life and work. She had increased discomfort from exposure to a variety of fumes. Her condition was persistent and medications provided little relief. The worker submitted that she was entitled to an award of 2.5% for her headaches under the Board's chronic pain policy.

The worker supplied new evidence with her May 2008 submission, including a medical opinion dated April 22, 2008 from her family physician, Dr. Blaxland; an April 13, 2008 opinion from Dr. Buscher, a specialist in environmental medicine from Washington State, along with results from chemical allergy tests he conducted; an April 23, 2008 opinion and a March 13, 2007 consult report from Dr. Stark; and an April 17, 2008 consult report from Dr. Carlsten.

**Reasons and Findings**

The first indication of permanent disability was prior to June 30, 2002. Therefore, the worker's entitlement in this case is adjudicated under the provisions of the Act that preceded changes contained in the *Workers Compensation Amendment Act, 2002* (Bill 49). Policy relevant to this appeal is set out in the *Rehabilitation Services and Claims Manual, Volume I* (RSCM I), which relates to the former (pre-Bill 49) provisions of the Act.

Section 239(2)(c) of the Act provides that a review officer's decision may not be appealed to WCAT where the decision relates to the application under section 23(1) of rating schedules compiled under section 23(2), where the specified percentage of impairment has no range, or has a range that does not exceed 5%. The applicable rating schedule compiled under section 23(2) is the Permanent Disability Evaluation Schedule (PDES), published as Appendix 4 of the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II). However, the worker's pension award was not a scheduled award, and therefore I have jurisdiction to consider all aspects of the award.

*Functional Award*

Section 23(1) of the Act states that if a permanent partial disability results from an injury, the Board must estimate the impairment of earning capacity from the nature and degree of injury.

Section 23(2) of the Act provides that the Board may compile a rating schedule of percentages of impairment of earning capacity that may be used as a guide in determining the compensation payable.

Policy relating to the section 23(1) assessment is found in item #39.00 of the RSCM I. Item #39.10 of the RSCM I provides that the PDES is a set of guide-rules, not a set of fixed rules. The disability awards officer or adjudicator in Disability Awards is still free to apply other variables in arriving at a final pension; but the "other variables" referred to means other variables relating to the degree of physical impairment, not other variables relating to social or economic factors, nor rules (including schedules and guide-rules), established in other jurisdictions. In particular, the actual or projected loss of earnings of a worker because of the disability is not a variable that can be considered in the assessment of the functional award.

Item #39.50 of the RSCM I states that any award where the schedule is not directly or indirectly used in the assessment is a non-scheduled award. This covers impairments in all parts of the body not listed in the schedule. Disabilities resulting from multiple injuries or occupational diseases may also involve non-scheduled awards. The policy governing respiratory and skin diseases are set out in #29.00 and #30.50 respectively.

The worker's claim was referred to the Disability Awards Department for assessment as a result of the March 10, 2006 WCAT decision, which found that the worker had developed permanent sensitivities to film processing chemicals resulting in recurring respiratory and skin irritations, rhinitis, headaches and gastrointestinal symptoms. These areas are not covered in the PDES and are therefore non-scheduled awards. However, the Board's Additional Factors Outline provides guidance on these areas. I shall address each of the areas in turn.

*Lower Respiratory Symptoms*

Item #29.20 of the RSCM I states the following:

> In the case of a compensable asthma or a reaction of the respiratory tract to a substance with irritating or inflammatory properties, temporary disability benefits are payable until the temporary disability ends or until the worker's symptoms become stabilized. Where the worker's symptoms do not entirely resolve and he or she is left with a permanent impairment of the respiratory system, a disability award may be granted. However, no

> such award can be made when the worker's symptoms have resolved and they are simply left with the underlying allergy or sensitivity. Not only is the worker not now suffering from the occupational disease set out in Schedule B, but they are not disabled from working. The Board cannot grant a permanent disability award to a person who has the same physical capabilities as they had previous to the occurrence of the occupational disease, but who is precluded from a limited number of occupations because of a remaining allergy or sensitivity. No permanent disability award can be made to a worker with a pre-existing condition when they have returned to their pre-exposure state.

In *WCAT Decision #2006-01164-RB*, the panel found that the worker did not have asthma, but accepted that the worker had developed a chemical sensitivity resulting in chronic symptoms of chest tightness, wheezing and shortness of breath as a result of her occupational exposures. The internal medicine consultant determined that the worker did not qualify for an award for her respiratory symptoms. He stated that there was no objective evidence for respiratory disease on pulmonary function testing and the worker did not require bronchodilator or steroid treatment.

A review of the worker's evidence shows that Dr. Stark first prescribed Ventolin, a bronchodilator, in October 1995. The worker stated that she carries her Ventolin inhaler at all times. She was first prescribed Pulmicort, a corticosteroid, in August 1997. The worker stated that she has taken it daily since that time.

In a medical opinion dated September 21, 2007, Dr. Abboud stated that the worker had demonstrated objective evidence of respiratory disease. He stated that in May 2007, the worker demonstrated a 12% improvement in forced expiratory volume in one second (FEV1) after taking a bronchodilator, indicating that she had mild bronchospasm. Also in May 2007, the worker had a methacholine challenge that was interpreted as showing normal bronchial reactivity. However, he stated the result "could well be interpreted as borderline increase in bronchial reactivity."

In a revision dated September 24, 2007, Dr. Abboud explained that in the methacholine challenge, the worker's FEV1 had decreased by 18%. If it had decreased by 20%, she would have been classified as having borderline hyper-responsiveness. He stated the difference between 20% and 18% amounts to only 0.05L which is close to the spirometer calibration tolerance of 0.03L. Thus, he stated, the decrease in FEV1 could be interpreted as suggestive of borderline bronchial hyper-responsiveness.

In the February 25, 2008 memorandum, the internal medicine consultant stated that, by repeated testing over several years, the worker had never had objective evidence of airway reactivity warranting inhaled steroid or bronchodilator treatment. He stated that the pulmonary function abnormalities "which Dr. Abboud struggled to identify" in his September 2007 opinion did not justify medication use by any standard clinical criteria.

He stated that dyspnea was a non-specific finding that was possibly associated with a variety of causes. Further, he stated that fluctuations in immunoglobulin blood levels identified by Dr. Stark were completely normal and did not reflect any diagnostic alteration in the worker's immune function. He concluded that the worker did not exhibit any respiratory findings that would justify a permanent functional impairment award.

Dr. Stark reviewed the internal medicine consultant's memorandum in an opinion dated April 23, 2008. He noted that Dr. Abboud interpreted the worker's results from a 2006 methacholine challenge test were compatible with bronchial hyperresponsiveness. He noted the worker's peak-flow readings showed significant drops in values with exposure to chemicals and perfumes in the work environment. He further noted that patch testing by Dr. Buscher showed that the worker was sensitive to formaldehyde. He stated that the worker had clearly had improvement of her respiratory complaints with the use of Ventolin and corticosteroid inhalers.

The worker argued that she had only had a methacholine challenge test twice, in 1997 and 2007. She submitted that the first test was done after she had been away from the workplace for a month. However, I consider that practice is consistent with the principles of evaluation of permanent functional impairment. The purpose of the evaluation is to determine the impairment over the long term, not during the acute stages of an injury.

I have reviewed the Lower Respiratory Symptom Conditions portion of the Additional Factors Outline and Chapter 5 of the AMA Guides on which it is based. The worker's May 2007 methacholine-challenge test was interpreted as showing normal bronchial reactivity. Dr. Abboud opined that the worker's results could be interpreted as suggestive of borderline bronchial hyper-responsiveness. I do not accept that opinion. The AMA Guides, at page 93, states that pulmonary function tests are performed on standardized equipment with validated administration techniques. Spirometric testing equipment, calibration, and administration techniques must conform to specific guidelines. Therefore, I consider that the calibration of the equipment is taken into account in the standard interpretation of the results. Furthermore, both the AMA Guides and the Additional Factors Outline state that airway hyper-responsiveness is defined as a positive methacholine or histamine challenge as reflected by a decrease in FEV1 of 20% from baseline, upon provocation with less than or equal to 8 mg/mL of methacholine or histamine. The worker's result of 18% decrease in FEV1 was obtained with a higher concentration of methacholine (16mg/mL). I find that the worker's methacholine-challenge test did not demonstrate bronchial hyper-responsiveness.

I accept the opinions of Drs. Blaxland, Stark and Buscher that the worker has symptoms such as shortness of breath, chest tightness, and wheezing on exposure to specific chemical irritants. I do not accept the statement of the internal medicine consultant that dyspnea is a non-specific finding in the worker's case. The original panel accepted those symptoms resulted from her workplace exposure. Dr. Buscher's

skin test results establish sensitization to chemicals including synthetic ethanol, phenol and formaldehyde. However, I find insufficient evidence that those symptoms qualify the worker for a permanent functional impairment award for respiratory symptoms. The worker argued that she should be entitled to an award based on her medication use. The AMA Guides at page 103, states: "Use of medication, as a score for impairment, is only used in individuals who have a diagnosis of asthma." The panel in *WCAT Decision #2006-01164-RB* did not accept the worker's claim for asthma on the basis that the worker's 1997 methacholine-challenge test did not provide evidence of bronchial hyperreactivity. Her 2007 methacholine challenge also does not support a diagnosis of asthma. Therefore, the worker does not have an accepted diagnosis of asthma and her medication use is not a factor in the calculation of her permanent functional impairment.

The worker's immunoglobulin results and skin test results are not a factor for consideration in providing a permanent functional impairment award for respiratory symptoms in either the Additional Factors Outline or the AMA Guides.

Dr. Abboud submitted that the worker may be categorized as having mild bronchospasm. However, that does not meet with the criteria for a permanent functional impairment award. I find that the worker is not entitled to a permanent functional impairment award for her lower respiratory symptoms.

*Upper Respiratory Symptoms - Rhinitis*

In *WCAT Decision #2006-01164-RB*, the panel found that the worker's pre-existing history of allergic rhinitis had been aggravated by the worker's occupational exposure. She noted that the worker had frequent symptoms of coughing, sneezing, post-nasal drip and sinus congestion. She considered that those symptoms reflected a permanent sensitivity and found that the worker had developed a chronic rhinitis.

In the internal medicine consultant's July 2006 memorandum, he stated that the worker's chronic rhinitis symptoms were minor. There were no significant examination findings documented. There was no evidence of mucosal ulceration and her condition was responsive to withdrawal from exposure. The nasal obstruction was bilateral but of minor significance.

The worker provided evidence at the oral hearing of sores in the corner of her mouth on two occasions, and sores inside her mouth and nose on two other occasions.

The internal medicine consultant stated oral or peri-oral lesions would not usually be associated with rhinitis or sinusitis, but theoretically could be. He stated that the deviation of the nasal septum was a developmental condition and unrelated to any compensable disease. He noted that many of Dr. Stark's examinations demonstrated that the worker was normal, while on other occasions the worker had nasal congestion. He assessed the worker to have rhinitis to a minor degree, with the most recent findings

showing normal results. He stated that there was no provision for quantifying medication use in assigning impairment due to rhinitis. The worker did not exhibit findings that would justify an award based on rhinitis.

The worker submitted that from 1995 to 2007 there were 157 reports of work-related sinus congestion, sinus irritation, coughing, sneezing, sore throat, hoarseness, and sores in her mouth and nose. Dr. Stark, in April 2008, described the worker's rhinitis as recurrent and requiring ongoing treatment with antihistamines, including Reactine and Benadryl.

The worker stated that she has used antihistamines on a daily basis since 2003. However, she has had 76 incident reports referring to upper airway symptoms since 2003. She submitted that her rhinitis was only partially responsive to medication or withdrawal from exposure, with past evidence of ulceration.

The Additional Factors Outline indicates that a worker is entitled to an award of 1% for rhinitis of a minor degree that is recurrent and unresponsive to treatment or withdrawal from exposure. I do not find that the evidence supports a conclusion that the worker's rhinitis is unresponsive to treatment or withdrawal from exposure. Dr. Stark did not provide an opinion on the responsiveness to treatment or withdrawal from exposure. He simply described her rhinitis as recurrent and requiring ongoing treatment. The worker submitted that her rhinitis was only partially responsive to medication. I would interpret that statement to mean that her rhinitis does respond to treatment, at least to some degree. I do not consider partially responsive to be the same as unresponsive. I find that the worker is not entitled to an award for rhinitis.

The Additional Factors Outline provides that a worker is entitled to an award of 5% for ulceration that is recurrent and unresponsive to treatment or withdrawal from exposure. I do not consider the few episodes of mucosal ulceration described by the worker as recurrent and unresponsive to treatment or withdrawal from exposure. For the above reasons, I find the worker is not entitled to an award for her upper respiratory system conditions or rhinitis.

*Skin and Eye Symptoms*

In *WCAT Decision #2006-01164-RB*, the panel found that the worker had intermittent symptoms of dermatitis prior to September 1998 due to her occupational exposure. The panel noted that the worker had frequently described "dry, tight, itchy skin, tingling, burning skin and eyes, and facial skin irritation" but there were few if any references to hives or rashes. I interpret that the panel accepted that the worker's burning eyes were a result of her occupational exposures.

In the July 2006 memorandum, the internal medicine consultant stated that skin disorder symptoms and signs were only intermittently present, there were no limitations

of performance of activities of daily living, exposure to certain chemical or physical agents temporarily increased the limitation and it required no or only intermittent treatment.

In the oral hearing, the worker described her skin condition as a burning feeling, like a bad sunburn. The skin reactions lasted for many hours and antihistamines did not provide relief. The reactions often caused difficulty sleeping. She stated she took antihistamines on a daily basis for her skin symptoms. She had ongoing skin reactions in the workplace on a regular basis. She continued to react to patients wearing perfumes or other scented products. Her symptom log referred to hives in a small number of cases. She also noted that she had chronic dry eyes and had been diagnosed with ocular surface disease by Dr. Lindley in December 1998.

The internal medicine consultant stated that Dr. Stark only documented one incidence of mild pruritic rash on June 3, 1996. There were no other signs of skin disease documented. He stated that the worker's main skin symptom was itching, but was not accompanied by objective signs such as lichenification, excoriation, or hyperpigmentation, as per the principles for assessment of skin conditions in the AMA Guides. He concluded that the worker did not qualify for an impairment award based on a single report of a mild pruritic rash.

The internal medicine consultant stated that lacrimal gland function was controlled by the parasympathetic and sympathetic nervous system through secretomotor fibbers carried in the opthalmic division of cranial nerve five and sympathetic innervation through the zygomatic then lacrimal nerve. He stated that there were systemic autoimmune diseases that had both skin and eye manifestations, but there was nothing to suggest that the worker's ocular surface disease was in any way related to her skin symptoms.

In April 2008, Dr. Stark stated that the worker had ongoing complaints of a burning, prickling or itchy sensation of her skin with occasional hive-like reactions, which was aggravated by exposure to chemical fumes. He noted that the worker had a positive film patch skin test, and that Dr. Buscher's skin tests confirmed skin sensitization with a significant flushing reaction.

Dr. Stark also stated that the ocular surface disease diagnosed by Dr. Lindley in 1998 could be related to exposure to irritant chemicals in the environment, initiated by the worker's original exposure to radiographic developing chemicals.

In his April 13, 2008 opinion, Dr. Buscher stated that the worker frequently complained of burning and irritation of her eyes from workplace exposures. He stated it would likely have occurred from irritation of the fifth cranial nerve, as explained by the internal medicine consultant, or via the sphenopalatine ganglion nerve distribution, or both.

In her May 2008 submission, the worker emphasized that the skin symptoms were a chronic condition that was not present prior to her workplace exposure. Medication provided only limited relief. She submitted that because formaldehyde was commonly used in cosmetics, shampoos, fabrics, and in pressed wood found in cabinets and furniture, her skin condition limited her performance of daily life and had imposed severe employment restrictions.

Item #30.50 of the RSCM I provides there is no disability unless the worker has an actual loss of body function or physical impairment resulting from the dermatitis which causes the worker to be disabled from earning full wages at the work at which he or she was employed. Neither temporary disability benefits nor a permanent disability pension is payable simply because the worker has developed a susceptibility to react to a certain substance as a result of his or her work which causes periods of temporary impairment if she is exposed to the particular substance, but otherwise causes no complaints.

I have reviewed Part IX of the Additional Factors Outline, Skin Conditions, as well as Chapter 8 of the AMA Guides on which it is based. The internal medicine consultant stated that the worker fit within Grade 1 (0 to 5% impairment). That category states:

> Skin disorder signs and symptoms present or intermittently present
>
> AND
>
> No or few limitations in performance of activities of daily living, exposure to certain chemical or physical agents may temporarily increase limitation
>
> AND
>
> Requires no or intermittent treatment

The internal medicine consultant stated that the worker was not entitled to an award for her skin disorder on the basis that she had symptoms (itching, burning and prickling) but few signs of skin disorder, if any. Dr. Stark referred to occasional hive-like reactions, however, his consult reports only referred to a mild itchy rash on one occasion (June 1996) that was prior to the date of plateau (April 1997). The worker noted the employee health nurse recorded a rash in 1995, but that was also prior to the date of plateau. In the worker's compilation of symptoms from the MRI Technologists Symptoms Log, Employee Incident Reports, and Indoor Air Quality Occupant Diary, after the date of plateau there were only ten mentions of hives over a ten-year period, none of which was medically documented. I find the internal medicine consultant's opinion that the worker is not entitled to an award for her skin condition is consistent with the policy as outlined in item #30.50.

Part XI of the Additional Factors Outline, Visual Conditions, at item 3(f), indicates that a worker is entitled to an award of 2% of total disability for dry eyes needing artificial tears. Dr. Lindley diagnosed the worker with ocular surface disease and dry eyes requiring artificial tears. I find that the prior panel accepted that the itching, burning sensation in the worker's eyes was related to her workplace exposures. That conclusion is also supported by Dr. Busher and Dr. Stark. I do not consider the internal medicine consultant's opinion that the eye condition is not related to the skin condition to be relevant, as I consider the eye condition was accepted by the panel. Based on the Additional Factors Outline, I find that the worker is entitled to an award for 2% of total disability for her dry eyes requiring artificial tears.

*Headache*

In *WCAT Decision #2006-01164-RB,* the panel accepted that the worker had developed headaches because of her exposures. In his July 4, 2006 memorandum, the internal medicine consultant noted that the worker's impairment due to headaches was evaluated using the chronic pain criteria. He awarded the worker 1.5% for headaches.

Item #39.01 of the RSCM I states that a worker will be entitled to an award of 2.5% for chronic pain where a worker experiences specific or non-specific chronic pain that is disproportionate to the associated objective physical impairment. Item #39.01 of the RSCM I provides: "Pain is considered to be disproportionate where it is generalized rather than limited to the area of impairment or the extent of the pain is greater than that expected from the impairment."

In the February 25, 2008 memorandum, the internal medicine consultant stated that the pain from the worker's headaches was disproportionate to any associated objective physical impairment. With respect to the worker's headaches, the disability awards officer stated there was no objective evidence of impairment for the headaches and it would appear that these complaints would be on a chronic pain basis, although they did not appear to be constant. He stated that the chronic pain issues had not been specifically addressed on the file. He concluded that the judgment award for the worker's headaches was an appropriate assessment of her impairment for those complaints.

The internal medicine consultant applied the chronic pain criteria from the AMA Guides and awarded the worker 1.5% for her headaches. However, policy item #39.01 of the RSCM I does not allow for a range in a chronic pain award. If the pain is disproportionate, the award is 2.5%. The internal medicine consultant opined that the worker's pain was disproportionate to the objective impairment. I do not find a medical opinion to the contrary. I do not accept the disability awards officer's opinion that a judgment award of 1.5% is appropriate, since the award was based on the chronic pain criteria.

*Gastrointestinal Symptoms*

In *WCAT Decision #2006-01164-RB*, the panel found that the worker likely developed gastro-intestinal symptoms because of occupational exposures. This included the worker's reactions to sulphite-containing chemicals in foods.

The internal medicine consultant originally evaluated the worker's permanent functional impairment due to gastrointestinal symptoms at 1%. The worker gave evidence that she was required to avoid sulphates in her diet. The internal medicine consultant stated that the requirement for a specific diet, which he had originally missed, would qualify the worker for an increased permanent functional impairment award. He stated that the worker had symptoms but no signs for colonic disease and a special diet was required, but there was no limitation of activity and no systemic manifestations. He stated that the worker would qualify for a Class 1 – 6% impairment of the whole person based on her colon disease. She did not qualify for a Class 2 impairment as objective evidence of colon disease was not present and she had not had any anatomic loss or alteration.

The worker did not make a further submission on her gastrointestinal symptoms after the internal medicine consultant provided an opinion that her symptoms would qualify for an award of 6% of total disability. The employer did not dispute the increased award for gastrointestinal symptoms. The internal medicine consultant provided a well-reasoned opinion and there is no medical opinion to the contrary. I accept his assessment of the worker's gastro-intestinal symptoms at 6% of total disability, which is an increase of 5% over the previous award.

*Loss-of-Earnings Award*

Section 23(3) of the Act provides that, if the Board finds it more equitable, it may award compensation based on the difference between the average weekly earnings of the worker prior to the compensable injury and the average amount that the worker is earning or is able to earn in a suitable occupation after the injury.

The policy with respect to the projected loss-of-earnings method is found in item #40.00 of the RSCM I. The policy provides that the Board must have regard to the nature of the condition or disability causing the inability to work or the loss of earnings. The worker must not only have a disability accepted by the Board, but the disability accepted by the Board must be a significant factor in the reduced employability or loss-of-earnings potential.

Item #40.10 of the RSCM I provides rules for assessing a projected loss-of-earnings pension under section 23(3) of the Act. Firstly, the Board will determine the average earnings prior to the injury in accordance with Board policy. The Board will then consider the evidence of the limitations imposed by the compensable injury and determine suitable

occupations that would reasonably be available to the worker in the long-term future. The Board will select earnings that maximize the worker's long-term potential from the jobs that are suitable and reasonably available. Earnings in those occupations will be determined as at the time of injury. The pension is 75% of the difference between the projected earnings and the worker's average earnings prior to injury.

Item #29.20 of the RSCM I provides:

> Where a worker who is allergic to western red cedar dust declines to take any employment which involves exposure to that dust, such worker is taking a preventive measure. Compensation is not payable for such preventive measures.

At the oral hearing, the worker provided a letter to her employer dated June 28, 1999 in which she had indicated her intention to reduce her work hours from 28.5 hours per week to 19 to 21 hours per week beginning September 1999. She stated that the reduction was "primarily for reasons of health." She said that an acute exacerbation of chemical sensitivities and debilitating ear and gastrointestinal problems had made her think seriously about her long-term health prospects. She indicated that she did not wish to permanently change to a half-time position at that time.

The worker stated that in January 2000, she formalized the request to reduce to a half-time position. In May 2006, she opted out of the employer's extended hours agreement, which allowed staff to work longer hours and fewer days. She indicated that this was due to fatigue and to ongoing symptoms in the workplace.

The worker's representative argued that the worker's career had been limited. Because of all the accommodations that the employer had made in the workplace, it was the only MRI unit in which the worker was able to work.

I do not consider that the worker is entitled to an award for a loss of earnings. Firstly, the effective date of the pension was April 1997. The worker worked part time prior to her occupational exposure. She was able to continue working her regular hours for another two years after the date of plateau. Unless the worker suffered a worsening of her condition, that would suggest she was capable of a full return to work in her pre-injury employment. No worsening of her condition has yet been accepted.

Secondly, the period of time that the worker reduced her hours in September 1999 coincides with the period which she began to work as a part-time art instructor, as noted in *WCAT Decision #2006-01164-RB,* at page 8. She continued to work as an instructor up to 2003. The reasons for leaving that position were varied, most of which did not relate to her compensable condition.

Furthermore, the Board has not yet adjudicated fibromyalgia and chronic fatigue or accepted them as compensable conditions on the claim. In a consult report dated March 13, 2007, Dr. Stark indicated that the worker was on partial disability for fibromyalgia symptoms working half time. Any non-fatigue related reasons for not working would be considered preventative.

For the above reasons, I find insufficient evidence that the worker has suffered a loss of earnings related to the conditions that have been accepted as compensable under the claim.

**Conclusion**

I allow the worker's appeal in part and vary the decision of the Review Division dated January 29, 2007.

I confirm that the worker is not entitled to an award for her lower respiratory symptoms, her upper respiratory symptoms (rhinitis), and her skin condition. I find the worker is entitled to an award of 2% for her eye condition. She is entitled to an award of 2.5% for her headaches (an increase of 1% over the previous award). She is also entitled to an award of 6% for her gastrointestinal symptoms (an increase of 5% over her previous award). The total award is 10.5% of total disability, which is an increase of 8% from the original award.

I confirm that the worker is not entitled to a loss-of-earnings award.

The worker requested to be reimbursed for Dr. Stark's medical opinion of April 23, 2008 in the amount of $285.00. She also submitted receipts in the amount of $258.33 for Dr. Buscher's medical opinion and for $732.00 for his consultation and allergy testing. I find that it was reasonable for the worker to have sought such evidence in connection with the appeal. I direct the Board to reimburse the worker for the expense of the medical opinions and evidence in accordance with Board policy.

The worker missed work to attend the hearing. Consistent with item #100.12 of the RSCM II, WCAT will generally order reimbursement of expenses for attending a hearing where the party was successful in the appeal. The worker was successful in her appeal. I see no compelling reason to depart from the general practice. As a result, I order reimbursement of the worker's expenses for lost wages to attend the hearing.

Hélène Beauchesne
Vice Chair

HB/jd