NOTEWORTHY DECISION SUMMARY

Decision: WCAT-2013-02405 **Decision Date**: August 27, 2013
Panel: W.J. Duncan, B.K. Anderson, L. Hirose-Cameron

Item #16.1.3.1 of the Manuals of Rules and Practice Procedure – Section 7 of the Workers Compensation Act Appeal Regulation – Reimbursement of Appeal Expenses – Expert evidence – No tariff rate or fee schedule

This decision is noteworthy for its discussion of factors that WCAT will consider when a party requests reimbursement of an expert opinion, and there is no applicable Board tariff rate or fee schedule.

In this case, the worker requested reimbursement for an ergonomist report provided to WCAT in support of his appeal. Pursuant to section 7 of the *Workers Compensation Act Appeal Regulation* and item #16.1.3.1 of the *Manual of Rules and Practice Procedure*, WCAT has discretion to order reimbursement for an expert opinion at the Board's tariff rate or fee schedule. The panel noted there was no applicable Board tariff rate or fee schedule for an ergonomist report, but the cost of the ergonomist report was excessive. The panel set out the following factors to guide their assessment of a reasonable amount for reimbursement:

- Complexity of the case;
- Proportionality (the significance of the injury, and impact on the worker or employer);
- Availability of specialists in the worker's geographic area;
- Duplication of work;
- Whether the expert had to review a significant body of material to prepare the report; and
- Extent to which the report can be understood by its intended readers (i.e. WCAT).

Workers' Compensation Appeal Tribunal 150, 4600 Jacombs Road, Richmond, B.C. V6V 3B1
Telephone: (604) 664-7800; 1-800-663-2782; Fax (604) 664-7898

WCAT Decision Number: WCAT-2013-02405
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Panel: William J. Duncan, Vice Chair
Beatrice K. Anderson, Vice Chair
Lisa Hirose-Cameron, Vice Chair

Introduction

[1] By letter dated February 15, 2011, the worker was advised by an officer of the Workers' Compensation Board[1] (Board) that his symptoms, diagnosed as right lateral epicondylitis, possible right elbow nerve involvement, and C6-7 foraminal narrowing, had not been caused by his employment.

[2] The worker requested a review of the Board's February 15, 2011 decision by the Review Division. On May 24, 2011, an officer of the Review Division confirmed the Board's decision (see *Review Reference #R0127405*). The worker appealed the decision to the Workers' Compensation Appeal Tribunal (WCAT).

[3] The worker and his representative attended an oral hearing on October 25, 2012. The worker does not dispute the review officer's decision that the Board officer properly concluded that the carpal tunnel syndrome was not compensable. As a result, our decision will be limited to the conditions of lateral epicondylitis, possible nerve involvement in the right elbow and C6-7 foraminal narrowing.

[4] The employer initially indicated they wished to participate in the appeal. However, just prior to the oral hearing, the employer advised they no longer wished to participate in the appeal.

Issue(s)

[5] At issue is whether the worker suffered a personal injury that arose out of and in the course of employment, as required by section 5(1) of the *Workers Compensation Act* (Act) or an occupational disease that was due to the nature of employment as required by section 6(1) of the Act.

Background and Evidence

[6] This is one of three claims filed by power engineers (L, B and K) employed as refuse crane operators by the accident employer. The claims were made in October and November 2010 for a variety of symptoms which came on gradually and which the workers believe were caused by their refuse crane operating duties. There are two

[1] Operating as WorkSafeBC.

reports that are common to all three claims. The first was done by a Board ergonomist, the Goyert report, in November 2010, at the employer's request. The second was the jobsite visit done by the adjudicator on January 13, 2011 and this report was the basis for the medical advisor's opinion (in all three cases) that the employment did not cause the various diagnoses.

[7] Turning to the specific facts of this case, this 42-year-old worker had been employed with the accident employer for 13.5 years as a refuse crane operator. His application for compensation stated that he had been having symptoms in his right wrist and elbow for 3 to 4 years. These symptoms included sharp pain and numbness in the fingers as well as pain in the right elbow and wrist.

[8] He first sought medical attention on November 8, 2010 from his family physician, Dr. Spooner, and was diagnosed with tennis elbow (also known as lateral epicondylitis) and carpal tunnel syndrome. He was then referred to an orthopaedic surgeon and for physiotherapy.

[9] The worker filled out an activity-related soft tissue disorder questionnaire in which he said that the symptoms, ongoing for 3 to 4 years, had been getting worse. The symptoms came on when he began running the refuse crane and worsened when he was operating the crane joystick. The worker characterized operating the joystick as "awkward". He also described the breakdown of work over a 12-hour shift. The worker works a 5-week rotation. He spends 7.5 hours a shift or 62.5% of the shift operating the refuse crane.

[10] The adjudicator's jobsite visit report on January 13, 2011 describes the work done by refuse crane operators. The report describes the operator's use of a cylindrical joystick with buttons on the front side in the right hand and a round knob-type of joystick in the left hand. The report describes the actions required to fluff garbage, operate the grapple arm of the crane and the movement required of the left and right hands and arms, combined with finger compression on the buttons on the front facing edges of the joystick.

[11] According to the adjudicator, the "movements all seem to be fast with approximately three cycles completed per minute. With approximately 3 – 6 wrist movements per cycle, this would see up to 18 wrist movements per minute". The adjudicator wrote that the worker's right elbow moved from flexion to extension at repetitive rates when operating the right joystick of the refuse crane; however, there was no forceful exertion of the right elbow in any of the right hand operations of the joystick.

[12] The decision to deny the claim rests heavily on an opinion of Dr. Robinson, a Board medical advisor. Dr. Robinson stated that her opinion was based on a review of the documents, images available and medical reports on file. She stated that she also reviewed the medical literature with regards to arm and neck conditions. She has provided separate opinions on all three claims.

[13] At the time the opinion of Dr. Robinson was given, the worker had been diagnosed with right elbow lateral epicondylitis, carpal tunnel syndrome, possible ulnar nerve involvement and C6-7 foraminal narrowing. The medical advisor said that the risk factors were not significant enough to have caused any of these conditions. The medical advisor conceded that some of the tasks were repetitive but pointed out that they did not involve high force and were sedentary for the majority of the work.

Oral Hearing Evidence

[14] At the oral hearing, the worker described the physical positions he had to adopt in order to work as a refuse crane operator, as well as the onset and development of his symptoms.

[15] The employer burns garbage, producing power from this process. The employees work in crews of 5 or 6 made up of an assistant ashcrane operator, an ashcrane operator, a refuse crane operator, a boiler room operator, an assistant shift engineer and a shift engineer. The crew works a 5-week rotation on 12-hour shifts, relieving each other on breaks. The worker was hired as an ashcrane operator but, by 2000, he got a permanent posting as a refuse crane operator.

[16] The worker's typical shift as a refuse crane operator breaks down this way. From 6:30 a.m. to 10:00 a.m., he worked with the refuse crane. From 10:30 a.m. to noon, he worked in the boiler room. From 12:30 p.m. to 2:30 p.m., he was back on the refuse crane. From 2:30 p.m. to 4:00 p.m., duties as assigned and breaks. From 4:00 p.m. to 5:00 p.m., he did plant rounds and from 5:00 p.m. to 6:30 p.m., he was operating the refuse crane.

[17] The worker was not completely certain when his symptoms began. He thought it might have been 2002 but he did not file a claim or seek medical attention until the symptoms got "too painful to move". The symptoms began in his right wrist and moved to his elbow and would increase over the course of a shift. By August 2010, the worker said he was not sleeping and had numbness in his fingers and pain in his forearm and elbow. The numbness was there all the time instead of going away, even on his days off. The worker also said he had "lots of neck pain".

[18] The worker complained to the employer about his symptoms and, in October and November of 2010, the joystick on the refuse crane was changed to a 45-degree angle but this caused an increase in his symptoms. In late November 2010, there was a shutdown and, as a result, a first aid attendant was on the site. The first aid attendant told the worker he had swelling in his forearm and elbow and should see his doctor. This prompted the first visit to Dr. Spooner.

[19] By the time the worker saw Dr. Spooner, he had no feeling in three fingers and pain in his forearm, elbow and up through the shoulder and into the neck. Dr. Spooner referred

the worker to Dr. Dawson, a neurologist. In January 2011, the worker was moved into the boiler room for two months. Between February and November 2011, the worker worked light duties away from the operations side of the business.

[20] In July 2011, the worker began receiving what he called "collagen shots" in the back of his neck and he had relief within two weeks. He returned to work in November 2011 as a refuse crane operator but was moved almost immediately into the boiler room. At the time of the hearing, the worker had just returned back full time as a refuse crane operator but there were now new chairs and an upright joystick with a button as a result of the changes the employer has made to that position.

[21] The worker gave a detailed description of the physical postures he had to adopt in order to work as a refuse crane operator before changes were made to the chairs in 2011. The refuse crane sits seven storeys atop piles of garbage. Each crane has two stationary chairs (A and B) which do not move and are separated by a console which controls the feed chute and has toggles which control communication with the garbage trucks dropping off loads.

[22] The A crane chair looks towards the right and the B crane chair in the other direction. The operator switches back and forth between chairs depending on which side the garbage is being piled on and which offers the best line of sight. Below the crane, there is one boiler to the left and two boilers to the right. There are piles of wet garbage and dry garbage which must be mixed together properly. The operator mixes the two piles by raising and lowering the crane so that wet and dry garbage is "fluffed" together.

[23] The right hand operates the joystick (3.5 inches wide by 1.5 inches in diameter) with 2 buttons which open and close the jaws of the crane (grapple). The worker uses his index finger to open the grapple and the ring finger to close the grapple. His middle finger rests on the metal of the cylinder. The joystick is pulled forward to raise the crane and backward to lower it. The grapple must be closed when lowering or raising the crane and, consequently, the worker pushes his arm forward or pulls it back while holding the control button with his ring finger held down for as long as 30 seconds.

[24] The worker said that the grapple can be opened and closed more than 200 times a shift. Controls are operated simultaneously, that is, buttons are pushed while moving the cylinder back and forth.

[25] Another aspect of the refuse crane operator's job is to make walls of garbage in a pit in order to maximize the storage area within it. Building the walls and fluffing the garbage required the operator to move the crane up and down as rapidly as possible. The operator must watch the grapple at all times. Because the chairs did not move before 2011, the operator's trunk was always twisted and the neck was flexed to look down to one side or the other. Crane chairs also had no armrests and, as a result, the worker's arms were often pulled back or pushed forward without any support.

[26] The worker commented on the videos taken of the refuse crane operator position by Mr. Goyert in November 2010, and again by Mr. Everett in 2012. Mr. Everett is an occupational therapist commissioned by the worker to provide an ergonomic risk assessment. The worker considered that both videos accurately portrayed the work of a refuse crane operator but said that because the emphasis was on showing the ergonomists how the work was done, the operators were probably not "moving as fast as usual". So, while the movements were normal, the speed was slower than usual.

New Evidence

[27] In support of his appeal, the worker has provided new material in the form of chart notes from his attending physician, Dr. Spooner, as well as an ergonomic risk assessment done by Mr. Everett, on April 30, 2011. (Additionally, when the worker's appeal was filed, the employer was participating in the appeal and submitted a report from Mr. Worthington-White, an occupational therapist retained by the employer to provide a critique of the report submitted by Mr. Everett. Mr. Worthington-White's report is dated March 12, 2012.)

[28] The Worthington-White report says that Mr. Everett provided an" overly detailed" and academic report that was apparently based on only five minutes of documented crane operation. He also considered that the risk exposure findings seemed inaccurate and affected by the goal of providing the highest possible values and forces.

[29] Mr. Everett then provided a 24-page response to the Worthington-White criticisms.

[30] The chart notes contain a physiotherapy referral from Dr. Spooner on November 5, 2010 diagnosing the worker with right-sided tennis elbow and carpal tunnel syndrome. Electromyogram (EMG) testing on December 1, 2010 confirmed the presence of "borderline carpal tunnel syndrome" as well as "wrist extensor and finger extensor abnormalities". The worker also submitted a medical-legal opinion from his attending physician, Dr. Spooner, dated October 18, 2012 which provided a description of the symptoms the worker complained of at various appointments and the investigation and treatment he prescribed. Dr. Spooner said that the worker's employment as a crane operator was the "main cause" of his diagnosed conditions.

[31] Dr. Spooner also included a copy of a cervical spine CT scan done on March 5, 2011 which showed "multi level disc protrusions/extrusions and evidence of spinal stenosis".

[32] The ergonomic report from Mr. Everett is 50 pages long and states that his analysis demonstrated sustained and repetitive awkward composite postures which were conservatively demonstrated "at least 25% of the 12-hour work shift". Mr. Everett submitted that there were sustained and repetitive awkward postures seen at the wrist, elbow, shoulder, neck and back. He concluded that "the work acts and work conditions of [the worker's] employment caused significant musculoskeletal risks that more likely

than not contributed to and/or aggravated (carpal tunnel syndrome) lateral epicondylitis with possible elbow nerve involvement to the non-dominant right side and C6-7 foraminal narrowing".

[33] The employer also provided documents entitled "Operations Overtime Hours Summary". The cover letter to those reports indicated a witness would be called at the oral hearing to provide evidence as it related to those reports. As noted earlier, however, the employer withdrew just before the oral hearing.

Reasons and Findings

[34] The current Act and the policies in the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II) apply to this appeal. The evidence does not support a traumatic event or series of traumatic events that would cause a personal injury pursuant to section 5 of the Act. We have adjudicated the appeal under section 6 as an occupational disease.

[35] It is not our intention to refer to every single piece of evidence or argument made in support of the claim. We will refer to that evidence that we consider was significant to our understanding of the nature of the employment and the question of causation.

[36] The worker submits that he developed lateral epicondylitis, possible nerve involvement in the right elbow and C6-7 foraminal narrowing as a result of working as a refuse crane operator. In submissions made at the oral hearing and subsequently in writing on November 26, 2012, he relies on the analysis done by Mr. Everett to establish that there are risk factors which support that his employment caused these conditions and argues that Mr. Everett alone has "fully analyzed the risk factors involved in the complex work motions of the refuse crane operator". Where there are conflicts in the ergonomic evidence about the risk factors, we are asked to prefer Mr. Everett's conclusions. The worker submits that Mr. Everett identified frequent and awkward postures for the right wrist, forearm, shoulder, trunk and cervical spine.

[37] The worker was critical of the Board medical advisor's opinion for not addressing the risk factors identified in the policy. For instance, the opinion does not address whether the motions required by the refuse crane operator are reasonably capable of stressing the inflamed tissues at the arm affected by epicondylitis but, rather, confined "the potential mechanism of injury to the elbow and to work actions which are forceful and repetitive". With respect to the symptoms in the ulnar nerve and neck, the worker argues that a complex work motion "may result in different but simultaneous injuries".

[38] The diagnosis that is common to all three claims of workers doing the same job is lateral epicondylitis.

[39] Policy item #27.31 of the RSCM II discusses the risk factors the Board associates with occupationally-caused epicondylitis. Where a worker is performing frequent, repetitive,

forceful and unaccustomed movements of the wrist that are capable of stressing the tissues of the arm affected by epicondylitis, a strong likelihood of work causation will exist.

[40] The policy also states that those risk factors are not "pre-conditions to the acceptance of a claim for epicondylitis, nor are they the only factors which may be relevant". The policy cautions that in every case, the adjudicator determines whether the evidence leads to a conclusion that the epicondylitis is due to the nature of the worker's employment.

[41] In assessing whether the worker's epicondylitis was a result of his employment as a refuse crane operator, we have considered the evidence contained on the worker's claim file, the Goyert and Everett ergonomic reports, the report of Worthington-White, and the medical information and opinion provided by Dr. Spooner, the worker's evidence about his symptoms and his job, and the information obtained by the adjudicator as well as the opinion provided by the Board medical advisor. We are also assisted by the oral and written submissions made by the worker's counsel. We have not considered the documents entitled "Operations Overtime Cost Summary" provided by the employer (when they were participating) as it is unclear, on its own, how that evidence is relevant to the issues under appeal.

[42] It was the medical advisor's opinion that the risk factors were not present to explain the development of epicondylitis. She said that despite repetitive elbow movement, there was no "requirement for forceful extension of the wrist, or forceful supination of the forearm, the two movements that engage lateral epicondyle tendons". Moreover, the tasks, while repetitive, did not involve high force.

[43] The worker argues that the risk factor of force is not a requirement for acceptance of the claim and that the work actions were repetitive, awkward and forceful "in a way that stresses the inflamed tissues of the arm".

[44] After reviewing the ergonomic reports and the medical opinions, we conclude that the worker's lateral epicondylitis was likely due to the nature of his employment as a refuse crane operator.

[45] At page 5 of the Goyert report, the physical work demands are broken down by frequency. The report identifies continuous wrist turning, wrist grasping and finger manipulation. There is also frequent pinching. A continuous action is described as one that occurs between 67% and 100% of the time or in excess of 200 repetitions a day. An activity that is frequent occurs between 34% and 66% of the time spent doing the task. The Goyert report rates repetition for wrists and hands as posing a "moderate/high risk". Based on these findings and after hearing the oral testimony of the worker, we find that the work demands involve repetitive movements of the arms, hands and neck.

[46] We have placed more weight on the content of the Goyert report than we do on the jobsite visit. This is in part because of the difference in qualifications of the authors - Mr. Goyert is a senior ergonomist at the Board and the identification of risk factors in an environment is his area of expertise. The job demands analysis that was the basis for the decision to deny the claim was done by the claims adjudicator and, while we accept that she had training in risk factor identification, this training is not a substitute for a specialization in ergonomics. There is no indication that the adjudicator had any specialization in ergonomics.

[47] Our preference for the substance of the Goyert report is also influenced by the reason for its existence. The employer asked the Board to look at this job because several of their operators had musculoskeletal complaints. The object of the report was to provide the employer with information about how factors could be modified so as to minimize or stop these complaints. This gives the report a purpose that is divorced from any specific claim. The contents are more detailed and are specific to the refuse crane operator position.

[48] The Goyert report identifies risk factors that are not emphasized in the adjudicator's report. We accept that these risk factors exist, based on the demonstrations by the worker at the hearing and the evidence in the photographs and videos. For instance, in the summary of risk factors at the end of the adjudicator's report, it does not mention the frequent gripping that is identified in the Goyert report, albeit with a light grasp. The job demands analysis states that there is no repetitive finger movement, while the Goyert report states there is continuous finger manipulation. The job demands analysis states that there are "two periods during the worker's day of 2 plus hours" where the job required the worker to move his right wrist and elbow at repetitive rates. The Goyert report does not limit the repetition to specific points throughout the workday. It characterizes the refuse crane operator's position as requiring "repetitious movements of the [both] arms, wrists and hands".

[49] We are of the view that the Goyert report identifies and describes a more complete assessment of the musculoskeletal risk factors for the refuse crane operator than does the adjudicator's report.

[50] While our conclusions with respect to the acceptance of musculoskeletal risk factors are based on the Goyert report, we note that the Everett report also discusses risk factors for epicondylitis. This 50-page report describes the refuse crane operator's job and the worker's body mechanics. The report is based on observation of the worker in a refuse crane while he was operating it. At pages 31, 32 and 33 of the report, Mr. Everett discusses the two forearm extensor muscles (extensor digitorum communis and extensor carpi radialis brevis). He identifies awkward wrist extension in excess of 60 degrees for 44% of a refuse crane operator's shift and 25% of the overall 12-hour work shift. Mr. Everett also said that the addition of work activities such as moving the hand controls while simultaneously pressing, holding and releasing buttons means that the postural loading would be "more than significant".

[51] The Everett report uses the same definition of physical work demands as does the Goyert report and agrees that moderate to high risk factors exist for the operator's wrists and hands.

[52] We acknowledge the criticisms made by Mr. Worthington-White but for the purpose of adjudicating these claims, we are satisfied, principally by the content of the Goyert report, that risk factors for epicondylitis were present in the refuse crane operator's position. Mr. Worthington-White does not deal in depth with identification of risk factors. His report is focussed on criticizing the methods used by Mr. Everett and had the Everett report been the only source of information on the risk factors, we might have delved into the alleged deficiencies in greater detail. As we rely primarily on the Goyert report in reaching our conclusions, we do not consider this necessary.

[53] We note also Dr. Spooner's report of October 18, 2012 in which he attributes the worker's epicondylitis to his refuse crane operator's duties, an opinion he said was formed after speaking to the worker, examining him over the timeframe of 2010 and 2011 and reviewing the video clips of his work. Dr. Spooner also commented on the fact that when the worker was on light duties and not operating a joystick or functioning as a crane operator, his symptoms improved.

[54] We accept Dr. Spooner's opinion about the cause of the worker's epicondylitis and prefer it to the Board medical advisor's. Dr. Spooner is the worker's treating physician and has physically examined the worker. The medical advisor's opinion was based on incomplete information about risk factors for epicondylitis provided by the adjudicator following the jobsite visit in January 2011. We are persuaded by the Goyert report in combination with the worker's evidence and simulation of job duties as shown during the oral hearing that the risk factors for epicondylitis are present in the refuse crane operator's position and the medical advisor does not give enough weight to those risk factors. We are persuaded by the Goyert report that the refuse crane ergonomics contained risks for musculoskeletal injuries and that in the work setting, given the high degree of repetition and the lengthy periods of time in which the workers were engaged in the job, it is more likely than not that the epicondylitis was due to the nature of the employment.

[55] The decision under appeal also denies the claim for "possible ulnar nerve involvement". It is unclear to us that the worker has such a "diagnosis". The worker relies upon the Everett report to support that the employment duties were a significant factor in causing nerve involvement. We find insufficient evidence to support this. Mr. Everett is not a physician. While we find he has expertise in the area of ergonomic risk assessment, we find he does not have the medical expertise to provide an opinion on causation. We place little weight on his opinion as it relates to ulnar nerve involvement and its cause.

[56] Dr. Spooner's report of October 18, 2012 which sets out his assessment of the worker at the various visits describes the worker complaining of a right hand and forearm pain,

but appears to link the hand pain to cervical radiculopathy. Dr. Spooner said that he diagnosed the worker with a probable carpal tunnel syndrome and tennis elbow of the right hand and arm. The "diagnosis" appears to come from the physiotherapist's report on December 6, 2010 on the basis of a positive Tinel's sign. However, Dr. Spooner's progress report on January 19, 2011 describes right arm tingling and paresthesia into three fingers which his medical-legal report attributes to cervical radiculopathy, not an ulnar nerve injury.

[57] We do not consider that reference in the physiotherapist's report is sufficient basis upon which to establish that the worker had a diagnosis of "possible" ulnar nerve involvement, particularly when Dr. Spooner, who was treating the worker, did not diagnose it and identifies the worker's neck pathology as the cause of the "paresthesia and pain in his right arm".

[58] The Review Division decision under appeal also states that the refuse crane operator's job is not responsible for the development of foraminal narrowing at C6-7.

[59] The Board medical advisor's opinion addresses this. She stated that foraminal narrowing of the C6-7 is a sign of cervical spine disc degeneration. She stated that this is a condition of natural causes and influenced by a number of factors such as age and genetic factors. At page 7 of the 8-page medical report, she said:

> …osteophytes narrow the intervertebral foramen and when extensive may significantly reduce the space through which the nerve roots exit. This leads to compression of the nerve and radiation of symptoms done on one and both arms. It is expected that intermittent radicular symptoms will arise, and eventually constant radiculopathy may occur as the degeneration progresses.
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> [all quotes reproduced as written, except as noted]

[60] The Board medical advisor said that degenerative processes can be enhanced, aggravated or accelerated but this would require "significant force…applied to the disc space and intervertebral disc region". She stated that the force must be sufficient to damage the discs and the joints more than the usual wear and tear and thus was usually associated with significant trauma, such as falls from a height or high velocity motor vehicle accidents. In the present appeal, we find insufficient evidence to support the type of trauma which would cause such damage to the disc space and intervertebral disc regions. We are not convinced by the evidence that the job demands were of such force to cause this condition.

[61] The worker submits that cervical spine strain or neck complaints in general should be accepted on the basis that Dr. Spooner opined that the worker had pre-existing disc protrusions in his cervical spine aggravated by constant moving of his neck and head in the crane. Firstly, the condition of a cervical spine strain was not adjudicated by the

Board officer or the review officer and, as a result, we have no jurisdiction to address that specific condition. With respect to Dr. Spooner's opinion, we disagree with the worker's interpretation of his opinion. Dr. Spooner stated:

> The condition of multi-level disc protrusions in his cervical spine may not have been caused by his work as a crane operator but the paresthesia and pain in the right arm would certainly have been aggravated by this type of work. [The worker's] seated posture with the constant moving of his neck and head would have been the most significant cause of his neck pain.

[62] We find that while Dr. Spooner confirms that the worker's CT scan showed "multilevel disc protrusions with evidence of spinal stenosis". He also said that these multilevel disc protrusions "may not have been caused by his work as a crane operator" and that the work would have aggravated his *arm pain and paresthesia* (emphasis added). We do not interpret his opinion to indicate that the work aggravated a pre-existing degenerative condition. We also find that his opinion lacked sufficient reasoning to support how movement of his neck would have caused any pain in the neck or how this related to the C6-7 foraminal narrowing, the specific condition adjudicated by the Board.

[63] We accept the Board medical advisor's opinion that there is no mechanism whereby the worker's degeneration, the C6-7 foraminal narrowing, would likely have been caused or materially aggravated by the work the worker did.

[64] For the reasons set out above, we find the worker's epicondylitis was due to the nature of his employment as a refuse crane operator. The evidence does not support a conclusion that the C6-7 foraminal narrowing or ulnar nerve injury was caused or aggravated by the occupation.

Conclusion

[65] We vary the Review Division decision (RD #R0127405) in part and conclude the worker's epicondylitis is compensable under section 6(1) of the Act. We confirm the Board's decision that the C6-7 foraminal narrowing or ulnar nerve injury are not compensable on a causative or aggravated basis.

Expenses

[66] Pursuant to section 7 of the *Workers Compensation Act Appeal Regulation,* B.C., Reg. 321/2002, we order reimbursement for the expenses of obtaining the records and opinion provided by Dr. Spooner to the level permitted by the Board's fee schedule as it was helpful to our analysis of the evidence in this appeal. We also order reimbursement for the physiotherapy notes in accordance with the Board's fee schedule as we

conclude that it was reasonable for the worker to obtain them both in light of the issue and because of the insistence of the employer's counsel (when they were participating) that all of the medical records be produced.

[67] The worker also seeks reimbursement for the expenses of obtaining the Everett report which was billed at $2,905.00. In this case, the worker also seeks reimbursement for an additional $2,872.80 (the reply report to Mr. Worthington-White) and $529.20 for the "response report to the Board's ergonomic assessment" for a total of over $6,300.00 in expenses.

[68] The basis for this fee is the British Columbia Society of Occupational Therapists' recommended fee guideline of $135.00 an hour plus 12% HST.

[69] Item #16.1.3.1 of WCAT's *Manual of Rules of Practice and Procedure* (MRPP) states that WCAT may direct reimbursement for different types of expert evidence. It also states that WCAT will usually "order reimbursement of expert opinion at the rate established by the Board for similar expenses". There is no tariff or fee schedule for ergonomic reports at the time of writing this decision. The worker submitted that the account should be paid in full. Although no detailed submission was made in relation to the reports in this case, the worker's counsel made specific submissions on expenses in the other cases and we have considered those submissions in relation to all three appeals.

[70] We were referred to decisions of WCAT in which panels had considered reasons why other reports by Mr. Everett should be paid.

[71] In *WCAT-2012-02739*, the panel was considering a request for full reimbursement of an ergonomic assessment by Mr. Everett in the amount of $2,642.68. The panel referred to the MRPP provisions on expert evidence and said that where there was no fee schedule, a WCAT panel had discretion and should assess the amount charged by the expert on the basis of its "reasonableness". The panel found that it was reasonable for Mr. Everett to charge an hourly rate of $135.00 because it was recommended by his professional body. It was also reasonable to charge for reviewing the reports, interviewing the worker, travelling, doing a worksite visit and preparing video and video analysis. The worker relies on the panel's assessment that the test should be whether the amount charged was reasonable in all the circumstances.

[72] *WCAT-2012-01863* "focused on the impact of reimbursement decisions on the worker's ability to call the best evidence". The worker argues that it was reasonable to obtain an ergonomic assessment and submits that he is entitled to obtain the best evidence and should not be penalized for doing so.

[73] We are aware of WCAT-*2012-01531* wherein the reconsideration panel stated that where there is no fee schedule, that the expectation would be that the expense would be reimbursed in full. However, that case is distinguishable from the present case, as

the original panel in that case did not request submissions as to how the quantum of the amount to be reimbursed should be determined. Given the quantum of the reimbursement requested we have requested and received submissions on this issue.

[74] In a noteworthy decision, *WCAT-2011-00522*, the former chair of WCAT (hereinafter referred to as the chair) was considering payment for a functional capacity evaluation report prepared by an occupational therapist. The chair identified a number of relevant considerations when determining the amount of the expense to be reimbursed. The chair concluded that it was reasonable for the worker to have obtained the report but declined to reimburse the entire cost of it. The occupational therapist had billed $150.00 an hour, 5.5 hours for the evaluation and 8 hours at the same rate for the preparation of the report.

[75] The chair reduced the hourly rate charged by the report writer from $150.00 to $135.00 an hour, which was the minimum rate established by the Society of Occupational Therapists. The chair also declined to pay for all of the hours that had been put in to the reports stating:

> In my judgement, the FCE report was overly lengthy and would have been more useful if it were more concise and if the information included was largely focussed on the worker's condition and merely supplemented by general information that was helpful in understanding the worker's functional capacity. In this way, readers of the report could establish the relevant facts without spending the time that is required to review such a lengthy document.

[76] We agree with the chair's rationale as well as the factors described in *WCAT-2012-02739* and conclude that WCAT has the discretion to consider, as one of the factors in assessing the reasonableness of the report, the content and length of the report, and whether it goes beyond what is necessary to accomplish the purpose of the report.

[77] We also set out some other factors which have served to guide us in our assessment of what it is reasonable to reimburse in this case.

[78] The first factor is the complexity of the issue. WCAT considers cases involving cancers or other serious and life-threatening illnesses and their relation to a particular occupation or work practice. In such cases, there is often the need to review very complex epidemiological studies, opinions from specialists and comprehensive analyses of risk factors. These cases can require the panel to embark on detailed reviews of lengthy reports which must be analyzed for relevance to the case before them and distilled for the reader of the decision. Sometimes, this is required by the unusual nature of the disease or injury, the rarity of the occupation or because of some significant difference of opinion in the expert reports.

[79] In contrast, this was a straightforward case of whether the worker's activity-related soft tissue disorder symptoms had been caused by his job as a refuse crane operator. The issue was not complex. The Board's policy about what constitutes risk factors is plainly laid out in the policy manual. Success in such a case turns on the identification of risk factors and the application of the test of causative significance.

[80] Another factor we have considered is that of proportionality. By this, we mean the significance of the injury and its impact on the worker or employer. WCAT panels regularly must deal with cases where injuries or occupational diseases have had profound effects on the worker both physically and in terms of their ability to continue working in their pre-injury employment or indeed to work in any employment. That is not the case here. While not diminishing in any way the pain and discomfort, we accept the worker experienced as a result of operating a refuse crane, the fact remains that he lost no time from work as a result of his accepted occupational disease. The impact was confined to medical and health care expenses he incurred.

[81] Another factor that could be relevant in considering the amount of a report is the limited availability of the appropriate specialist. There are places in this province where there are few specialists or subject matter experts. The ability to choose an expert and curtail the resulting expense is extremely limited. The worker is not in this situation. He lives in a large urban area. There are a number of ergonomists who can be hired to undertake the task of producing a risk factor analysis.

[82] Another factor relevant to these three cases is duplication. This worker is one of three power engineers who filed claims and received negative decisions at the same time. Although we have separated the decisions for privacy reasons and acknowledge that at first, these appeals were travelling through the appellate system separately, the Goyert report was common to all three claims as was the site visit done by the adjudicator who made the decision in all three cases. In two of the three workers, Mr. Everett visited the work site and assessed the worker in situ, assessing the equipment himself, taking measurements of the workers while operating the equipment. Of the reports prepared in the three cases, this was the first one, done in April 2011. We accept that a lengthier visit was required in this worker's case in order that Mr. Everett could familiarize himself with the work site and with the equipment that was being used by the refuse crane operators. We accept that it is reasonable to have spent more time on this, the first of the three cases, than in the others.

[83] Another factor we consider relevant is whether the expert had to review a significant body of material in order to prepare the report. Here, Mr. Everett was required to review the Goyert report which is eight pages long, the adjudicator's site visit which is six pages long, as well as view the video footage and photographs prepared by Mr. Goyert and the adjudicator. In addition, he had to read Mr. Worthington White's report. In our view, this does not comprise a significant body of material and extensive literature reviews were not necessary to respond to the information that was on the record.

[84] A final factor when considering the reasonableness of the cost of the report, to be considered in conjunction with the others, is the extent to which it can be understood by the reader for whom the report is written. In our view, an expert report must transparently communicate the facts upon which the report is founded and clearly and plainly identify the reasons for the report's conclusions. These reports are deficient in this regard as illustrated by this example:

> The forearm extensors are predisposed to static postural loading by nature of their shorter length; unique contractile units, that unlike the flexors must shorten to generate internal muscle force; narrower cross sectional area relative to the forearm flexors; and the internal muscle force that the extensors must generate to counterbalance forearm flexor force (Fagarasanu, 204; Leiber, 1998)

[85] This is a representative sample of the contents. This report was not written to another ergonomist (or some other related discipline) where an exchange of extremely technical information was warranted and could be readily comprehended by the reader. This report was written for us, so that we, the triers of fact, could understand what risk factors were present in the operation of a refuse crane and to which the operator would be exposed. Jargon, complex formulae, pages of diagrams and language that varies from the norm in ergonomic or medical reports, is extremely unhelpful and serves to obscure meaning rather than elucidate it. This puts the decision-maker in a very difficult position when they are asked to rely upon the contents of the report and order payment of large sums of money from the accident fund for it.

[86] The Everett reports contained much more material than was necessary to identify the risk factors in the job. The report's overly technical nature made it difficult to understand how and where those risk factors were present in the job the worker was doing. We acknowledge that we have relied on Mr. Everett's report to a limited degree inasmuch as we accept that the report confirms what is clearly established by the Goyert report, which is that risk factors existed for the worker's wrists, hands and arms.

[87] We have also looked at other reimbursement schedules. For instance, WCAT has created a list of independent health professionals, surgeons, specialists, psychiatrists and psychologists, to whom we turn for opinions in appropriate circumstances. The independent health professional can be required to review extensive medical records, read and digest the factual background prepared by the panel and answer a series of questions. For this, they are generally paid a fee of $1,485.00. We mention this because we take notice that those professionals are required to have more education and training than those professionals doing ergonomic reports and that will be reflected in their compensation received for their reports.

[88] The Board does have a fee schedule for reimbursement of occupational therapists and kinesiologists who do job demands analysis. The fee for service plus a report is $400.00

The Board also has a fee schedule for the production of a medical-legal report. The current fee schedule is $873.12. It seems to us that an ergonomic report combines features of both. The assessment of the equipment in relation to the equipment user and the assessment of the ergonomic setup is equivalent to the job demands analysis. The risk factors are then identified in a report which can include recommendations for ergonomic alterations.

[89] We consider that it was reasonable for the worker to have obtained an ergonomic report given the Board medical advisor's opinion that the risk factors were not significant enough to have caused the worker's complaints. We do not consider, in light of the factors we have identified, that it is reasonable to pay the entire cost of both reports.

[90] Mr. Everett billed $2,905.00 for the risk assessment dated April 30, 2011 (18.75 hours at $135.00 an hour plus 12% HST). We accept that it was reasonable to review documents, interview the worker, travel to the work site and do a worksite assessment, as well as prepare a report. Mr. Everett also billed 6 hours for an SEMG analysis and evaluation, work systems analysis (frame by frame analysis of refuse crane operations analyzed at 5-second time frames) and human digital imaging of three workplace postures. In our judgement, the report was unnecessarily long and complex, given the factors we have outlined above. Recognizing that this is a judgement call, we reduce the number of hours spent recruiting the raw data from 11.75 hours to 5.75 hours. We reduce the hours required to produce the report from 7 to 6 for a total of 11.75 hours. We note this brings the cost of report generally in line with the cost for an independent health professional's report.

[91] Mr. Everett billed $2,872.80 for the reply to Mr. Worthington-White's comments about his first report. Nine of these hours were for a review of Mr. Worthington-White's report, a literature review and a biomechanical analysis of lever arms. Ten hours were billed for the report itself. We consider that the analysis of lever arms was necessary as this was responding directly to a criticism. In addition, the review of the report was also necessary. A literature review of 5-hour duration seems disproportionate. We do not consider that 10 hours to prepare a report, which was longer than the original report which was criticized, is reasonable. Mr. Everett's response to the Worthington-White criticisms exceeds what is necessary for a cogent response. We reduced the literature review to 2 hours and the report to 5, for a total of 11 hours, less than the amount of time required to produce the original report.

[92] We order the Board to reimburse the worker or his union:

1. For the April 30, 2011 report, 11.75 hours plus 12% HST at $135.00 per hour.
2. For the March 12, 2012 report, 11 hours plus 12% HST at $135.00 per hour.
3. For the information provided to the employer's counsel, the amount of $529.20.

William J. Duncan
Vice Chair

Beatrice K. Anderson
Vice Chair

Lisa Hirose-Cameron
Vice Chair

BKA/WJD/LHC/jkw