WCAT Decision Number: WCAT-2016-00651
WCAT Decision Date: March 02, 2016
Panel: Grace Chen, Vice Chair

Introduction

[1] The worker injured his back while lifting a bucket of concrete on January 11, 2012. The Workers' Compensation Board (Board), operating as WorkSafeBC, accepted the worker's claim for an L3-4 disc herniation and chronic low back pain as a result.

[2] On October 31, 2014, the Board indicated the worker requested depression and anxiety be accepted on his claim. The case manager denied acceptance of a psychological condition.

[3] On May 19, 2015, the review officer in *Review Reference #R0187293* indicated counsel for the worker requested Major Depression with Anxiety and a Pain Disorder be accepted. The review officer denied the worker suffered from any psychological condition and confirmed the Board's decision.

[4] The worker appeals *Review Reference #R0187293*.

Issue(s)

[5] Does the worker suffer from a psychological condition that is a compensable consequence of his accepted work injury?

Jurisdiction

[6] The appeal was filed with the Workers' Compensation Appeal Tribunal (WCAT) under section 239(1) of the *Workers Compensation Act* (Act), which provides for appeals of final decisions by review officers regarding compensation matters.

[7] Section 254 of the Act gives WCAT exclusive jurisdiction to inquire into, hear, and determine all those matters and questions of fact, law, and discretion arising or required to be determined in an appeal before it. WCAT reviews the record from previous proceedings and can hear new evidence. WCAT has inquiry power and the discretion to seek further evidence, although it is not obliged to do so. WCAT exercises an independent adjudicative function and has full substitutional authority. WCAT may confirm, vary, or cancel the appealed decision or order.

[8] I am bound to apply the published policies of the board of directors of the Board, subject to the provisions of section 251 of the Act. The *Rehabilitation Services and Claims Manual, Volume II* contains the published policy applicable to this appeal.

[9] The worker requested the appeal be heard in writing. I am able to consider the appeal through a different procedure, including an oral hearing, if I consider it necessary. I have reviewed the issues, evidence, and submissions on the worker's file and presented to WCAT and considered the rule and the other criteria set out in the *Manual of Rules of Practice and Procedure* (MRPP) at item #7.5. I do not consider there to be a significant credibility issue in this appeal. The issues turn primarily on weighing the evidence, and applying and interpreting the applicable law and policy. I am satisfied that an oral hearing is not necessary.

[10] Counsel for the worker provided written submissions. The employer did not participate in the appeal.

Background and Evidence

[11] After his work injury in January 2012, the worker attended an occupational rehabilitation 2 (OR2) program.

[12] On April 26, 2012, Dr. Aronshtam, general physician, told Board medical advisor Dr. Ebrahim the worker suffered from severe anxiety, which may affect his OR2 program assessment. Dr. Ebrahim mentioned there were labour relations issues between the worker and his employer.

[13] In June 2012, Dr. Aronshtam reported the worker was finding his pain unbearable in the OR2 program and the worker stopped participating in it.

[14] A pain management program assessment report dated July 9, 2012 indicated the worker reported he had been treated with anti-depressants in the past. He reported he had seen pain medicine specialist, Dr. Pam Squires for chronic pain management for the past two years; she prescribed gabapentin, Percocet, and medical marijuana. He reported his anxiety and weight loss started in July 2011 when he hit another truck at work and was put on probation. He also reported he had "thinning of the knees"[1] in his past medical history. He reported Zoloft caused him to freak out and cipralex made him dizzy.

[15] The pain management program discharge report of August 24, 2012 stated the worker's score on the Beck Depression Inventory (BDI-2) II suggested mild depressive symptomatology. He had significant anxiety and tried SSRIs (selective serotonin reuptake inhibitors) with little success. Under the section on diagnosis, it was noted the worker had "significant anxiety and possible depressed mood."

[16] On November 15, 2012, the worker underwent a psychological assessment with Dr. Hait, registered psychologist, arranged by the Board. Dr. Hait was supervised by Dr. Feehan, registered psychologist. In his November 23, 2012 report, Dr. Hait

[1] All quotations are reproduced as written, except where indicated.

diagnosed the worker with a Major Depressive Disorder, Single Episode, Severe, and a Pain Disorder Associated with Both Psychological Factors and a General Medical Condition. Both were attributed to the work injury.

[17] Dr. Hait said the worker's validity scores indicated a tendency to under-report some negative aspects of his character and over-report others. Caution was warranted when reviewing hypotheses derived from his clinical profile. The worker scored very high on the BDI-2. He reported severe impairment in all areas of daily life. Inconsistent with those results, he reported little fear of activity–related increase in pain and scored low on the measure of one's tendency to ruminate about pain. These inconsistencies could either reflect a misreading of the questionnaire items or an attempt to appear more disabled by pain than is likely true. The worker's responses indicated a much greater level of psychopathology than was identified in his pain management program discharge report. Dr. Hait said the worker's presentation on interview was plausible but his questionnaire results suggested he may have over-reported his problems in a manner probably best considered a "cry for help."

[18] The worker minimized the significance of his pre-existing depression and back pain. He said he was doing well at work and in most aspects of his life in the weeks and months prior to the work injury.

[19] Dr. Hait said the worker's prognosis was guarded. He continued to report a debilitating level of back pain in spite of ten months of treatment. His pain problems seemed worse than ever. By all reports, he was also more depressed than ever. Dr. Hait said the worker's prognosis could improve with appropriate psychological intervention and for this reason, he wrote that he could not conclude the worker had reached "maximum psychological recovery" yet.

[20] The Board granted the worker a permanent functional impairment award for his physical injuries.

[21] In February and March 2013, counsel for the worker (different from present counsel) requested the Board adjudicate the worker's psychological conditions. Also around this time, the Review Division requested Dr. Aronshtam's pre-injury records with respect to another review.

[22] On March 25, 2013, Board psychologist advisor, Dr. Lai was of the opinion that Dr. Hait was not provided with Dr. Aronshtam's pre-work injury records. Dr. Hait relied too much on the worker's narrative and failed to recognize the worker's pre-existing pain difficulties. Dr. Hait should have queried the worker more extensively as to his pain difficulties before the work incident. Instead, Dr. Hait attributed the worker's Pain Disorder as primarily caused by the work incident and his difficulties coping with pain. The medical records show the worker had acute difficulties with pain 20 days before the work incident to the point that he needed to visit his doctor and take Percocet to help him manage, but the worker denied he had difficulty with pain before the work incident.

Dr. Lai suggested the worker's unvetted pre-existing medical records regarding pain, depression and anxiety be examined to determine the extent of his depression and anxiety prior to the work injury.

[23] Dr. Lai said the Dr. Hait should have read the file carefully and asked the worker why his depression/anxiety deteriorated so much after discharge from the pain management program. The worker told Dr. Hait of some labour relations matter at work and Dr. Hait should have asked how these issues contributed to the worker's symptom presentation. Dr. Lai said there was significant oversight on the part of Dr. Hait that rendered his clinical opinions questionable. His examination of the evidence was not thorough or comprehensive. Dr. Lai suggested Dr. Hait review the records and revise his analysis or the Board should request a seasoned psychologist to conduct another assessment.

[24] The case manager advised counsel for the worker the assessment by Dr. Hait did not meet the Board's contracted clinical standards and could not be used. She was in the process of gathering prior medical records on the worker's pre-existing depression and anxiety and would then arrange for a formal psychological assessment.

[25] A different counsel for the worker argued the Board was attempting to seek a second opinion simply because it did not like Dr. Hait's report. He said the Board only seeks a second opinion when the first opinion is in favour of the worker. He asked the Board to clarify why the report did not meet the Board's standards.

[26] The Board obtained Dr. Aronshtam and Dr. Squires' pre-work injury records. The worker saw Dr. Squire prior to the work injury for knee and back pain.

[27] Dr. Aronshtam's pre-work injury records show:

- On June 20, 2011 he noted the worker had long standing anxiety that was getting worse. He was anxious about work and finances. He had headaches, palpitations, and was tearful. He was mainly on Zoloft for the last three years for sexual dysfunction. Dr. Aronshtam assessed the worker as having anxiety and headache (not yet diagnosed) and prescribed him clonazepam.
- On June 27, 2011, the worker was feeling better and wanted to re-start Zoloft. The worker was relaxed and not anxious. Dr. Aronshtam diagnosed anxiety and panic attacks and prescribed Zoloft.
- On July 5, 2011, the worker was slightly anxious and had not started using Zoloft.
- On August 16, 2011, the worker had a minor accident at work; he was suspended for a month and put on probation for a year. This triggered severe anxiety, insomnia, and chest pain. Dr. Aronshtam assessed anxiety and panic attacks. He prescribed Zoloft, clonazepam, and zoplicone.
- On September 3, 2011, the worker was tearful, anxious, and had depressed mood. Dr. Aronshtam assessed depression and anxiety. He prescribed clonazepam and Cipralex.

- On September 21, 2011, the worker was working full time and trying to avoid medication. He lost 40 pounds in the past few months. Dr. Aronshtam diagnosed Generalized Anxiety Disorder and panic attacks in partial remission. The worker was to continue with clonazepam.
- On October 1, 2011, the worker was still anxious and depressed. He was to restart Cipralex. Dr. Aronshtam assessed the worker with anxiety and depression.
- On November 14, 2011, the worker was stable and working full time. His mood was mildly dysthymic. Dr. Aronshtam diagnosed anxiety and prescribed clonazepam.
- On December 21, 2011, the worker was still anxious and having frequent panic attacks. His mood was dysthymic. Dr. Aronshtam diagnosed Generalized Anxiety Disorder and depression.
- On December 22, 2011, the worker had exacerbation of lower back pain. He was using percocet. He missed work. Dr. Aronshtam referred the worker for a CT scan.

[28] Dr. Squire's pre-work injury records show:

- She saw the worker on August 4, 2011 for mechanical low back pain, osteoarthritis in his knees and elbow pain. He advised her that he stopped Zoloft, had some anxiety, was taking another medication for some time, and had not been off medication; his mood was "ok". Dr. Squire said the worker was only on low dosage to help with sexual dysfunction. He was using medical marijuana tea for his pain.
- She saw the worker on October 19, 2011. The worker had anxiety concerning his joint and wondered if he should change jobs. He was having constant pain in his right knee. She gave him an injection. The worker was using medical marijuana tea for pain.
- She saw the worker on November 18, 2011. The worker had temporary relief from the injections. The plan was to treat the knee pain with Oxycocet, orthotics, and prolotherapy.
- She saw the worker on December 7, 2011 and again recommended prolotherapy.

[29] Dr. Aronshtam's post-work injury records show:

- On January 14, 2012, the worker had persistent lower back pain and was unable to work. There is no mention of the work incident.
- On January 16, 21, and 27, and February 10 and 17, 2012, Dr. Aronshtam saw the worker mostly for back pain. There is no mention of mood disorders.
- On February 24, 2012, the worker said he had anxiety daily and was taking clonazepam.
- On March 30, 2012, the worker reported his anxiety level increased substantially. He was afraid the Board would cut off his benefits. Dr. Aronshtam diagnosed severe anxiety and "Cluster C personality traits."

- On April 2, 13, 25, and May 2 and 22, 2012, Dr. Aronshtam saw the worker mostly for back pain.
- On May 29, 2012, the worker was anxious, and concerned about further treatment.
- On June 12, 2012, Dr. Aronshtam recommended the worker stop his rehabilitation program because he was unable to tolerate it. The worker had anxiety and depressed mood.
- On July 20, 2012, Dr. Aronshtam diagnosed Generalized Anxiety Disorder, depression and chronic pain. The worker had fear about employment, finances, and relationships.
- On October 6, 2012, Dr. Aronshtam said the worker had severe anxiety.
- On November 6, 2012, Dr. Aronshtam diagnosed the worker with depression and anxiety in early remission. The worker was having relationship problems.
- On December 5, 2012, Dr. Aronshtam recommended counselling for the worker's anxiety and depression.
- On December 13, 2012, Dr. Aronshtam referred the worker to a psychiatrist for depression.

[30] Dr. Squire's post-work injury records show:

- She saw the worker on March 28, 2012. His lower back pain was worse than usual and he had nerve root irritation. The treatment plan was a nerve root block and trials of different pain medication. She prescribed more Oxycocet
- She saw the worker on September 12, 2012. The worker looked unwell and lost a great deal of weight. He was walking slowly with a cane. She refilled his Oxycocet prescription.
- She saw the worker on March 19, 2013. The worker had severe low back and leg pain. He lost more weight. She gave him another injection and more Oxycocet.

[31] On June 24, 2013, Dr. Ebrahim noted the worker initially did not indicate he experienced any significant prior low back or chronic pain condition. There was also no indication initially from Dr. Aronshtam of any prior low back issues or chronic pain issues. Furthermore, assessment by Dr. Chan, neuro surgeon, also failed to reveal the true nature of the worker's pre-existing low back condition. It was only following the pain management assessment and following review of past medical records that it appears the worker had a significant pre-existing chronic pain condition related to his low back, for which he required significant narcotic medications, as well as medical marijuana. Dr. Squire had diagnosed a chronic mechanical low back condition. Dr. Ebrahim said the worker had pre-existing chronic pain and mechanical low back pain.

[32] On May 29, 2014, the worker was assessed by Dr. Saper, psychologist, arranged by the Board. Dr. Saper reviewed the worker's pre-work injury medical records. In 2011, Dr. Squire indicated the worker was prescribed with an anxiolytic due to anxiety after

stopping Zoloft. He had anxiety, panic attacks, and depressed mood. In January 2012, the worker complained of persisting pain in his right leg and mild/moderate distress.

[33] On examination, the worker said he had low back pain in the past but had been able to function. The worker denied any pre-injury depression or psychological treatment. He said everything was manageable before his work injury. He said he had anxiety before his work injury due to a car accident. The worker said he got depressed after his work injury when the rehabilitation programs were unsuccessful.

[34] Dr. Saper said the worker's validity scores indicated his responses were not likely to be valid. Dr. Saper administered two tests for malingering. Dr. Saper said the worker did not provide accurate information in interview or on testing. His self-report of symptoms and impairment/disability were not reliable. Medical records suggested that any depressive and anxiety symptoms were present before the work injury and continued to be present immediately after the injury. The medical records did not show any clear evidence of an exacerbation of depression, anxiety or pain at the time of the work injury.

[35] Dr. Saper said the worker's denial of depression problems before the work accident, and his description of himself as a "happy guy" when this was clearly not the case, did not enhance his credibility. When challenged, the worker reiterated assertions that were inconsistent with file information.

[36] Dr. Saper said he was not making any diagnoses as there was no credible evidence to base a diagnosis. He said Dr. Hait and Dr. Feehan accepted the worker's self-report of symptoms as valid despite clear evidence of distortion and inconsistency. Dr. Saper said he was unable to assert the worker malingered his symptoms, as the intent of the worker could not be determined.

Submissions and New Evidence

[37] I confirm that I have reviewed and considered the submissions and evidence provided to the Review Division as well as those provided to WCAT.

[38] The worker submitted to the Review Division that Major Depression with Anxiety and Pain Disorder should be accepted on his claim. He submitted he was never diagnosed with any psychological condition prior to the work injury. He submitted he was given medication for anxiety in 2011 due to being suspended from work for one month following an accident. He submitted he was prescribed medication in 2011 for sexual dysfunction. He submitted he had pre-existing pain in his low back, pelvis and knees and received pain treatments prior to the work injury but was able to work full time.

[39] The worker submitted Dr. Saper's assessment was "biased, unreliable, and somewhat absurd." The worker submitted a report from Ms. Rados, his counsellor dated September 1, 2013, which supported his position. He submitted Dr. Hait, Dr. Feehan, Dr. Aronshtam and Ms. Rados all diagnosed Major Depressive Disorder. He submitted

his treating doctors were aware of his pre-injury anxiety. There was little evidence of pre-injury depression except for sexual dysfunction. He argued Dr. Hait and Ms. Randos conducted collateral interviews that confirmed his emotional condition had decreased dramatically since the work injury.

[40] Ms. Rado's September 1, 2013 report indicates she is a clinical counsellor with 29 years of experience. She assessed the worker on August 1, 2013 and interviewed his wife and brother-in-law. She also reviewed the various psychological reports but she does not mention Dr. Saper's report specifically. Her opinion was the worker suffered from symptoms of severe clinical depression and severe anxiety resulting from the work injury.

[41] The worker submitted to WCAT again that Dr. Saper's opinion was biased. The worker also submitted a report from psychologist, Dr. Nader dated August 4, 2015.

[42] Dr. Nader assessed the worker on July 31, 2015. Dr. Nader said the worker had a history of anxiety and panic attacks prior to the work injury, with an exacerbation of his symptoms after he discontinued use of Zoloft (for premature ejaculation) in the summer of 2011. In June 2011, he was prescribed clonazepam and his anxiety improved slightly. In July 2011, the worker had a minor accident at work and was suspended for a month. He reported severe anxiety and panic attacks and was prescribed several medications. He continued to work during this time. Dr. Nader reviewed Dr. Aronshtam's records and said the worker continued to report depression symptoms between June 2011 and the work incident but there was no indication he experienced these symptoms on a daily basis for a prolonged period.

[43] Dr. Nader said the worker's responses to validity scales on assessment showed he responded without undue exaggeration of problems and without undue defensiveness. Overall, his self-reports of symptoms were consistent with psychometric test results and medical records. Dr. Nader diagnosed the worker with Major Depressive Disorder, Somatic Symptom Disorder, Panic Disorder and Agoraphobia. He said there was no evidence to suggest a diagnosis of malingering or any indication the worker was being deceptive or feigning his symptoms.

[44] Dr. Nader said there was no evidence the worker experienced a Major Depressive episode prior to the work injury. His current symptoms meet the full diagnostic criteria for Major Depressive Disorder. Dr. Nader said the worker's chronic low back pain was a primary contributing factor to his Major Depressive Disorder. With regards to the Somatic Symptom Disorder, Dr. Nader said the worker had prior chronic pain complaints before the work incident but they did not interfere with his ability to work or other areas of his life. With regards to the Panic Disorder and Agoraphobia, he was of the opinion the worker had these symptoms prior to the work incident and his current symptoms are a continuation of those complaints and likely exacerbated due to stresses in his life in the past three years.

[45] Dr. Nader was critical of Dr. Saper's report and conclusions. Dr. Saper did not administer any psychometric measures specifically assessing symptoms of anxiety, depression, or pain. He thought Dr. Saper ignored evidence contrary to his pre-disposed conclusion that the worker was being deceitful and malingering. He dismissed the worker's self-report and based his opinion on select clinical records while ignoring others. Dr. Nader said Dr. Saper's comment that the worker's self-report was so unreliable that it is unclear whether the worker has pain or not is a stunning comment and ignored medical information from the worker's doctors, the OR2 program assessments, and various other medical records, as well as the fact the worker's claim has been accepted for chronic pain. He said Dr. Saper did not address the data in Dr. Hait and Dr. Feehan's reports, or the collateral information from the worker's wife. Dr. Nader agreed Ms. Rados is not a registered psychologist but Dr. Saper dismissed her report based solely on her qualifications rather thanchallenging the content of her report.

[46] The worker submitted to WCAT that Dr. Saper's report should be inadmissible and excluded due to bias. The worker also requested an order for production of documents in relation to Dr. Saper's earned income from the Board to demonstrate his bias. The worker submitted Board documents obtained through a Freedom of Information (FOI) request relating to payments made by the Board to Dr. Saper or his corporation. The worker argued the documents showed the Board paid Dr. Saper and/or his company as follows:

- 2009: $147,175.00
- 2010: $130,403.00
- 2011: $214,709.11
- 2012: $303,276.22
- 2013: $304,210.88
- 2014: $276,401.25
- 2015: $228,281.00

[47] The worker submitted documents showing Dr. Saper is the sole owner and employee of his corporation. The worker argued Dr. Saper's report was also unreliable because of adverse credibility assumptions, and internal and external inconsistencies.

Reasons and Findings

[48] The standard of proof is the balance of probabilities, subject to section 250(4) of the Act. Section 250(4) of the Act provides that if WCAT is hearing an appeal regarding the compensation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the appeal tribunal must resolve that issue in a manner that favours the worker. Policy item #97.00 provides guidance regarding the acceptance and weighing of evidence.

[49] Section 5 of the Act provides that a personal injury is compensable if it arises out of and in the course of a worker's employment.

[50] Policy item #C3-12.00 (Personal Injury) defines a personal injury as "any physiological change resulting from some cause". A personal injury includes a sprain and strain, or aggravation of a pre-existing non-compensable disease, attributable to a specific event or trauma, or to a series of specific events or traumas.

[51] Policy item #C3-14.00 (Arising out of and In the Course of the Employment) explains that "arising out of the employment" generally refers to the cause of the injury or death, whereas "in the course of the employment" generally refers to whether the injury or death happened at a time and place and during an activity that is consistent with, and reasonably incidental to, the obligations and expectations of the employment. The employment does not have to be the sole cause of the injury. For the injury to be compensable, the employment has to be of causative significance, which means more than a trivial or insignificant aspect of the injury.

[52] Policy item #C3-16.00 (Pre-existing Conditions or Diseases) requires that in cases involving pre-existing deteriorating conditions, consideration must be taken of whether the pre-existing disease was at a critical point at which it was likely to manifest as a disability, regardless of the employment activity. The policy states that evidence that the pre-existing condition or disease has been accelerated, activated, or advanced more quickly than would have occurred in the absence of the employment activity may be confirmation that the aggravation resulted from the employment activity.

[53] Policy item #C3-22.00 (Compensable Consequences) states the Board looks at the matter broadly and uses a "common sense" point of view to consider whether the compensable injury was of causative significance in the further injury or increased disablement. If the compensable injury was of causative significance in the further injury or increased disablement, then the further injury or increased disablement is sufficiently connected to the compensable injury so that it forms an inseparable part of the compensable injury, and is therefore, also compensable.

[54] Where a further injury, increased disablement, disease, or death arises as a direct consequence of treatment for a compensable injury, it is sufficiently connected to the original employment-related injury as to form part of that injury. The further injury,

increased disablement, disease, or death is therefore considered to arise out of and in the course of the employment and is also compensable.

[55] Where a worker sustains a further injury, increased disablement, disease, or death while participating in a vocational rehabilitation program undertaken as part of a Board approved rehabilitation plan, the further injury, increased disablement, disease, or death may be regarded as a compensable consequence of the compensable injury. Policy item #C3-22.30 deals with psychological impairment as compensable consequences.

[56] The worker sought production of Dr. Saper's earnings documents to prove Dr. Saper's bias and have his report ruled inadmissible. The worker cited *Baker v. Workers' Compensation Appeal Tribunal* (2007 BCSC 1517) where the Court found it was patently unreasonable and unfair for WCAT not to have considered the issuance of subpoenas and production of the worker's personnel file in relation to his claim for psychological injury related to his knee injury. The Court found it was unfair the worker was disadvantaged by the lack of his own personnel file to rebut the employer's position that labour relations were not unusual as it pertained to the worker, especially in light of information in the file that was used by the employer and referenced by WCAT. It was also unfair the worker did not have the opportunity to cross-examine the witness who he said caused him the stress. The Court found WCAT took an unacceptable risk by not having all information before the panel which could have affected the decision.

[57] Counsel for the worker rightly submits the documents requested here are different from the ones requested in *Baker* but argues WCAT would err here by failing to ensure all relevant information is before it, namely records concerning the relationship between Dr. Saper and the Board.

[58] I am not persuaded an order to produce documents relating to Dr. Saper's earnings is necessary in this case to support the worker's argument of bias. I am also not persuaded the Court comments in *Baker* can be extended to this case given the difference in the nature of the documents the worker seeks to produce and the purpose for which it is to be used. In *Baker*, the issuance of the order for the production of the worker's personnel file was remitted back to WCAT for reconsideration as to whether there was relevance to the issue of whether the labour relations situation created an unusual stimulus that was reasonably capable of causing psychological injury. In this appeal, the worker is seeking documents with the intent to impeach an expert's credibility and to have his report ruled inadmissible, rather than to prove his case directly. The *Baker* case is distinguishable on this basis.

[59] The worker also refers to *WCAT 2012-02422* in which the panel sought an independent health professional opinion from Dr. X. After the worker was assessed, the worker's representative submitted that at the same time when WCAT was retaining Dr. X to provide assistance and advice on the appeal, Dr. X was also being paid by the Board to render health professional services on its behalf. The worker's representative noted that section 249(3) of the Act provides that the list of independent health professionals

established by the chair of WCAT must not include "any person who is employed by the Board." The panel found Dr. X was in circumstances that could result in a reasonable apprehension of bias and the retention of Dr. X to provide independent health assistance and advice on that appeal contravened section 249(5)(f) of the Act. The panel ruled Dr. X's report not admissible in that appeal.

[60] *WCAT-2012-02422* is also distinguished on the basis that it was dealing with an independent health professional hired by WCAT and section 249(3), which specifically provides that these professionals must not be employed by the Board. In this appeal, the issue pertains to a psychologist who was specifically retained by the Board for the purpose of assessing the worker for the Board. I am not persuaded by the worker's arguments that the same standard should be applied here. An independent health professional assessment is different in nature from an assessment contracted for the Board. Section 249(3) does not apply to Board assessments.

[61] Counsel argues that the contents of Dr. Saper's report shows bias and I agree. I also conclude that it is more effective to look at the contents of Dr. Saper's opinion to consider whether bias is apparent rather than look to his earnings records. Inconsistencies and ignoring evidence that favours the worker is far more demonstrative of bias than his level of earnings from the Board. I accept the FOI documents provided from the Board are reflective of its payments to Dr. Saper and/or his company. I conclude production of further earnings would not be of assistance as it is the content of Dr. Saper's opinion, not the records of his earnings, where his bias will be most evident and would be the most relevant to the weighing of his evidence.

[62] The worker's submissions to WCAT do not state specifically which psychological conditions should be accepted but I gather from his previous Review Division submissions and Dr. Nader's report that he seeks to have the following accepted: Major Depressive Disorder, Somatic Symptom Disorder, Panic Disorder, and Agoraphobia.

[63] The case manager only considered "Depression and Anxiety". The review officer considered Major Depression with Anxiety and Pain Disorder. The diagnoses listed above that have not been considered by the case manager or review officer are Somatic Symptom Disorder, Agoraphobia, and Panic Disorder.

[64] Dr. Nader explained Somatic Symptom Disorder is when a person experiences one or more somatic symptoms that is distressing and results in a significant disruption in a person's life. Dr. Nader also explained Agoraphobia as anxiety in situations where escape may be difficult in the event of having a panic attack or panic-like symptoms. Dr. Nader explained Panic Disorder involved the experience of panic attacks followed by one of: a) persistent concern about additional panic attacks, b) worry about the implication and consequences of the panic attacks, or c) significant change in behaviour related to the panic attacks.

[65] I accept Dr. Nader's explanations and find these conditions are closely related to pain disorder and anxiety, which were considered by the Board and Review Division. Thus, I find I have jurisdiction to consider all of the diagnoses listed above in this appeal.

[66] I will discuss each medical opinion.

[67] Dr. Hait interviewed the worker and administered the Personality Assessment Inventory, the Beck Depression Inventory, and three questionnaires to assess pain beliefs and behaviour. The worker said he never sought psychological assistance in the past for mental health issues but felt low when his father died and admitted he had pre-existing pain in his low back and right knee. Dr. Hait said there was evidence that the worker had problems with depression and back pain before his work injury but the worker minimized their significance when asked about them. Dr. Hait said the worker was managing his job with medication prior to the work injury.

[68] Dr. Hait had access to the pain management program reports, which indicated the worker reported previous problems with anxiety and had taken medication for it. I find the worker's willingness to discuss his pre-existing mood problems at the pain management program lessens the concern that he was trying to hide them from medical professionals.

[69] The Board did not provide Dr. Hait with Dr. Aronshtam or Dr. Squire's pre-work injury records prior to his assessment. I have taken this into consideration in assessing the weight I give his opinion. I place less weight on his diagnoses because he did not provide detailed comments on the effects of the worker's pre-existing mood disturbances on his current state.

[70] Dr. Lai criticized Dr. Hait for not having the worker's prior medical records. She noted past records indicated he used percocet for pain and saw Dr. Squire for pain management. She said this contradicts the worker's denial that he had pain before the work injury. However, Dr. Hait's report is clear that the worker admitted he had pre-existing pain and never denied it. Dr. Lai said medical records show the worker saw Dr. Aronshtam for "Anxiety & Depression" in late 2011. This is not inconsistent with the worker's statement to Dr. Hait that he never sought psychological assistance in the past for mental health issues, but it does conflict with his statement that his mood was quite good just prior to the work injury. However, Dr. Hait was not aware there was evidence of pre-existing problems with depression and back pain and the worker was on medication prior to the work injury so he had considered these factors even though he did not have access to the worker's pre-work injury records.

[71] Overall, I find Dr. Lai's criticisms are tempered when one takes a closer look at what Dr. Hait actually said in his opinion and what the worker had told him. I give little weight to her criticisms of Dr. Hait's opinion.

[72] Ms. Rado reviewed the worker's pre-injury records and interviewed the worker and his brother in law. I accept Ms. Rado's evidence that the psychological symptoms he suffered before the work injury were different from the symptoms after his injury. I accept her review of the medical records and her explanation that prior to the work injury, the worker had some anxiety symptoms related to his joints, was given medication for sexual dysfunction, and had dysthymia (a condition that is much less severe than clinical depression). I accept her opinion that the worker was able to function with these issues before the work injury, but after the work injury, his psychological picture became very different. I give weight to Ms. Rado's evidence regarding her comparison of the worker's functioning before and after the work injury. I give no weight to her opinion on the diagnoses of the worker's mental conditions because she is not a registered psychologist.

[73] Dr. Saper interviewed the worker, reviewed the pre-injury records, and administered the Personality Assessment Inventory, the Structured Inventory of Malingered Symptomology, the Test of Memory Malingering, and the World Health Organization Disability Assessment Schedule. Dr. Saper said the worker's results showed his responses were likely invalid and was suggestive of malingering. I do not take issue with Dr. Saper testing the worker for malingering given the worker's apparent inconsistent statements about his pre-existing symptoms.

[74] Dr. Saper clearly took issue with the worker's credibility. Dr. Saper used words such as:

- "...did not enhance his credibility"
- "..did not reassure the writer that his verbal report of symptoms could be trusted"
- "...as there is no credible evidence on which to base a diagnosis"
- "...there was objective evidence of significant distortion in the worker's self report"
- "...[w]hen challenged, he did not offer any satisfactory explanation as to why his self-report was at variance with the written record..."

[75] The use of these words suggest, in my opinion, that Dr. Saper was acting more as an advocate despite his acknowledgment that he had a duty to be impartial and not act as an advocate.

[76] Moreover, Dr. Saper does not analyze whether it is possible the worker had mental disorders arising out of the work injury. He simply discounts it as not possible because of the worker's inconsistent statements in his history. I agree with Dr. Nader that Dr. Saper did not administer any psychometric testing to assess anxiety, depression, or chronic pain and appeared to be focused on assessing malingering. I also agree with Dr. Nader that Dr. Saper's comment that the "worker's self-report was unreliable to the point that it was unclear whether he had pain or not" ignores medical information that the worker has pain. Dr. Squire, a pain specialist, would be in the best position to determine whether the worker actually suffers from pain and her records and reports do not indicate she was concerned the worker was malingering. Dr. Aronshtam's records and reports also do not show any such concerns.

[77] These issues and the fact that Dr. Saper did not administer testing for the mental conditions in question is the basis for my conclusion to place little weight on his opinion. While it may be that Dr. Saper is biased against the worker in his opinion, I find the main fault in his opinion lies in the fact he did not perform a thorough assessment and his opinion is unreliable as a result.

[78] Dr. Nader interviewed the worker and his wife, reviewed the pre-injury records, and administered the Personality Assessment Inventory, Penn State Worry Questionnaire, Anxiety Sensitivity Index, State-Trait Anger Expression Inventory, Depression Anxiety Stress Scales, Short-Form McGill Pain Questionnaire, Pain Catastrophizing Scale, Pain Disability Index, and World Health Organization Disability Assessment Schedule.

[79] I give Dr. Nader's opinion the greatest weight because he set out the worker's history in great detail, obtained collateral information from the worker's wife, and administered more tests. He also explained the outcome of each of the tests administered. His report was thorough, detailed, and well reasoned.

[80] I accept Dr. Nader's opinion that the worker did not have Major Depressive Disorder prior to the work injury although he had episodes of low mood. I accept his opinion that the worker's depressive symptoms prior to the work injury were at a subclinical level. I appreciate the worker may not have been a "happy guy" as he stated but the records do not show he received any formal diagnosis of Major Depressive Disorder from a psychologist or psychiatrist prior to the work injury. I accept Dr. Nader's opinion that the worker's post-work injury depressive symptoms were much greater and met the criteria for Major Depressive Disorder. Dr. Nader acknowledged there may be other factors such as relationship conflicts and difficulties with the employer that contributed to the depressive symptoms, but he concluded the back pain and the impact of that pain was the primary contributing factor. I accept this opinion as it correlates with the medical records and Dr. Hait's opinion.

[81] I accept Dr. Nader's opinion that the worker's Somatic Symptom Disorder is directly related to his work injury. I agree with his finding that the worker's prior pain complaints did not interfere with his ability to work. I accept this opinion as it correlates with the medical records and Dr. Hait's opinion on the worker's Pain Disorder. I accept Dr. Nader's diagnosis of a Somatic Symptom Disorder over Dr. Hait's diagnosis of a Pain Disorder because Dr. Nader used the newer DSM-5[2] for assessment, whereas Dr. Hait used the DSM-IV.

[82] I accept Dr. Nader's opinion that the worker's Panic Disorder and Agoraphobia pre-existed his work injury. However, I do not accept his opinion that they were exacerbated by the work injury. The medical records do not show these conditions were increased significantly after the work injury. The records do not show the worker had

[2] The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, 4th and 5th Editions*

experienced agoraphobia after the work injury. Most of his anxiety was about his relationship, finances, and work. There was insufficient evidence he had fears about leaving his house. The level of his panic attacks also does not appear much changed from his pre-injury condition.

[83] I find the worker's Major Depressive Disorder and Somatic Symptom Disorder are compensable consequences of his work injury. I find the worker's Panic Disorder and Agoraphobia are not compensable consequences of his work injury.

Conclusion

[84] I allow the worker's appeal and vary *Review Reference #R0187293*.

[85] I find the worker's Major Depressive Disorder and Somatic Symptom Disorder are compensable consequences of his work injury.

[86] I find the worker's Panic Disorder and Agoraphobia are not compensable consequences of his work injury.

[87] Item #16.1.3 of WCAT's MRPP provides that WCAT will generally order reimbursement of expenses for obtaining or producing written evidence, regardless of the result in the appeal, where the evidence was useful or it was reasonable for the party to have sought such evidence in connection with the appeal. The worker requested reimbursement of the expense associated with Dr. Nader's report in the amount of $3,609.38. I find Dr. Nader's report was helpful and it was reasonable for the worker to have sought such evidence in connection with his appeal.

[88] The worker submitted that Dr. Nader's invoice is broken down as 13.75 hours at a rate of $250 per hour. He submitted his hourly rate is in line with the rates charged by psychologists with his expertise. He submitted Dr. Nader had specific expertise in pain, depression, and anxiety.

[89] The Board's psychologist fee schedule provides a maximum fee of $180 per hour.

[90] Item #16.1.3.1 of the MRPP provides a WCAT panel has the discretion to award reimbursement of an expert opinion in an amount greater than the fee schedule, but will do so only in limited circumstances. If the bill or account exceeds the Board fee schedule, the party seeking reimbursement of the full amount must explain the reasons the account exceeds the fee schedule, and why the panel should order reimbursement of the full amount. In the absence of a request and a satisfactory explanation of the circumstances, WCAT will limit reimbursement to the fee schedule amount. Examples of the limited circumstances include

- The issue being addressed is unusually complex.

- The expert was required to review a significant body of evidence and it was reasonable to do so.
- The expert has a high level of expertise in a unique area and it was reasonable to engage such an expert.
- There is limited availability of experts in the geographical area and it was reasonable to engage such an expert.
- The expert was required, for the purposes of providing the opinion, to test or examine parties or witnesses.

[91] In each case, even if the circumstances above exist, the principle of proportionality must be taken into account in determining whether to award reimbursement of an expert opinion in an amount greater than the fee schedule.

[92] I am not persuaded the worker's case involves any of these circumstances. The only item that may apply pertains to expertise level, but I do not accept pain, depression, and anxiety are unique such that it required a high level of expertise.

[93] The Board's fee schedule also caps the hours at 12 hours. I find this is only slightly above the maximum. I also note Dr. Nader administered numerous tests and his detailed breakdown of his hours on his invoice appears reasonable.

[94] I order the worker be reimbursed for Dr. Nader's report at a rate of $180 per hour at 13.75 hours.

Grace Chen
Vice Chair

GC/cv