WCAT Decision Number: WCAT-2004-00072-RB
WCAT Decision Date: **January 09, 2004**
Panel: Anthony F. Stevens, Vice Chair

Introduction

The worker appeals eight decisions of the Workers' Compensation Board (Board) that were communicated to him by decisions dated December 6, 1995, January 9, 1996, July 9, 1996, February 7, 1997, June 16, 1997, July 18, 1997, February 5, 1999 and March 7, 2001. Those decisions were in relation to his 1990 knee claim and his 1995 back claim.

A claims adjudicator undertook the December 6, 1995 decision to advise the worker that his 1995 back claim had been accepted by the Board. However, the claims adjudicator noted that the worker had a pre-planned vacation to Mexico for approximately one month commencing December 11, 1995 and suspended his entitlement to wage loss benefits for that absence.

A vocational rehabilitation consultant issued the January 9, 1996 decision in relation to the worker's 1990 knee claim to advise the worker that he would not be extended vocational rehabilitation benefits from January 31, 1993 to the end of November 1993. In particular, the vocational rehabilitation consultant noted that such benefits had been terminated by decision dated March 17, 1993 when the worker undertook no rehabilitation efforts, and were recommenced in November 1993 when he established that he was doing so. The vocational rehabilitation consultant indicated that the March 17, 1993 decision applied to the interval in question, and suggested that unless the worker was involved in rehabilitation efforts such benefits could not be paid.

The July 9, 1996 decision was forwarded to the worker by a claims adjudicator, and was in regard to his 1995 claim. The claims adjudicator advised the worker that costs associated with prescriptions for Leritine would not be accepted beyond the date of that decision.

An officer with the Board's Health Care Benefits Office provided the worker with the February 7, 1997 decision in relation to health care expenses under both his 1990 and 1995 claims. The Board officer indicated that costs associated with certain prescriptions had been accepted by the Board, but others were not. Specifically, the Board officer indicated that narcotic drugs such as the worker's prescriptions for Demerol, Talwin, and Oxycodan are only acceptable for eight weeks, such that further reimbursement would not occur and prescription receipts for such medications were being returned to him. The Board officer also declined to accept costs associated with Synthroid, on the basis that it was prescribed for hyperthyroidism and not for the injuries under his claims.

Also in relation to the 1995 claim was the June 16, 1997 decision. The claims adjudicator who undertook that decision concluded, on the advice of a Board medical advisor, that the worker had already been seen by a number of specialists and their opinions included the suggestion that there was no need for referrals to more specialists. The claims adjudicator noted that although two referrals took place when a previous appointment to see Dr. Brownlee did not come about, although the worker ultimately did see Dr. Brownlee costs associated with that consultation would not be accepted by the Board. The claims adjudicator acknowledged that the Board had extended transportation costs to the worker for his visit to see Dr. Brownlee, but suggested such costs were paid in error given that visit had not been pre-authorized. The claims adjudicator also concluded that the Board would not pay for any further consultations with specialists.

A vocational rehabilitation consultant provided the worker with the July 18, 1997 decision in relation to his 1995 claim and to advise that benefits were to end August 3, 1997. The vocational rehabilitation consultant noted the worker's statements that he was not capable of undertaking any form of employment. The vocational rehabilitation consultant noted that the worker had been extended job search allowances since May 5, 1997 and that such benefits were provided on the basis that he was considered capable of returning to suitable employment. As a result of the worker's contention that he was not employable the vocational rehabilitation consultant indicated that job search allowances could not be paid, as he was not actively pursuing vocational initiatives.

The Board provided the worker with the February 5, 1999 decision in relation to both his 1990 and 1995 claims. That decision followed pension assessment under both claims. The claims adjudicator who issued that decision advised the worker that there was no change in the level of his permanent knee disability under his 1990 claim, such that a change in entitlement from that reflected in the earlier award was not warranted. The claims adjudicator accepted that under the worker's 1995 claim he had entitlement to a 6.57 percent functional award, for 6.44 percent functional impairment and a 0.13 percent age adaptability. That award was effective May 5, 1997 and calculated with regard to $2,051.00 monthly average earnings. However, the worker's pension entitlement was provided on a loss of earnings basis pursuant to section 23(3) of the *Workers Compensation Act* (Act), and the dual system of pension assessment. In particular, the claims adjudicator acknowledged that the worker was unable to resume his pre-injury employment but concluded that he could undertake suitable alternate work such as a security guard and earn $1,400.00 per month doing so. His loss of earnings entitlement was calculated to be $497.01 per month, being 75 percent of the difference between his pre-injury and post-hearing earnings.

The March 7, 2001 decision was in relation to both the 1990 and 1995 claims. The case manager who undertook that decision advised the worker that there was no evidence that surgical intervention was warranted, as there was no nerve root deficit or

significant neurological compromise. The claims adjudicator also advised that the Board had accepted two further conditions under his 1995 claim, being chronic pain syndrome and depression. The case manager noted that the worker had been assessed by Dr. Weideman, who thought that psychotherapy would not likely make a difference in the worker's condition. The case manager further noted that the worker was subsequently referred to the Vancouver Pain Centre, and that he made some gains but still had limitations on discharge. As such, the case manager concluded that the worker had attained medical plateau status, as no further treatment or surgery was recommended. The case manager declined to provide the worker with wage loss benefits, and noted that he declined to work subsequent to August when he had been deemed fit to resume employment. The case manager referred the worker's 1995 file to the Board's Vocational Rehabilitation Services and Disability Awards Departments for consideration of what other benefits may arise given the further accepted conditions.

I have concluded that these appeals can be fully and properly considered without an oral hearing. As such, they have been determined following a review of the worker's 1990 and 1995 claim files, together with the arguments undertaken within the appeal documents and by way of a September 23, 2003 written submission from a workers' advisor. The employer did not participate in the worker's appeals, although it was invited to do so.

Issue(s)

There are eleven issues in these appeals. They are:

1. Whether the worker is entitled to vocational rehabilitation benefits between January 31, 1993 and November 22, 1993.

2. Whether the worker is entitled to wage loss benefits between December 10, 1995 and February 12, 1996.

3. Whether the worker was entitled to health care costs associated with his prescriptions for Demerol, Talwin, Oxycodan, Leritine, and Synthroid.

4. Whether the worker was entitled to health care expenses associated with his consultation with Dr. Brownlee.

5. Whether the Board appropriately indicated that no further consultations with specialists would be accepted under the claim.

6. Whether the vocational rehabilitation consultant appropriately terminated rehabilitation benefits effective August 3, 1997.

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

7. Whether the worker was entitled to an increased permanent partial disability award for his residual knee disability.

8. Whether the worker's award for residual back impairment was correctly determined by the Board. This includes consideration of the functional impairment assessment, the loss of earnings assessment, the effective date of the award, and the average earnings used to calculate the award.

9. Whether the worker was entitled to additional wage loss benefits in relation to his subsequently accepted depression and chronic pain syndrome.

10. Whether those conditions were appropriately accepted under the worker's 1995 claim.

11. Whether the worker had other psychological conditions that reasonably relate to his 1990 and/or 1995 claims.

Jurisdiction

These appeals were filed with the Workers' Compensation Review Board (Review Board). On March 3, 2003, the Board's Appeal Division and the Review Board were replaced by the Workers' Compensation Appeal Tribunal (WCAT). As these appeals had not been considered by a Review Board panel before that date, they have been decided as WCAT appeals. (See the *Workers Compensation Amendment Act (No. 2), 2002*, section 38.)

Under section 250 of the *Workers Compensation Act* (Act), effective March 3, 2003, WCAT may consider all questions of fact and law arising in an appeal, but is not bound by legal precedent. It must make its decision based on the merits and justice of the case, but in so doing it must apply policies of the board of directors of the Board which apply to the case, except in circumstances as outlined in section 251 of the Act.

This is an appeal by way of rehearing, rather than a hearing *de novo* or an appeal on the record. WCAT has jurisdiction to consider new evidence, and to substitute its own decision for the decision under appeal.

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

Background and Evidence

1990 BILATERAL KNEE CLAIM

The Board initially established the worker's 1990 claim for a left knee injury that he sustained in the course of his July 22, 1990 employment as a produce buyer. The worker unfortunately injured his right knee during his treatment, and the Board accepted that right knee injury as a compensable consequence of the claim.

The worker's long-term rate of compensation was determined to be $397.02 gross per week, which was calculated with regard to his earnings in the one year prior to his injury less an interval for which medical disability had been certified.

The worker underwent arthroscopic surgery to his left knee on March 5, 1991. That surgery was directed to a tear of the anterior horn of his medial meniscus and chondromalacia of his patella.

On November 26, 1991 the worker had arthroscopic surgery of his right knee to address the right medial meniscus tear he sustained during treatment of his compensable left knee condition.

On February 5, 1992 a Board medical advisor concluded that the worker required a Generation II brace for his right knee. On March 30, 1992 the orthopaedic surgeon, Dr. Vaisler, concluded that the worker required training to a lighter type of work. On September 21, 1992 another orthopaedic surgeon, Dr. Sundby, outlined the worker's evidence that he was nearly incapacitated due to pain in both knees. Dr. Sundby noted that examination established that the worker had pain and instability in both knees, right more than left, and that his pain could be explained by patellofemoral joint problems.

By decision dated May 21, 1992 the Board advised the worker that prolonged use of narcotic medications such as Tylenol No. 3 and Leritine was not indicated. The worker was further advised that prescription costs for narcotics or benzodiazepine would not be accepted beyond February 5, 1992. The worker did not appeal this decision of the Board.

The Board extended wage loss benefits to the worker to June 15, 1992. Those temporary disability benefits were terminated by decision dated June 4, 1992, which advised the worker that his condition was considered to be plateaued and no longer temporary in nature. The worker returned to work with his injury employer, although as a truck driver, and experienced further knee complaints. The Board extended further wage loss benefits to him from August 5 to 19, 1992, at which point his condition was again considered to have plateaued.

The worker was examined for residual functional disability assessment purposes on January 7, 1993. The worker complained of bilateral knee pain made worse with activity, weight bearing, walking, and stairs. Examination revealed crepitus with movement of both knees, some clunking on the left, and significant medial collateral laxity on the right. The disability awards medical advisor suggested that the worker should be assessed by an orthopaedic surgeon in relation to his significant retropatellar crepitus, and that he should also use the Generation II brace on his right leg. The disability awards medical advisor also advised that the worker may require antidepressants, but other medication apart from anti-inflammatories should not be accepted under this claim.

By decision dated February 3, 1993 the Board again advised the worker that narcotic medication was not considered appropriate in his case, as long-term use was contraindicated.

In a further decision issued on February 3, 1993 the Board advised the worker that his physical condition was again considered to have stabilized such that his entitlement to wage loss benefits would end.

A consultation report of February 13, 1993 contained Dr. Offer's opinion that the worker at that time probably had an element of fibromyalgia, and that given his unusual psychological status and delusions a psychological assessment was indicated. A February 17, 1993 consultation report of Dr. Mowry also indicated that a psychiatric consultation was recommended. A copy of a March 30, 2001 letter by Dr. Shaw to the Board included comment that the worker had been admitted to hospital on February 4, 1993 for depression and he also met some of the criteria for fibromyalgia.

The Board provided the worker with vocational rehabilitation assistance, initially through job search allowance. The worker's job search allowance was terminated by the Board by letter dated March 17, 1993. The vocational rehabilitation consultant indicated that such benefits could not be continued, as the worker advised that his knee complaints were sufficiently significant that he was unable to undertake job search activities.

A functional capacity evaluation indicated that the worker was able to undertake medium strength activities. However it also noted that he had difficulties lifting from lower levels, climbing stairs, and being compromised by reduced knee function. In a further functional capacity evaluation as performed on May 10, 1993 the worker demonstrated the ability to undertake light strength activities, although he was able to perform occasional medium strength activities. Suggested employment options included that of a jewellery manufacturer or hotel desk clerk. Thereafter, the Board sponsored six months of upgrading and training-on-the-job to enable the worker to return to work with his pre-injury employer to work on computer, office management, supervision, and advertising.

Of note, the May 10, 1993 functional capacity evaluation report indicated that the worker had previously been seen by Dr. Mollerup, a psychiatrist. A copy of that particular consultation report is on file. It establishes that the worker was assessed by Dr. Mollerup on April 13, 1993, who recommended use of amitriptyline as an antidepressant and to treat his chronic pain syndrome. Dr. Mollerup's report also indicated that the worker had anxiety and that there was a delusional disorder present with somatic preoccupation and associated major depression.

The Board also arranged for the worker to undergo an assessment by Dr. Paredes, a psychiatrist. That assessment took place on July 22, 1993 and in the associated report Dr. Paredes concluded that the worker fulfilled the DSM-III-R criteria for major depression, and that the depression was of moderate intensity. Dr. Paredes also said that the worker had some "pre-injury personality traits such as schizoid, schizotypical, paranoid and especially avoidant", although some of those had become more prominent since his injury. Dr. Paredes also concluded that there was no indication the worker had depression prior to his injury, and that the depression was the reason he had been hospitalized in February 1993. Dr. Paredes said:

> The combination of depression and delusions are not easy to treat…
>
> The specific questions about the relationship between his current psychiatric condition and his injury in 1990 is not an easy one. The emotional reaction, ie depression, anger and possible aggravation of these delusions are out of proportion to the knee injury. This is parallel to the development of chronic pain syndrome.
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> [reproduced as written]

Dr. Paredes undertook an October 28, 1993 memorandum that was sent to the claims adjudicator, and said therein that the worker's depression was likely related to the claim. In terms of the worker's delusional traits Dr. Paredes noted that the worker was functioning until his claim. Dr. Paredes in the end indicated that he considered "his current psychological problems as more than 50% related to this claim".

Dr. Mollerup subsequently treated the worker and in a November 10, 1993 consultation report outlined that he was "obviously more depressed" and expressed a sense of hopelessness, frustration, and anger that there had been no settlement through the Board. The worker was not working at the time, and was instead living off the proceeds of a tractor he sold previously.

A claims adjudicator undertook a November 15, 1993 memorandum on file to indicate that the worker's chronic pain and depression were accepted under the claim.

The worker was admitted to the hospital on January 6, 1994 for increased agitation, anxiety and depression. He was discharged on January 19, 1994.

A vocational rehabilitation consultant wrote the worker on May 5, 1994 to indicate that the Board had agreed to a training-on-the-job opportunity with his pre-injury employer that was to run from May 16, 1994 to October 30, 1994.

By decision dated January 4, 1995 the Board awarded the worker a 10.50 percent functional pension in relation to his residual bilateral knee disability. That award was effective June 15, 1992 and was calculated with regard to $1,725.00 gross monthly average earnings. The claims adjudicator who issued that decision also concluded that the worker had not sustained a loss of earnings consequent to his functional disability, as he had resumed alternate employment with his pre-injury employer.

The worker sustained a low back injury on November 3, 1995. That is the injury for which the Board established the worker's 1995 claim. The details of that injury will be outlined later in these findings.

The worker's knee impairment was reassessed on June 5, 1998, at which time full range of movement was observed and knee laxity was considered to be comparable to what had existed during the previous disability assessment. The disability awards medical advisor concluded that the worker had no increased knee impairment, and that conclusion was a component of the February 5, 1999 decision that the worker has appealed.

A workers' advisor wrote the Board on June 5, 2000 to request consideration of an award for permanent psychological impairment. The workers' advisor noted that the worker had previously been assessed by Dr. Mollerup and Dr. Paredes, and also that on November 15, 1993 a claims adjudicator had accepted depression and chronic pain syndrome under the claim. The workers' advisor attached an April 3, 2000 report of Dr. Anderson, who outlined the worker's evidence that since his 1995 back injury he had become more depressed. Dr. Anderson indicated that the worker had Adjustment Disorder with depression, some mild schizoid-paranoid features, back injury and knee injury, and fibromyalgia. Dr. Anderson said:

> Based on the examination of this man today I believe that he is unemployable and he is in chronic pain.
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> [reproduced as written]

The Board's Claims Department ultimately undertook a referral to their Disability Awards Department on February 14, 2001, which indicated that the worker's chronic pain and depression were accepted. However, that referral document establishes that those conditions were accepted under the worker's 1995 back claim.

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

1995 BACK CLAIM

The Board accepted this claim for a low back injury that the worker sustained on November 3, 1995 as a clerk at the produce operation where he had sustained his 1990 compensable injury. The worker's back injury occurred when he attempted to adjust the fork on a forklift.

In issuing the December 6, 1995 decision that the worker has appealed, the Board indicated that his claim was accepted for a low back strain. In a subsequent decision of April 29, 1997 the Board indicated that the worker's injury included a compensable aggravation of underlying degenerative disc disease between L4 and S1. On December 14, 1998 the Board advised the worker that a small disc protrusion found at the L5-S1 level of his spine was considered to have resulted from the injury sustained under his claim.

In terms of the suspension of wage loss benefits when the worker went to Mexico on a pre-arranged vacation, the Board suspended his benefits effective December 10, 1995. The Board subsequently reinstated wage loss benefits commencing February 12, 1996, being the date the worker sought medical attention on his return to Canada. The worker's evidence to the Board was that he sought medical attention in Mexico on December 20, 1995 and January 3, 1995. He sought reimbursement of costs associated with those medical visits.

The worker's long-term rate of compensation was determined by the Board with regard to the $20,838.00 employment income that he had in the one year prior to his 1995 back injury. That calculated to a $469.02 gross weekly rate of compensation.

By decision dated June 3, 1996 the Board advised the worker that his cervical complaints were not likely associated with this claim.

A neurosurgeon, Dr. Faridi, assessed the worker on June 11, 1996 and concluded that a myelogram that had been performed revealed disc bulging but no nerve root compression. Dr. Faridi stated that surgery was only indicated because of the worker's pain. A Board orthopaedic consultant, Dr. Sabir, examined the worker on August 1, 1996 and indicated that the myelogram revealed a small central disc herniation at L4-5 and a centrally-projecting vertebral endplate osteophyte at L5-S1 that indented the thecal sac. Dr. Sabir, however, also concluded that there was no neurological deficit and that as such disc surgery was not indicated.

The worker's attending physician, Dr. Sokol, thereafter referred the worker to Dr. Brownlee for further opinion on whether lumbar disc surgery was indicated. Dr. Brownlee, a neurosurgeon, undertook a consultation report on October 2, 1996 to indicate that the worker had back pain of uncertain etiology, with no specific radicular finding evident. Dr. Brownlee indicated that he intended to review the imaging studies

that had been performed previously. On February 20, 1997 Dr. Calder, a specialist in physical medicine and rehabilitation, performed EMG studies and noted that the EMG nerve root screen was normal, including in relation to the worker's lumbar spine. On March 13, 1997 a Board physiatrist, Dr. Murray, examined the worker. MRI scanning was completed on March 12, 1997 in preparation for that assessment. Dr. Murray concluded that the worker had mechanical low back pain and there was an absence of evidence of significant disc herniation or nerve root compromise. Dr. Murray recommended abstinence from drugs and a graduated return to normal activity.

Dr. Sokol undertook a letter on April 15, 1997 to support the worker's application for Canada Pension Plan disability benefits. Dr. Sokol outlined therein that the worker had chronic low back pain, he was not a surgical candidate, and those back problems precluded a return to manual labour. Dr. Sokol also noted that the worker had bilateral knee problems which also precluded manual labour. Dr. Sokol further noted that the worker had marked depression and his present state of mind precluded any gainful employment.

The Board terminated the worker's wage loss benefits effective May 4, 1997 when they concluded that his back condition was no longer temporary in nature. The claims adjudicator who undertook the associated April 29, 1997 decision referred the worker's file along for consideration of entitlement to vocational rehabilitation and permanent disability benefits.

The worker was provided with job search allowances commencing May 20, 1997. He was advised by decision dated May 20, 1997 that he was to fully participate in job search efforts, and that in order to remain eligible he had to provide a record of his efforts. It was thereafter that the Board issued the June 16, 1997 decision to indicate that no further medical consultations would be accepted, and the July 18, 1997 decision to terminate job search allowances. The worker next wrote the Board to enquire whether he would get other benefits or a pension to replace his lost income.

Dr. Brownlee wrote the Board on July 30, 1997 to say that he reviewed the imaging studies and they revealed some disc abnormalities at L4-5 and L5-S1. That said, Dr. Brownlee indicated that those changes were minor and there was no specific abnormality which could produce nerve root compression or require surgery.

On a number of occasions the worker informed both his doctors and the Board that he requires narcotic medications in order to deal with his ongoing pain. He held the view that the Board's limitation of coverage for only eight weeks of such medication was unreasonable.

An August 25, 1997 consultation report on file establishes that the worker was hospitalized when he became acutely distressed. The worker apparently had threatened to commit suicide as well as blow up the Board. He was medicated and the

consultant, Dr. Whitman, outlined that the worker had severe depression with some obsessional compulsive components.

A disability awards medical advisor examined the worker on June 5, 1998 and concluded that the worker had residual signs and symptoms associated with his low back and right lower extremity. The disability awards medical advisor concluded that those difficulties were associated with the worker's degenerative disc disease at L4-5 and his disc protrusion at L5-S1. The worker was found to have what was described as fairly restricted lumbar extension and moderate restriction in flexion. Right and left lateral flexion were also reduced. The worker's total functional back impairment was assessed as being 6.44 percent of total.

A claims adjudicator in the Board's Disability Awards Department completed a memorandum on January 12, 1999 to indicate that the worker was to be provided with the 6.44 percent functional award, but he had sustained a loss of earnings in excess of that amount. In terms of possible future employability the claims adjudicator concluded that the worker could be retrained into positions such as computer warehouse/buying, condominium/apartment manager, or security guard. The claims adjudicator noted the vocational rehabilitation consultant's concern with the condominium/apartment manager position about how the worker might react to difficult tenants and concluded that position was not likely suitable. The claims adjudicator also concluded that the position of computer warehouse/buying was not available, such that it would not be used in the loss of earnings assessment. In the end, the claims adjudicator concluded that the worker could become a security guard and earn $1,400.00 per month in 1995 dollars from such employment.

The Board next issued the February 5, 1999 pension decision. The worker continued to maintain that he was unemployable.

The worker completed a chronic pain program at the Vancouver Pain Clinic on January 19, 2000. The associated reports indicated that in addition to his physical complaints he had depression, anger, and anxiety. The worker made some limited functional gains and had some reduction in his medication usage.

A further MRI scan was undertaken on July 13, 2000 and according to a subsequent August 18, 2000 consultation report by Dr. Boshoff revealed a mild to moderate posterior protrusion of L4-5. A Board medical advisor, Dr. Atkins, reviewed the MRI and in noting the new findings as well as the worker's increase in right leg radicular pain since about May 2000 concluded a further neurosurgical consultation by Dr. Boshoff was indicated. Dr. Atkins also concluded that the new finding of a sequestrated L4-5 disc represented acceleration of the worker's underlying degenerative disc disease, with that acceleration resulting from the compensable injury.

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

By decision dated September 19, 2000 the Board accepted the sequestrated disc fragment found at L5-S1 of the worker's spine, on the basis that his injury had accelerated his underlying degenerative disc disease. The Board also advised that an appointment with a neurosurgeon was being arranged.

Dr. Weideman undertook an extensive report to detail the results of her psychological assessment of the worker. She stated therein that:

- There was documented medical opinion that the worker suffered from either a delusional disorder, an anxiety disorder, or hypochondriasis before the 1990 and 1995 work injuries but "none of those conditions is currently active".

- Per DSM-IV the worker was suffering from a diagnosed Pain Disorder Associated with Both Psychological Factors and a General Medical Condition, as well as an Adjustment Disorder with Depressed Mood. Both of those conditions were stable.

- In AMA Guide terms the worker met the criteria for Chronic Pain Syndrome.

- The currently active diagnoses were related more to the back injury than to the knee injury, although there was subjective distress during the 1990 knee injury claim. It was likely that the 1990 and 1995 claims contributed to his current psychological status.

- The worker had a premorbid vulnerability, rather than a pre-existing personality disorder.

Dr. Bishop at the Visiting Specialists Clinic examined the worker on October 20, 2000 and concluded that he had mechanical back pain with a discogenic component, although examination did not reveal any objective evidence of spinal nerve root deficit. Dr. Boyd at the Clinic also examined the worker on that date and concluded there was significant pain magnification and some inappropriate pain behaviour. Dr. Boyd concluded that the small sequestrated disc fragment found on the July 13, 2000 MRI was not of any significance in the worker's overall complaints and that surgery was not indicated.

The Board arranged for the worker to be assessed by Dr. Bogyo, a registered psychologist. Dr. Bogyo undertook a report on May 30, 2001 to indicate that the worker had been assessed on May 18, 2001 and he presented as depressed and emotionally unstable. Dr. Bogyo indicated that the worker presented with many symptoms consistent with schizoaffective disorder and that no definitive plan could be made to treat his depressive symptoms and emotional instability without psychiatric involvement. In a further report undertook on August 15, 2001 Dr. Bogyo said:

> Attempts were made to engage [the worker] in treatment for depression and to provide supportive psychotherapy. After our second session, it was clear that the underlying personality disorder was interfering with progress toward better coping with depressive symptoms…It was determined that [the worker] may benefit from a psychiatric consult to better establish appropriate treatment for pain, depression, and an underlying thought disorder of marginally delusional proportions. Dr. John Snelgrove, psychiatrist, agreed to see the patient in [a town in BC] but [the worker] claimed that he was "broke and in too much pain to attend".
>
> [The worker] was upset with the writer because I failed to attend a follow-up appointment. I explained to him that no additional progress could be made until he complied with a meeting with psychiatry…
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> [reproduced as written]

On September 13, 2001 a Board psychologist commented that according to Dr. Boygo's opinion the worker had a thought disorder, being delusional, that was unrelated to his claim. Moreover, that thought disorder made dealing with any other psychological problem, or even assessing such problems, impossible. The Board psychologist indicated that a psychiatric assessment and likely medication would be required prior to evaluating the worker any further.

On October 16, 2001 the Board declined to provide the worker with transportation expenses related to his consultation with Dr. Faridi that was to occur on January 10, 2002. The Board's decision was that the consultation with Dr. Faridi was not a medical requirement under the worker's claim. In a further decision that was issued by the Board on January 30, 2002 the Board again declined to provide the worker with transportation expenses for the visit to Dr. Faridi, as well as costs associated with the consultation itself. The case manager who issued that decision also advised the worker that the Board was not accepting the percutaneous radiofrequency facet rhizotomy that had been proposed by Dr. Faridi, as he suggested that it may only provide some benefit and such benefit could be temporary only. In particular, Dr. Faridi's January 10, 2002 consultation report outlined that there was no indication for an invasive surgical procedure or discectomy, but he could benefit from percutaneous facet rhizotomy but "only 50% of patients have some benefit" and benefits varied "from 10% to 80% and benefit may last only 6 months or less and sometimes longer". Dr. Faridi also noted that, "I have also advised the patient that this procedure never has that much improvement that the patient could return to work but certainly may make life a little easier".

Board medical advisor Dr. Atkins provided a January 17, 2002 opinion on file that the proposed rhizotomy should not be accepted by the Board as appropriate treatment, as the medical opinion was that surgical intervention was not warranted and the worker

was known to have pain problems with no clear anatomical correlation to his variable complaints. Dr. Atkins also noted that there were psychological matters further complicating the worker's claim.

In a report of September 11, 2002 Dr. Faridi indicated that the worker had quite a good result with the rhizotomy, although he was likely to continue to have pain and disability.

To date, the Board has not assessed the worker's potential disability entitlement associated with his accepted depression and chronic pain syndrome.

The workers' advisor undertook a number of submissions associated with the worker's appeals. He seeks a number of remedies including a finding that the worker is entitled to wage loss for the time he was in Mexico, a finding that he is unemployable, and a finding that he is entitled to a pension award for psychological impairment retroactive to Dr. Paredes' October 23, 1993 consultation report. He also argued that the worker is entitled to continued reimbursement of narcotic medications, and that they disputed the Board's decision declining costs for Dr. Brownlee's assessment. The workers' advisor also indicated that they disputed the decisions terminating vocational rehabilitation assistance. Specific arguments undertaken by the workers' advisor included the following:

- The worker is entitled to a loss of earnings award. He is in receipt of a 10.50 percent functional pension award for his knees and 6.44 percent for his back. The effect of the worker's psychological conditions on his employability has not been adjudicated, but there is medical opinion on file that the worker is unemployable.

- The worker's pension for psychological impairment should be retroactive to 1993. Also, the panel could conclude that the Board should have determined the matter of psychological impairment and refer that matter back to the Board for a determination pursuant to section 246(3) of the Act.

- The Board's denial to provide the worker with health care benefits for narcotic medication "is inconsistent with the Board's ability to vary its own practice regarding narcotic medication". In the worker's case his attending physician prescribed that medication to treat the effects of his compensable injuries.

- The worker is entitled to wage loss for the time he was in Mexico. The trip was approved by the case manager, who also advised the worker that payment of wage loss could be considered subsequently if the worker was able to provide proof that he undertook treatment. The worker provided the Board with such documentation and accordingly should have been extended wage loss benefits from December 10, 1995 to February 9, 1996.

Reasons and Findings

I have outlined the evidence in some detail as it pertains to the issues under appeal, in hopes that it will assist the reader with understanding the background to the conclusions to follow.

December 6, 1995 Decision

The workers' advisor correctly noted that the claims adjudicator did request the worker to provide documentation respecting treatment that he undertook during his vacation to Mexico, and the worker did so. However, according to the worker he sought medical attention only on December 20, 1995 and January 3, 1996 and accordingly there is little to support an argument that the worker was under more continuous medical care while on vacation from December 10, 1995 and February 12, 1996 when he again saw his attending physician. Section 57(2) of the Act provides the Board with the discretion to suspend benefits in the event a worker persists in injurious or unsanitary practices, or fails to submit to medical treatment considered reasonably essential to promote recovery. In the worker's case there is no medical opinion to suggest that there was such necessary treatment at that time. There is similarly no medical evidence to support an argument that the worker's recovery was prolonged due to the vacation that he took. Accordingly I find that there was no apparent valid reason for the Board to have suspended the worker's entitlement to wage loss benefits for the interval at issue.

More significantly, Board policy pertaining to pre-planned vacations that are taken while in receipt of wage loss benefits is contained in item #34.41 of the *Rehabilitation Services and Claims Manual, Volume 1* (RSCM), which provides:

> If a vacation period or statutory holiday occurs while a worker is receiving wage-loss benefits, the Board continues to pay those benefits or, in the case of a pay employer claim, to the employer.

In the result, I vary the Board's December 6, 1995 decision and find that the worker is entitled to wage loss benefits between December 10, 1995 and February 12, 1996.

January 9, 1996 Decision

The Board's decision to decline vocational rehabilitation benefits between January 31, 1993 and November 22, 1993 was based on the worker's statement that his bilateral knee complaints were sufficiently significant that he was unable to undertake any employment. Moreover, he was not actively participating in any vocational rehabilitation endeavor during that particular interval and the Board only reinstated such benefits once the worker directed his attention to possible future employment options.

Section 16 of the Act provides that the Board may provide entitlement to vocational rehabilitation that it considers is necessary or expedient to lessen or remove a resulting handicap. In turn, Board policy as outlined in item #85.30 of the RSCM is that:

> Successful vocational rehabilitation requires that workers be motivated to take an active interest and initiative in their own rehabilitation. Vocational programs and services should, therefore, be offered and sustained in direct response to the commitment and determination of workers to re-establish themselves.

I confirm the Board's January 6, 1996 decision to decline to provide the worker with vocational rehabilitation assistance between January 31, 1993 and November 22, 1993. In short, the worker maintained that he was unable to work and was not undertaking any active vocational rehabilitation during that interval. Therefore, it follows that he was not entitled to vocational rehabilitation allowances for that period.

However, additional comment is necessary.

The Board had previously terminated the worker's entitlement to wage loss benefits under the 1990 claim on the basis that that his bilateral knee disability had stabilized and was no longer temporary in nature. That is not a matter before me in the context of the present appeals. It is notable, however, that as early as February 1993 there were questions raised about the worker's psychological status and thereafter assessments were undertaken that confirmed that the worker had depression and chronic pain syndrome.

Although I find that the worker was not entitled to vocational rehabilitation allowances between January 31, 1993 and November 22, 1993 the Board has not considered whether the worker remained temporarily disabled and entitled to wage loss benefits during that interval. Specifically, on November 15, 1993 the Board ultimately accepted that the worker had depression and chronic pain syndrome consequent to his 1990 knee claim, that investigation and adjudication occurred during the interval at issue here, and it could reasonably be argued that the worker was entitled to wage loss benefits for that interval. That is not a matter for me to decide in this appeal and, accordingly, I refer it back to the Board for initial adjudication and decision.

July 9, 1996 Decision

This decision involved the Board's decision to deny continued prescriptions for Leritine under his 1995 claim.

Section 21(6) of the Act provides that health care must at all times be subject to the direction, control and supervision of the Board.

Leritine is a narcotic analgesic medication, and as such Board policy as outlined in item #77.30 of the RSCM applies. It provides that:

> Board responsibility for narcotic analgesics, hypno-sedatives and tranquilizers…will be limited to a post-injury or post-surgery period of eight weeks. An extension of this eight-week period may be considered, however, where there are special or extenuating circumstances; for example, where a worker has received or will receive, a permanent disability pension and requires regular intermittent and limited narcotic preparation for the relief of pain.

The worker's position has at all relevant times been that he requires unfettered access to narcotic medications in order to cope with his pain. In contrast, there is relative unanimity in medical opinions from both Board medical advisors and the treating specialists that such drug use is contraindicated. I also note that the pain program the worker attended attempted to reduce such medication use, rather than endorse continued use. On my review of the totality of the medical evidence on file I find that the use of narcotic medication such as Leritine is contraindicated for the worker.

I acknowledge that he has received a pension in relation to his back complaints under his 1995 claim, but the Board's policy referred to above does not provide for an absolute entitlement. Board policy instead suggests that any entitlement is limited and discretionary. From the evidence before me I confirm the Board's July 9, 1996 decision and find that the worker was not entitled to further reimbursement in relation to Leritine prescriptions under his 1995 claim.

February 7, 1997 Decision

For the same reasons outlined above I find that the Board appropriately declined to accept continued prescription costs under the worker's 1990 and 1995 claims for Demerol, Talwin, and Oxycodan.

Also, Synthroid was prescribed for the worker's longstanding hyperthyroidism and not for the effects of either injury.

As such, I confirm the Board's February 7, 1997 decision.

June 16, 1997 Decision

This decision under the worker's 1995 claim was that costs associated with an earlier assessment by Dr. Brownlee would not be accepted, as in the Board's view the worker had been assessed by a number of specialists previously and no surgery was indicated. The Board also indicated that no further consultations would be accepted.

On the second issue identified in the preceding paragraph it is clear that portion of the Board's decision is moot. Specifically, the worker underwent subsequent consultations, including those arranged at the Board's initiative, and associated health care expenses were accepted under his claim. I find, therefore, that there is no longer an appealable issue on the aspect of the Board's June 16, 1997 decision that no further consultations would be accepted under the worker's claim.

I also tend to accept the Board's decision that the earlier assessment by Dr. Brownlee was unnecessary. It warrants mention that Board policy does not preclude a worker from exercising his or her own personal choice of practitioner. Also, section 21(7) of the Act states:

> Without limiting the power of the board under this section to supervise and provide for the furnishing of health care in every case where it considers the exercise of that power is expedient, the board must permit health care to be administered, so far as the selection of a physician or qualified practitioner is concerned, by the physician or qualified practitioner who may be selected or employed by the injured worker.

Item #74.50 of the RSCM also notes that any decision not to allow a claimant the "qualified practitioner" of choice must be justified by a judgment made in a particular case that the selection would be medically unsound by reason of circumstances relating to that particular case. In the worker's case I endorse the Board's view that the earlier consultation with Dr. Brownlee was not necessary given the previous numerous investigations and consultations that preceded it.

However, the June 16, 1997 decision further acknowledged that the Board had extended travel expenses to the worker to attend that earlier consultation. While the claims adjudicator who undertook the June 16, 1997 may have viewed the payment of those earlier travel expenses to have been in error the fact remains that the Board previously knew of the appointment and extended benefits to the worker to attend it. In the end, I find that the worker thereafter acted appropriately when he attended that earlier assessment by Dr. Brownlee, and that he acted reasonably on the belief that the Board had endorsed that visit. In such circumstances I vary the June 16, 1997 decision and find that the worker is entitled to health care costs that are reasonably associated with that consultation with Dr. Brownlee.

July 18, 1997 Decision

I confirm the decision to terminate the worker's vocational rehabilitation benefits under his 1995 claim effective August 3, 1997. In short, the worker maintained that he was not employable, and he was not undertaking any vocational rehabilitation for which such benefits could be directed.

February 5, 1999 Decision

I confirm the conclusion that there was no objective change in the worker's pensionable bilateral knee disability. That was the opinion of the disability awards medical advisor and I have no contrary expert medical opinion before me on that particular matter.

Similarly, the disability awards medical advisor indicated what range of motion deficits existed in relation to the worker's low back, and that residual disability calculated to 6.44 percent of disability. I confirm the decision to provide the worker with that level of entitlement for back impairment, together with the 0.13 percent age adaptability factor. I also find that the May 5, 1997 effective date was correct, as was the long-term earnings used to calculate the award.

Other matters warrant consideration related to the worker's pension entitlement, particularly in regard to the loss of earning assessment as well as the fact that the Board ultimately accepted that the worker had depression and chronic pain syndrome as compensable consequences under his 1995 claim. That issue will be discussed subsequently in my decision, and although my findings differ somewhat with the Board the end result is that the worker's pension entitlement cannot be properly determined without assessment of the worker's accepted psychological condition.

In the end, I find:

- The Board referred the worker's compensable psychological condition for pension assessment. That assessment did not take place, and the file suggests that was because the worker's thought disorder made it difficult to evaluate the worker's compensable psychological condition. While there may very well be difficulties in that regard I nevertheless find that the worker's accepted compensable psychological condition of depression and chronic pain syndrome (and per later Pain Disorder) requires a determination of what level of functional impairment may be warranted in the worker's case. I return the worker's files back to the Board to complete that determination.

- There is also an abundance of comment on the worker's claim file that the worker's psychological condition significantly impacts on his employability. That too requires assessment, and a determination on whether an increase in the loss of earnings award is indicated.

- In terms of the present loss of earnings assessment on file I find that it was incomplete, as it did not include consideration of the impact of the worker's psychological condition that the Board ultimately accepted under the worker's claim. I nevertheless note that I disagree with the Board's decision that the worker could undertake work as a security guard given both his knee and back disabilities. With respect, there is a paucity of information related to what is associated with such a position and whether it is physically suitable. The matter

of the worker's future employability, however, requires a complete assessment that includes consideration of his functional disabilities and his compensable psychological conditions.

March 7, 2001 Decision

At the outset, I decline to undertake a section 248(3) of the Act referral to the Board. That type of referral is limited to the situation where the Board has overlooked consideration of a matter. In the worker's case, although he was initially diagnosed with psychological conditions in 1993 the Board ultimately formalized acceptance of them, although under the 1995 claim. As a result, a referral is not necessary.

I confirm the Board's decision that the worker was not entitled to wage loss benefits in relation to his accepted psychological condition as it existed when the March 7, 2001 decision was rendered. The medical evidence indicates that the worker's psychological condition was plateaued at that time, such that temporary disability benefits are not indicated.

I vary the Board's decision to accept the worker's depression and chronic pain syndrome under his 1995 claim. That is not to say that the worker's 1995 claim was not responsible for a part of those specific difficulties, and in fact the directed assessment performed by Dr. Wiedeman indicates that the worker's psychological diagnoses were related more to the 1995 back injury than the 1990 knee injury.

The difficulty with the Board thereafter attributing all of the worker's depression and chronic pain syndrome to his 1995 claim is that those diagnoses were undertaken previously in 1993 under his 1990 claim. Moreover, the Board already accepted those conditions according to an earlier 1993 memorandum on his 1990 claim file. As a result, I find that the worker's depression and chronic pain syndrome are at least in part caused by his 1990 injury and that any pension assessment must consider that portion as entitlement under that claim. I leave it to the Board to apportion causation and resulting disability between the 1990 and 1995 claims.

One further consideration is necessary. Dr. Weideman also indicated that the worker had a DSM-IV diagnosed Pain Disorder with Both Psychological Factors and a General Medical Condition, as well as an Adjustment Disorder with Depressed Mood. She also indicated that the current active psychological diagnoses, of which these were two, were associated with worker's 1990 and 1995 claims. The March 7, 2001 decision failed to include those two diagnoses, although the consideration underway by the Board was in relation to what psychological sequelae were compensable. My finding, therefore, is that the worker's Pain Disorder and Adjustment Disorder are also compensable, and I refer apportionment between the claims back to the Board for determination.

It follows that the worker's depression, chronic pain syndrome, Pain Disorder, and Adjustment Disorder require assessment for potential functional disability award and loss of earnings entitlement.

In summary, I find:

1. The worker is not entitled to vocational rehabilitation benefits between January 31, 1993 and November 22, 1993, as he was not participating in any vocational rehabilitation during that interval.

2. The worker may be entitled to temporary wage loss benefits during that specific interval for psychological conditions that were being investigated and were accepted under his 1990 claim by the Board. I refer this particular matter back to the Board for adjudication.

3. The worker is entitled to wage loss benefits under his 1995 claim between December 10, 1995 and February 12, 1996 when he went to Mexico on a pre-planned vacation.

4. The worker is not entitled to health care costs associated with his prescriptions for Demerol, Talwin, Oxycodan, Leritine and Synthroid.

5. The worker is entitled under his 1995 claim to health care costs associated with the consultation undertaken by Dr. Brownlee.

6. The issue of whether further consultations with specialists should be accepted by the Board is moot, as the Board did ultimately accept such further consultations.

7. The worker is not entitled to vocational rehabilitation benefits beyond the August 3, 1997 termination of such benefits by the Board, as he was not undertaking any vocational rehabilitation.

8. The worker is not entitled to an increased pension award under his 1990 claim for residual bilateral knee disability.

9. The worker's back impairment under his 1995 claim was appropriately determined by the Board to be 6.44 percent plus 0.13 percent for age adaptability, or 6.57 percent of total. The effective date of the award and the average earnings used to calculate the award are also correct.

10. The position of security guard used to determine the worker's entitlement to a loss of earnings award was not likely suitable, given his physical disabilities. Moreover, it was premature to consider potential future employability without regard to the depression and chronic pain syndrome that the Board accepted.

11. The worker's chronic pain syndrome and depression were plateaued when the March 7, 2001 decision was undertaken by the Board, such that temporary disability benefits were not indicated at that time.

12. The worker's accepted chronic pain syndrome and depression are to some degree the result of his 1990 claim. Those conditions were diagnosed prior to the 1995 claim and had been accepted by the Board in 1993 under the worker's 1990 claim. The Board has yet to undertake permanent disability assessment for those conditions, and as such I refer both files back to the Board to determine what functional disability exists, the apportionment between both claims, and the effect those conditions have on the worker's future employability.

13. The worker has also been diagnosed as having a DSM-IV Pain Disorder with Both Psychological Factors and a General Medical Condition, as well as an Adjustment Disorder with Depressed Mood. The medical evidence is that those conditions were also associated with the worker's 1990 and 1995 claims. I find those conditions are compensable and refer the questions of apportionment and what benefit entitlement may arise back to the Board for adjudication.

No appeal expenses were requested.

Conclusion

I confirm the July 9, 1996, February 7, 1997, and July 18, 1997 decisions. I vary the December 6, 1995, January 9, 1996, June 16, 1997, February 5, 1999 and March 7, 2001 decisions.

Anthony F. Stevens
Vice Chair

AFS/cmm/gl