Noteworthy Decision Summary

Decision: WCAT-2004-04903 **Panel:** Randy Lane **Date:** September 21, 2004

Jurisdiction of Review Division – Findings Beyond the Decision Under Review – Review Officer Exceeding Jurisdiction – Determinations Cancelled – Section 96.2(1) of the Workers Compensation Act

Pursuant to section 96.2 of the *Workers Compensation Act* (Act), a review officer's jurisdiction is limited to matters decided by the Workers' Compensation Board (Board) in the decision under review. A review officer exceeds her jurisdiction if she makes findings about a worker's claims other than those dealt with in the decision under review.

The worker had a complex history of knee injuries, surgeries and claims. The worker sought review of a refusal to reopen one claim. The issue on the reopening was whether there had been a significant change in his symptoms. The review officer made a finding that certain medical conditions were not caused by the worker's work, and that a certain medical condition was not accepted, contrary to claim log entries on the file.

In order to determine the jurisdiction of the Workers' Compensation Review Division (Review Division), the panel considered its origins. The panel referred to the Core Services Review report issued by Alan Winter in March 2002, which recommended that the Review Division have a broad scope of review to avoid the delay and frustration which often arises when matters must be referred back to the Board and then be subject to a new application for review. Policy items A3.6 and B4.4 of the Review Division's *Practices and Procedures* seem to adopt this broader view, in that they permit a review officer to deal with a new issue or change a decision if it is essential, not too complex, and the evidence needed is available or easily obtainable. The panel stated that no statutory authority is provided for this broader jurisdiction, noting that section 96.2 of the Act is the only section granting the Review Division authority. Pursuant to section 96.2(1), the jurisdiction of a review officer is limited to the decision being reviewed, regardless of the desirability of addressing all possible matters to avoid cycling through the appellate system. The panel cancelled the determinations made by the review officer in excess of her jurisdiction.

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

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Panel: Randy Lane, Vice Chair

Introduction

The worker's claim for an October 19, 1988 left knee injury was accepted by the Workers' Compensation Board (Board). Temporary disability benefits were paid for three days in October 1988. (The worker had experienced left knee symptoms as early as 1983.)

The claim was reopened for temporary disability benefits for the periods from February 1989 to June 1989, July 1989 to July 1990 (save for brief periods in October 1989), and September 1991 to May 1992. The worker underwent a December 1988 arthrogram and several surgeries (April 1989: arthroscopic partial meniscectomy; March 1990: shaving of the medial femoral condyle, drilling of chondral defect on the medial femoral condyle, and an open patella shave; January 1992: arthroscopic medial meniscectomy and debridement; and July 1998: arthroscopic debridement). The worker also suffered further knee injuries (December 1988, September 1990, December 1995, July 1996, December 1997, and May 1998). The claims for injuries in July 1996 and May 1998 were consolidated into claims for the other injuries. A medical report from January 1990 refers to the worker having fallen and scraped his knee while running.

His claim for the October 1988 injury was reopened for the payment of temporary disability benefits for the period from December 12, 1997 to July 15, 2001. (The payment for this period was not seamless, as there were developments on the claim which resulted in the eventual payment of benefits for that period.) The worker was then paid vocational rehabilitation benefits from July 16, 2001 until February 24, 2002. Those benefits terminated, as the worker indicated that he was in too much pain to be able to return to work.

By decision of April 17, 2003 the worker was advised that his claim would not be reopened because there had not been a significant change in his condition of either a temporary or a permanent nature. In her December 10, 2003 decision (*Review Reference #5938* viewable on the Board's website on the Internet at http://www.worksafebc.com/) a review officer of the Board's Review Division confirmed the April 17, 2003 decision.

The worker appealed the December 10, 2003 decision to the Workers' Compensation Appeal Tribunal (WCAT). He provided a January 26, 2004 notice of appeal which was accompanied by a January 25, 2004 submission. The worker's 1988 employer is

no longer registered with the Board. The office of the Employers' Advisers was notified of the appeal, and an undated submission was received from an employers' adviser on June 21, 2004. The worker provided a June 30, 2004 response.

I consider a fair and thorough decision may be reached on this appeal without holding an oral hearing.

Issue(s)

At issue is whether the worker's claim should be reopened.

Jurisdiction

The *Workers Compensation Act* (Act) was amended effective March 3, 2003 by the *Workers Compensation Amendment Act, (No. 2), 2002* (Amendment Act).

Under section 96(2) of the Act as amended by the Amendment Act, the Board may reopen a matter that has been previously decided by the Board or an officer or employee of the Board, if one of two conditions exists. The reopening may be on application or at the Board's own initiative.

In cases where a decision to reopen or not to reopen has been made under subsection 96(2) on the Board's initiative, that decision may be appealed to the Review Division. The Review Division's decision may then be appealed to the appeal tribunal which is defined as the Workers' Compensation Appeal Tribunal (WCAT) and which was established on March 3, 2003 by the Amendment Act.

WCAT may consider all questions of fact and law arising in an appeal, but is not bound by legal precedent (subsection 250(1) of the Act). WCAT must make its decision on the merits and justice of the case, but in so doing, it must apply a policy of the Board's board of directors that is applicable in the case. WCAT has exclusive jurisdiction to inquire into, hear, and determine all those matters and questions of fact and law arising or required to be determined in an appeal before it (section 254).

Background and Evidence

I do not consider it necessary to review in detail the history of the claim. I consider that medical reports commencing in early 2002 set out key information concerning reopening of the worker's claim.

The worker's knees were x-rayed on March 27, 2002 and the x-rays regarding the left knee were interpreted as follows by a radiologist:

> …There is mild narrowing of the right medial compartment and moderate narrowing on the left. This is associated with mild osteophyte formation on the right and moderate osteophyte formation on the left.
>
> There is also mild osteophyte formation at the left patellofemoral joint.

Dr. Day, an orthopaedic surgeon, saw the worker through the Visiting Specialists Clinic at the Board. His March 27, 2002 report to a Board nurse advisor provided as follows:

> I saw and examined [the worker] on the 27th of March, 2002. He presents with persistent knee symptoms in regard to the left knee. He has medial pain and clearly has deteriorated over the last four years since I saw him. [Dr. Day performed the 1992 and 1998 surgeries.]
>
> Unfortunately, when I saw him at the Board, none of his previous records were available in terms of operative reports and I will try to get these for his next visit. He clinically has quite advanced medial compartment osteoarthritis with crepitus and grinding of joint manipulation in flexion and extension. I have asked for an MRI in order to determine the status of the lateral compartment. It may be that he is a candidate for a unicompartmental knee arthroplasty. I will write you after his next visit and after the MRI has been done.

Dr. Day's follow-up report of April 15, 2002 addressed to the "medical advisor" in the Board's service delivery location responsible for the worker's claim provided as follows:

> I saw this man recently with a history of left knee symptoms. He has medial compartment osteoarthritis and persistent medial pain, which has become more troublesome over the last four years since I saw him. I felt he might be a candidate for a unicompartmental knee and I ordered an MRI to determine the state of the lateral compartment, but it really has not been as helpful as I thought, since it did show extensive medial compartment OA, but there are some changes in the lateral femoral trochlear groove, which may not extend onto the weightbearing surface laterally.
>
> The lateral meniscus is intact, however.
>
> I would be grateful if you (Dr. Masri) could see this patient, since he is certainly a candidate for knee joint arthroplasty, but will probably require an arthroscopy to determine the true status of his lateral compartment.

[Dr. Masri was not a Board medical advisor, but rather he was another orthopaedic surgeon at the Visiting Specialists Clinic.]

The Board initially considered that surgery should be undertaken. That is obvious from the case manager's December 6, 2002 claim log entry which included the comment "Therefore, the surgery will be authorized." That the claim would be reopened is set out in the case manager's February 12, 2003 claim log entry, in which he noted that he had received an opinion from Dr. M, a Board medical advisor (who is not Dr. Masri), that the probability was greater than 50% that the proposed surgery was related to the work incident that established this claim, and in which he observed that a reopening date would need to be established.

The case manager also wrote a February 14, 2003 decision letter which included the following comments:

> A review has been undertaken in regard for your need for a total knee replacement of the left knee. The weight of evidence support that your need for a knee replacement is considered reasonable and in keeping with the injuries accepted under this claim.
>
> I have referred you back to the Visiting Specialist Clinic for an assessment by Dr. Masri.

Dr. M's February 14, 2003 claim log entry includes the following comments:

> I spoke with Dr. Samaroo at the Visiting Specialist Clinic today regarding a referral of this worker back to the Visiting Specialist Clinic. He requested that a letter be sent to him referencing Dr. Day's consult report of April 15, 2002. He will arrange for an assessment at the Visiting Specialist Clinic once he is in receipt of this letter.

Dr. M's February 14, 2003 letter addressed to the Visiting Specialists' Clinic included the following comments:

> The worker was last seen by Dr. Day in April 2002. In his VSC consult report of April 15, 2002, Dr. Day referred the worker to Dr. Masri for a possible left knee unicompartmental arthroplasty. At the time, it was not known if this surgery was specifically related to the claim and this assessment did not take place.
>
> It has now been accepted that the claim incident has likely resulted in an earlier need for the proposed surgery and it would therefore be appreciated if you would arrange for this worker to undergo the appropriate surgical assessment.

The case manager's March 19, 2003 claim log entry documenting a team meeting noted that a total knee replacement had been accepted under the claim. He observed that

there was evidence that the worker's condition had deteriorated but it was not clear whether that deterioration was significant and temporary or permanent.

On April 3, 2003 the worker was assessed at the Visiting Specialists Clinic by Dr. Werry, an orthopaedic surgeon. In his report Dr. Werry noted the following about x-rays taken in March 2002 (the reference in the quotation to "March 2000" is a typographical error):

> X-rays from Brooke Radiology, March 2000, show 50% loss of medial compartment cartilage space and some medial compartment osteophytes. There may also be some patellofemoral cartilage loss and some femoral side osteophytes in the intercondylar notch area. There is also some slight sharpening of the lateral compartment tibial joint margin.

Dr. Werry made the following recommendations regarding surgery:

> I have given him a requisition for weightbearing views of the left knee in both full extension and slight flexion to assess the medial compartment cartilage space.
>
> Although I will need to see the x-rays before making a final recommendation for [the worker], I do not feel that surgical treatment is indicated for this man at this time. I suspect, based on clinical examination today, that there is still some medial compartment cartilage space remaining and that arthroplasty, therefore, would not be indicated, both on the basis of his degree of disability as well as the extent of cartilage loss.
>
> I do not feel that osteotomy is indicated because again both his symptoms and the degree and pattern of cartilage loss would not lead to any successful outcome with a valgus type of osteotomy. Any significant patellofemoral disease is a contraindication to both medial compartment arthroplasty as well as osteotomy.
>
> I am not sure that return to what sounds to be fairly heavy physical work with long days is a realistic expectation for this gentleman, since he has already been off work for a very long time. He might be able to do some different type of carpentry which is not so physical with his present symptoms but I did not discuss that with him today.
>
> [The worker] does not require further follow-up at the VSC. I will send a follow-up report to Dr. Petrovic once I've had a chance to see the new x-rays.

The April 3, 2003 x-rays requisitioned by Dr. Werry were interpreted, as follows, by a radiologist:

> …There is moderate narrowing of the medial joint compartment associated with moderate osteophyte lipping. Mild osteophyte formation at the margins of the patella is present. There is irregular hypertrophy of the tibial spines. Bony irregularity on the mid articular surface of the lateral femoral condyle is noted and suggests old trauma. …

There is no further report from Dr. Werry on file concerning the x-rays he requisitioned.

The case manager's April 16, 2003 claim log entry of a team meeting attended by Dr. M contained the following observation:

> The medical advisor has reviewed the client's radiological studies as well as consults dating back to 2000. The medical advisor has noted that the client's flexion and extension have largely remained the same. The medical advisor has further noted that the assessments of the client's remain one of moderate narrowing of the medial joint compartment associated with moderate osteophyte lipping. The medical advisor noted little change from the previous radiological assessment done in March 2002.
>
> **DECISION:**
>
> The client's left knee condition has not significantly deteriorated either temporarily or permanently since his knee had plateaued in July of 2001.

In her April 16, 2003 claim log entry, Dr. M made the following comments:

> Further to team meeting today, I can confirm that based on Dr. Werry's Visiting Specialist Clinic consult report of April 3, 2003, there does not appear to be any significant change in this worker left knee range of motion since the functional capacity evaluation examination of July 5 & 6, 2001. In addition a comparison of a left knee xray report of March 27, 2002 with the most recent left knee xray report of April 3, 2003 shows no significant change in the degree of degeneration affecting the medial compartment of the left knee. Dr. Werry has indicated that the worker has painful mild degenerative arthritis in the left knee which does not require surgery. Based on this information therefore, it would appear less than 50% likely that there has been a significant permanent deterioration in this worker's left knee condition since July 2001.

The case manager then issued his April 17, 2003 decision. He noted that the worker's knee condition had been deemed to have plateaued as of July 1999. He noted that the worker had been working part-time in his union office. He reviewed the medical evidence, and he advised that there had been no significant deterioration.

The worker sought a review of the April 17, 2003 decision. In her December 10, 2003 decision the review officer made the following comments of interest regarding what law and policy was applicable:

> Because the worker was injured before June 30, 2002 and the circumstances indicating that a reopening might be required came to the attention of the Board before June 30, 2002 the law that applies to this review is found in the *Act* as it read immediately before June 30, 2002. The current *Act* applies to a recurrence on or after June 30, 2002. …
>
> Because the worker was injured before June 30, 2002 and the circumstances indicating that a reopening might be required came to the attention of the Board before June 30, 2002, the policy relating to this review is found in the *Rehabilitation Services and Claims Manual* ("RSCM"), Vol. I: ….
>
> As the decision that the worker did not suffer a recurrence of his injury or a significant change in his condition was made on April 22, 2003, the policy that applies to the reopening is found in the RSCM Vol. ll.
>
> Policy item #C14-102.01, *Changing Previous Decisions – Re-Openings*, states that a "significant change" means a change in the worker's physical or psychological condition that the Board had previously decided was compensable. It does not mean a change in the Board's knowledge about the worker's medical condition. A "significant change" would be a physical or psychological change that would on its face warrant consideration of a change in compensation or rehabilitation benefits or services. This policy also states that a "recurrence" refers to a recurrence of the original injury without a second compensable injury.

The review officer's "Reasons and Decision" section of her decision is lengthy, but I consider that it would be useful to reproduce it:

> Although I accept the worker's evidence that his pain is increasing in intensity and duration, I do not find that this constitutes a significant change in his compensable condition or a recurrence of his injury that would allow the Board to reopen the worker's claim for further wage loss or health care benefits.

The decision that the worker's condition had stabilized on July 9, 1999 was made by the Board on May 15, 2001 and was based on all of the evidence available up to that date. Dr. M. concluded on April 16, 2003 that there was a less than 50% chance that there was a significant permanent deterioration in the worker's left knee condition since July 2001. I accept the evidence of Dr. M. as it was consistent with the other medical evidence on file and was based on a comparison of the worker's x-rays and range of motion is his left ankle. There is no objective evidence that the worker's condition has worsened since the Board determined the worker's condition to be stabilized.

There is no evidence that the worker's increase in subjective symptoms is attributable to the conditions accepted under his claims. Prior to the worker's work injuries, the worker was noted to have chondromalacia patella. The MRP found that the work incident in October 1988 temporarily aggravated the worker's pre-existing condition of chondromalacia patella. Dr. H.'s, March 20, 1990, operative report indicated large areas of cartilage loss in the worker's knee. Dr. D.'s July 31, 1998 operative report documented extensive medial compartment degeneration and Grade ll chondromalacia change in the worker's lateral compartment. Dr. W. diagnosed the worker with degenerative arthritis in his left knee. The worker's claims have never been accepted for chondromalacia patella, compartment degeneration or degenerative arthritis. There is no evidence that the worker's work has caused these conditions.

On October 21, 2002, Dr. M and Dr. R. concluded that the worker's 1998 claim caused a permanent impairment. The degree of this impairment is a matter to be determined by the Disability Awards Department. The worker failed to attend his examination on May 27, 2003 and his file in the Disability Awards Department has been closed.

I find that the increase in the worker's subjective symptoms is in keeping with the normal fluctuations which can be expected with the worker's type of disability pursuant to policy item #34.54. These symptoms do not meet the criteria set out in policy item # C14-102.01 for reopening.

Dr. D. does not indicate that the worker required a knee replacement due to his work-related injuries. He indicated on April 15, 2002 that a knee replacement ought to be considered. The Board sought an opinion with respect to a knee replacement from Dr. W., an orthopedic surgeon. After reviewing weight bearing views of the left knee in full and slight extension

> to assess the medial compartment cartilage space, the worker's ability to function and the prior diagnostic testing, Dr. W. concluded that further knee surgery was not indicated. I accept the opinion of Dr. W. because it is based on an accurate understanding of the worker's history, a thorough examination of the worker and full diagnostic testing. Dr. W.'s opinion is not disputed or contradicted by another medical doctor. Although, the worker has accused the Board of doctor shopping no other medical opinion was sought or provided. There is no evidence that a knee replacement was indicated for the worker due to his compensable injuries.
>
> As a result, I deny the worker's request.
>
> [reproduced as written]

Reasons and Findings

What Findings Were Made By The Review Officer?

The case manager dealt with the issue of reopening of the 1988 claim. The review officer framed the issue in her decision as follows: "The issue on this review is the Board's decision not to re-open the worker's claim for further wage loss and health care benefits."

Yet, as established by the above excerpts from her decision, the review officer made several comments about matters other than a reopening of the worker's claim for an October 1988 injury. Those comments found in the third paragraph of her "Reasons and Decision" are found between other paragraphs which contain such phrases as "I do not find", "I find", and "I accept." The fact that she did not use those terms in the third paragraph may mean that she was not making findings regarding the worker's other claims or his work, but rather that she was making observations. Thus, one could argue that what is involved is a "reading down" of her comments.

Yet, statements which start out with the phrase "There is no evidence" are fairly interpreted as determinations rather than mere observations. Thus, I consider that the review officer made a finding about whether an increase in the worker's subjective symptoms was due to the conditions accepted under his claims, and made a finding that the worker's work did not cause chondromalacia patella, compartment degeneration or degenerative arthritis.

I consider that the review officer's comment about whether those conditions had been accepted on the worker's claims (as opposed to the issue of whether they were due to his work) was an observation, rather than a finding. I do not interpret her comment as purporting to decide what conditions should have been accepted under the claim. Yet, a concern with her observation regarding compartmental degeneration is raised by the

numerous claim log entries on the file. In an April 17, 2001 claim log entry Dr. L, a Board medical advisor, commented that the worker's temporary disability in 1998 and 1999 was "secondary to medial compartment degeneration from the original medial meniscectomy and from the subsequent arthroscopic debridement in 1998." Somewhat later, a case manager commented in his August 29, 2002 claim log entry that the claim had been "accepted for a left medial meniscal tear, medial meniscectomy, damage to the articular cartilage of the medial femoral condyle, and medial compartment degeneration…."

That claim log entry was followed by a file review conducted by Dr. M who made the following observations of note in her October 21, 2002 claim log entry, concerning the medial compartment:

> … The Medical Review Panel (MRP) has however directed that the work incident of October 19, 1988 resulted in both a tear to the medial meniscus and damage to the articular cartilage of the medial femoral condyle. Due to the nature of articular cartilage, it is not likely that this would be a temporary phenomenon and as supported by Dr. [R], this likely means permanent damage to the articular cartilage. The worker's left medial compartment condition is therefore worse now than it might otherwise have been were it not for the work incident of October 19, 1988.
>
> In answer to your question therefore, the surgery proposed by Dr. Day is being recommended to correct the worker's left knee osteoarthritic condition. The MRP has however directed that the work incident of October 19, 1988 resulted in damage to the worker's left knee medial articular cartilage. Given the nature of articular cartilage, this is likely permanent and has reasonably resulted in an acceleration of the degenerative process in the medial compartment. It is therefore in my opinion at least 50% likely that the October 19, 1988 incident has brought the need for the proposed surgery forward.

Further, a March 19, 2003 claim log entry documenting a team meeting indicated that the following was accepted on the claim: "Left knee medial meniscus tear, medial meniscectomy, damage to the articular cartilage of the medial femoral condyle, and medial compartment degeneration…". That entry also indicated that "Osteoarthritis in the medial compartment of the left knee" was not accepted.

Thus, there may be some concern with the accuracy of the review officer's observation as to compartment degeneration. While no issue of entitlement appears to turn, at this point, on her observation, I consider it appropriate to review the matter so that future readers of the file will be alerted to this issue. The review officer's comment concerning the worker's chondromalacia patella appears to be an accurate observation with respect to the claim for the October 1988 injury, given the determination found in

the February 16, 1995 certificate issued by the Medical Review Panel referred to by her (the same Medical Review Panel certificate referred to by Dr. M, in her claim log entry reproduced above). The Medical Review Panel found that the October 1988 injury temporarily aggravated the worker's pre-existing chondromalacia patella.

Did The Review Officer Have Jurisdiction To Make Findings Beyond The Matter Of A Reopening?

As noted above, the issue before the case manager was the reopening of the worker's claim. That, in turn, was the issue before the review officer, and is the issue before WCAT.

WCAT's jurisdiction in reopening matters is as follows. Subsection 96.2 (1) of the Act provides that a person may ask a review officer to review a Board decision respecting a compensation or rehabilitation matter. The April 17, 2003 decision was not a reopening decision on application under subsection 96(2) of the Act; thus, it was not excluded from review by the Review Division as a result of paragraph 96.2 (2)(g). Had the April 17, 2003 decision been a decision under subsection 96(2) on application, it would have been appealable directly to WCAT as a result of the language of subsection 240(2).

The Review Division decision was appealable to WCAT further to the terms of subsection 239(1) of the Act which provides that a final decision made by a review officer in a review under section 96.2 may be appealed to WCAT. According to subsection 253(1), on an appeal, WCAT may confirm, vary or cancel the appealed decision or order. Those are broader remedies than the remedies set out in subsection 253(2) which provides that, on an appeal under subsection 240(2), WCAT may make one of two decisions: determine that the matter that is the subject of the application "must be reopened" or determine that "the matter may not be reopened."

Item #14.30 of WCAT's *Manual of Rules Practices and Procedure* provides that "Where a decision of the Review Division is appealed to WCAT, WCAT has jurisdiction to address any issue determined in either the Review Division decision or the prior decision by the WCB officer which was the subject of the request for review by the Review Division." That expression of WCAT's jurisdiction is subject to the Board officer and the Review Division having had jurisdiction to reach the decisions which they did.

I consider that the case manager was within his jurisdiction to render a decision concerning reopening of the worker's claim. As well, the review officer was within her jurisdiction to address the reopening of the worker's claim.

However, I question whether the review officer in the case before me had jurisdiction to decide matters beyond those decided by the Board officer at first instance. To address that question, it is necessary to consider the origins of the Review Division and its practices.

The creation of the Review Division via the Amendment Act was preceded by the *Core Services Review* report issued by Alan Winter in March 2002. The report offers the following comments at pages 28 and 29, regarding the scope of reviews:

> The subject matter of the internal review should not be limited to what the initial decision-maker actually dealt with in the four corners of the decision letter. Rather, the review would encompass any issue which the Review Manager believes should have reasonably been dealt with by the initial decision-maker in his/her letter. My reasoning for this broader scope is to avoid the delay and frustration which will often arise when the matter is referred back to the initial decision-maker to determine the additional issue(s), which could then become the subject of a further application for internal review.

Item A3.6 of the Review Division's *Practices and Procedures* (Practices) (a document that may be viewed on the Internet at the Board's website) explains that a review officer may become aware of an issue that was not raised in the initial decision under review or review request. In considering whether to deal with this issue as part of the review, the factors considered by the officer will include:

(a) whether it is essential to deal with the new issue in order to resolve the original issue under review, or if not essential, how incidental the new issue is to the original issue,

(b) the difficulty or complexity of the new issue,

(c) whether all the necessary information is available or easily obtainable, and

(d) the views of the parties, if known.

The review officer will also advise the parties of any new issue he or she proposes to deal with.

Item B4.4 of the Practices provides that one of the aims of the changes to the Act that created the review system is to promote greater finality of decision making. Therefore, a review officer who "considers that a decision should be changed" will in most cases make the new decision. In some cases, "it will not be possible or desirable" to do this. In such cases, an issue may be referred back to the Board division that made the initial decision where significant further investigation or assessment would be required that would be beyond the scope of the review function. This referral back may be with or without directions, as set out in section 96.4(8) of the Act.

Yet, the passages in the Practices do not articulate the statutory authority for the review officer to deal with new issues, especially if the issue deals with other claims or the worker's work. If review officers were initial decision-makers at the Board, it could be argued that they have jurisdiction to deal with such other issues concerning the worker's other claims and his work. Yet, review officers are not initial decision-makers; pursuant to subsection 96.2 (1) of the Act, review officers deal with requests for reviews of decisions. The jurisdiction of a review officer is a function of the decision being reviewed, regardless of the desirability of addressing all possible matters so that workers, dependants, and employers are not required to cycle through the appellate system.

As a result, I find that the review officer exceeded her jurisdiction when she made findings about the worker's other claims and his work generally. Thus, I cancel those determinations by the review officer.

I am aware that WCAT may refer a matter back to the Board for determination under subsection 246(3) of the Act, and suspend the appeal. WCAT must then take into account the Board's determination in the appeal. As a result, WCAT then has jurisdiction to deal with the whole matter, including the Board's further determination. Subsection 246(3) is applicable when WCAT "considers there to be a matter that should have been determined but that was not determined by the Board."

Yet, I do not consider that matters involving the worker's other claims and work "should" have been determined by the Board at first instance when the April 17, 2003 reopening decision was issued, such that it would be appropriate for me to invoke subsection 246(3). The issue before the case manager was whether the worker's 1988 claim should have been reopened. I do not consider that that issue dealt with other claims and work. I do not have the authority to direct that the Board consider the matter of the worker's other claims and work. It is open to the worker to raise the matter with the Board.

Which Versions Of The Law and Policy Are Applicable To The Reopening Issue?

The review officer offered contradictory comments as to the applicable law and policy.

While the March 27, 2002 and April 15, 2002 reports of Dr. Day came to the attention of the Board before June 30, 2002, I do not consider that those circumstances dictate which law and policy apply to the reopening. Had the Board accepted, in April 2002, that the worker's claim should have been reopened for temporary disability benefits effective April 2002, the version of the Act in effect as of April 2002 would have been applicable. That would have resulted in the payment of temporary disability benefits using a formula of 75% of gross earnings because the provisions of the *Workers Compensation Amendment Act, 2002* (Bill 49) which came into effect as of June 30, 2002 would not have been applicable. That legislation brought into effect the 90%-of-net-earnings formula.

However, the case before me does not involve an actual reopening, but rather it involves a denial of a reopening. That denial decision letter was issued in April 2003, one month after the *Workers Compensation Amendment Act, (No. 2), 2002* (defined earlier in this decision as the Amendment Act) came into force. The Amendment Act introduced new language concerning the reopening of claims, specifically subsection 96(2) of the Act, which provides as follows:

> Despite subsection (1), at any time, on its own initiative, or on application, the Board may reopen a matter that has been previously decided by the Board or an officer or employee of the Board under this Part if, since the decision was made in that matter,
>
> (a) there has been a significant change in a worker's medical condition that the Board has previously decided was compensable, or
>
> (b) there has been a recurrence of a worker's injury.

Assistance in determining if subsection 96(2) of the Act is applicable to this case is obtained from *Practice Directive #58* (viewable on the Internet at the Board's website). Practice directives issued do not have the status of policy, and therefore there is no requirement that they be applied. However, they set out the expectations placed on Board officers adjudicating reopening cases, and they are of note. The directive defines the legislation and policies relating to reopenings, reconsiderations, reviews, and appeals, as they read on March 3, 2003, as the "current provisions." It then provides that "Where a reopening was requested before March 3, 2003, but decided after March 3, 2003, the current provisions apply." That means that the Act as amended by the Amendment Act applies, as does the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II). The practice directive observes that item #102.01 of the RSCM II provides guidance on determining whether one of the grounds in subsection 96(2) of the Act has been met.

I find that the Act as amended by the Amendment Act is applicable to the case before me. As well, the RSCM II is applicable to the case before me.

Item #102.01 of the RSCM II noted above (and cited by the review officer) indicates that "significant change" refers to a change in the worker's physical condition, and not knowledge by the Board of medical information concerning the worker. A "recurrence" of a compensable injury occurs without a second compensable injury.

At least four items in the RSCM II are of assistance with this issue. Item #34.10 provides that a temporary physical impairment is one which is likely to improve or become worse and is therefore not stable. It remains temporary only when a change can reasonably be foreseen in the immediate future. Item #34.12 deals with permanent disabilities, and provides that temporary disability benefits are payable where there is medical evidence of a temporary significant deterioration in the permanent disability which goes beyond the normal fluctuation for the particular permanent disability. Item #35.30 provides that a temporary total disability ceases when it resolves entirely or stabilizes as a permanent impairment.

Item #34.54 deals with whether a worker's condition is permanent to the extent that a pension should be assessed. If a condition has definitely stabilized, it is considered permanent. A condition will be deemed to have plateaued or become stable where there is little potential for improvement, or any potential changes are in keeping with the normal fluctuations in the condition which can be expected with that kind of disability. If a condition has definitely not stabilized, a worker will be maintained on temporary disability wage loss benefits. If there is a likelihood of minimal change, the condition will be considered permanent. If there is a likelihood of significant change, the condition will be considered temporary if the potential change is likely to resolve relatively quickly (generally within 12 months); the condition will be considered permanent if the potential change is likely to be protracted (generally over 12 months).

Should The Claim Have Been Reopened?

At the outset, I note that the February 13, 2003 decision letter of the case manager accepted the surgery, and claim log entries indicate that a reopening would take place. The April 17, 2003 decision superseded that earlier decision and earlier claim log entries. I was unable to locate any material on the claim file which indicated that the case manager was aware that he had reconsidered his earlier decision. I consider that the case manager was not precluded from readjudicating the matter, given that subsection 96(5) of the Act permits the Board to reconsider a decision within 75 days of the initial decision.

It should be kept in mind that the worker has not been awarded a pension for permanent partial disability on this claim. He did not have a disability when examined by the Medical Review Panel in 1995. His claim was reopened a few years later, and temporary disability benefits were paid for the period from 1997 to 2001. A referral to the Disability Awards Department was made in April 2003. The worker advises that he attended a late May 2003 appointment for a permanent functional impairment examination, but the examination was not conducted owing to pain.

I draw attention to these events because it seems that the Board accepts that the worker has a permanent disability due to his 1998 injury. That provides a key

circumstance relevant to the reopening issue. That is why the case manager cited item #34.12 in his April 17, 2003 decision noted above.

That policy is relevant even though a pension had not been awarded as of April 2003. The issue is whether there was a significant deterioration. I consider that is similar to the reopening test in subsection 96(2) the Act regarding the need for a significant change in a worker's medical condition that the Board has previously decided was compensable.

In assessing the issue of deterioration, I note the comments of Dr. L in his April 17, 2001 memorandum in which he reviewed the medical reports received by the Board after the worker's July 31, 1998 surgery and drew attention to the May 28, 1999 report of Dr. Petrovic, the worker's family physician, which referred to continued knee pain with scant effusion, full range of motion and stability, and Dr. Petrovic's report of July 9, 1999 which recorded a full range of motion and no effusion. He considered that there was no specific change recorded in subsequent reports and that the worker had plateaued around May 28, 1999 or July 9, 1999, at the latest.

The worker was then paid temporary disability benefits for the period up to July 9, 1999. Yet, in September 2001 he was paid temporary disability benefits for the period from July 10, 1999 to July 15, 2001. (He did some work in 1999, 2000 and 2001, and some benefits were paid as temporary partial disability wage loss.) The rationale for the payment of the additional two years of temporary disability benefits is set out in a September 11, 2001 claim log entry in which a case manager noted that while the evidence indicated the worker's condition had plateaued effective July 10, 1999, it had been determined that wage loss benefits would be paid for the period from July 10, 1999 to July 15, 2001. He observed that vocational rehabilitation benefits would normally have commenced effective July 10 1999; however, the file was not brought to the attention of the rehabilitation consultant until May 2001.

I consider that the extension of temporary disability benefits to July 2001 when the worker underwent a functional capacity evaluation means that, for the purposes of evaluating whether there had been a deterioration or significant change in the worker's disability, the point of comparison is July 2001, rather than July 1999.

Dr. M commented in her April 16, 2003 claim log entry that there was no significant radiographic change. That comment accords with the reports associated with the x-rays of March 27, 2002 and April 3, 2003. Both x-ray reports identify moderate narrowing of the medial compartment. The first report refers to moderate osteophyte formation associated with the moderate narrowing of the compartment, and the second report refers to moderate osteophyte lipping associated with the moderate compartment narrowing. The first report refers to mild osteophyte formation at the left patellofemoral joint, and the second report refers to mild osteophyte formation at the margins of the patella. The second report refers to bony irregularity on the mid articular surface of the

lateral femoral condyle suggestive of old trauma, whereas there is no reference to that irregularity in the first report. Whether any of the worker's compensable injuries involved such trauma to the lateral femoral condyle is not before me for decision.

Dr. M also observed that the worker's range of motion had not changed significantly since the July 2001 functional capacity evaluation. I note that the initial left knee range of motion measurement taken on July 5, 2001, at the commencement of the functional capacity evaluation, was 2 to 131 degrees. The worker's range of motion decreased over the course of that first day to 2 to 119 degrees. On the second day, it started at 6 to 124 degrees and reduced to 4 to 122 degrees. In April 2003 Dr. Werry found a range of motion of 5 to 130 degrees.

The functional capacity evaluation contains conclusions as to the level of work the worker is capable of performing. The issue of what type of permanent work restrictions the worker has as a result of his 1998 injury is not before me for determination, as the appeal does not involve the issue of pension entitlement. I am relying on the functional capacity evaluation for the information as to the worker's range of motion.

I consider that the first July 5, 2001 measurement should be compared to the April 3, 2003 measurement. The ranges of motion are very similar. I consider that those two measurements would be indicative of the long-term state of the worker's left knee. The measurements taken during the course of the functional capacity evaluation reveal that there is fluctuation in the worker's knee function in response to it being tested. Had similar testing been conducted in April 2003, it is likely that the worker's range of motion would have decreased as well.

Dr. Day's March 27, 2002 and April 15, 2002 reports were received by the Board between July 15, 2001 and April 2, 2003, and they do not contain any measurements of the worker's range of motion. His comments that the worker's pain had become more troublesome and that the worker clearly had deteriorated since he last saw the worker in 1998 are of note, but they do not establish that the worker's condition deteriorated significantly after July 2001. Dr. Day's 1998 point of reference pre-dates the termination of temporary disability benefits by some three years.

I have considered the issue of the worker's report of pain. The review officer's comments regarding the worker's pain are problematic. As can be seen from the excerpts from her decision, it appears that she suggested that the worker's pain was not due to the conditions accepted under the claim and then later she found that the increase was in keeping with the normal fluctuations for the worker's type of disability. That latter observation might be seen as acceptance that the worker's pain stems from his compensable disability. Yet, that is not clear, as she may be referring to knee problems forming part of his disability which she considered might not be due to the worker's 1988 injury.

I consider that the evidence does not establish that the worker's pain is due to conditions other than those accepted under the claim. The opinions of Dr. M noted above do not intimate that the problems for which Dr. Day suggested surgery were unrelated to the 1988 injury. Those problems included the worker's reports of pain. The case manager's materials do not contain a suggestion that the worker's pain stemmed from non-compensable conditions.

I find that the worker's pain is due to the effects of the 1988 injury. While I accept that pain is due to the 1988 injury, I do not accept that the increase in pain referred to by the worker constitutes a significant change in the worker's medical condition that the Board had previously decided was compensable. The worker comments that if the intensity of his pain and its duration is increasing, then it stands to reason that the injury has not plateaued. I understand his point, but I am not persuaded by it. I consider it very important that no significant change was seen on x-ray or suggested by range of motion evaluation.

Whether the worker's compensable condition necessitates an arthroplasty is part of the reopening question. I say this because if such surgery was required to treat the worker's compensable condition, then that would constitute a significant change in the worker's condition given that in July 2001 such surgery was not considered to be required.

The review officer's comments about whether the worker required an arthroplasty are problematic as they appear to contain the suggestion that Dr. Day was proposing surgery for reasons other than the worker's compensable condition. Dr. M's October 21, 2002 claim log entry comments above, in which she drew on Dr. R for support, are to the effect that the surgery was being proposed for medial articular cartilage damage stemming from the October 1988 injury which resulted in an acceleration of the degenerative process in the medial compartment. There is no persuasive contrary evidence which would support a conclusion that the 1988 injury did not result in medial particular cartilage damage which resulted in an acceleration of the medial compartment degenerative process.

As a result, I consider that the issue is not whether the symptoms for which surgery was proposed were due to the 1988 injury, but rather the issue is whether surgery was necessitated by those symptoms. By that, I mean that the issue is not one of causation, but rather the issue concerns the Board's power in subsection 21(6) of the Act which provides, in part, as follows:

> Health care furnished or provided under any of the preceding subsections of this section must at all times be subject to the direction, supervision and control of the Board ... and all questions as to the necessity, character and sufficiency of health care to be furnished must be determined by the Board.

In assessing whether surgery was necessitated by the worker's compensable condition, I am aware of the worker's comment that Dr. Day is recognized by the Board as an expert. Indeed, Dr. Day saw the worker in March and April 2002 through the auspices of the Board's Visiting Specialists' Clinic. The worker asks why the Board questions Dr. Day's opinion.

I consider that further orthopaedic assessment was appropriate, given that Dr. Day's April 15, 2002 report suggested assessment by Dr. Masri, an orthopaedic surgeon. Dr. Day considered that an arthroscopy would probably be required. Dr. Werry did not undertake an arthroscopy. I do not consider that undermines Dr. Werry's evaluation of the worker. He considered that x-rays were sufficient.

I question the assertion of the review officer that Dr. Werry's opinion was informed by full diagnostic testing. There is no evidence on file that Dr. Werry saw the April 3, 2003 rays. I do not consider that the fact that Dr. Werry may not have prepared a further report regarding those x-rays undermines the weight that can be attached to his report. He indicated that he needed to see the x-rays before making a final recommendation, but his initial opinion that no surgery was needed was predicated on the presence of space in the medial compartment. As noted above, Dr. M viewed the x-ray reports and offered her opinion which seems to be supported by the reports. There was space in the medial compartment, given that there had been no significant change since the earlier March 27, 2002 x-rays noted by Dr. Werry in his report.

I accept Dr. Werry's opinion. There is no subsequent contrary opinion. There is Dr. Day's earlier opinion, but I consider that the evaluation by Dr. Day was not as thorough as that conducted by Dr. Werry. Dr. Day's materials were on the file when Dr. Werry assessed the worker. As well, Dr. M's February 14, 2003 letter addressed to the Visiting Specialists Clinic noted that the need for surgery had been accepted. I consider that, in those circumstances, Dr. Werry's comment that surgery was not recommended is noteworthy. His opinion provides reasons as to why surgery was not appropriate, and I accept those reasons.

I find that the Board properly denied coverage of the surgery proposed by Dr. Day, and properly declined to reopen the claim.

There are no further medical reports on file subsequent to Dr. Werry's assessment of the worker. Whether the worker's left knee has changed between April 2003 and September 2004, such that a reopening should be considered, is not before me. Thus, my decision is very time-specific and does not preclude further consideration of a reopening.

Conclusion

I deny the worker's appeal. I vary the review officer's December 10, 2003 determination by cancelling her determinations regarding the worker's other claims and his work, but I find that the reopening of the claim was properly denied.

Randy Lane
Vice Chair

RL/jy