Noteworthy Decision Summary

Decision: WCAT-2006-02669 **Panel**: Randy Lane **Decision Date:** June 27, 2006

Reconsideration – Authority of Workers' Compensation Board to reconsider – When is a decision "made" – Does a decision need to be communicated within 75 Days to be "made" – Section 96(5) of the Workers Compensation Act – Nature of communication

In the absence of specific direction in the *Workers Compensation Act* (Act), or in Workers' Compensation Board (Board) policy, the Board does not have the authority, pursuant to section 96(5) of the Act, to reconsider an original Board decision unless the reconsideration decision is communicated to the affected party(ies) within 75 days. Communication can be oral or written.

The worker, a firefighter, experienced chest pain at work and applied for compensation (the Workers' Compensation Appeal Tribunal (WCAT) decision involved two separate chest pain claims, three weeks apart, but this noteworthy summary relates to only the first claim). The worker had pre-existing coronary heart disease. The Board officer noted in the Board's electronic file that the claim was accepted for "health care only", and that same day the Board issued a decision letter which advised the worker that the Board had accepted his claim for compensation benefits for his work injury. No medical information had yet been received on the claim. Three weeks after the original decision, a Board officer reviewed the worker's claim and purported to reconsider the original decision by changing the status of the claim from "health care only" to "information only" in the Board's electronic file. Subsequently, and more than 75 days after the original decision was made, the Board issued a letter to the worker denying the worker's request for reimbursement of prescription expenses on the basis that claim had been accepted for information purposes only. A month later the Board issued a letter to the worker denying his claim. The worker requested a review of both the prescription decision and the subsequent decision denying his claim. The Review Division of the Board upheld both Board decisions.

The WCAT panel found that the Board did not have the authority to deny the worker's claim arising out of the first incident as it had failed to communicate the reconsideration decision within 75 days of the original decision to accept the worker's claim. The panel concluded that a decision is not made until the Board issues a decision via a letter or an oral communication. There is no requirement that the decision be issued in writing to be effective. The panel found that the Board's original decision accepted that the work incident was of causative significance with respect to the worker's pain associated with his heart. However, that the Board accepted such pain does not amount to an acceptance of the worker's pre-existing coronary artery disease. The panel declared void the Board decision denying all aspects of the worker's claim.

The panel adopted the reasoning of the three member panel in *WCAT Decision #2006-02121* (also a noteworthy decision) which concluded that a decision is not "made" unless it is communicated. In coming to its conclusion the panel in *WCAT Decision #2006-02121* found that a decision was not "made" for the purposes of the review and appeal provisions of the Act unless it was communicated. The panel determined that the reconsideration process should not be treated differently.

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The panel in this decision noted that prior to the amendments to the Act arising out of the *Workers Compensation Amendment Act (No. 2), 2002* (Bill 63), the review and appeal provisions of the Act expressly required that a Board decision be communicated before the time period for review or appeal begin to run. The panel also noted that the *Core Services Review of the Workers' Compensation Board* (the Winter Report) proposed that the reconsideration, review and appeal periods all run from the date the disputed decision was communicated, in writing, to the affected party(ies). The panel considered and rejected the argument that, by amending the Act in the way that it did, and failing to implement the Winter Report's recommendation, the legislature intended to remove a communication requirement. The panel found the amendments reflected a desire to have consistent language with regard to the commencement of appeal periods as prior to Bill 63 the Act was notable for varying provisions regarding the commencement of appeal periods with respect to the various appeal bodies. Also, Bill 63 was intended to bring finality to the workers' compensation system. A decision-making process that lacks a communication component would involve the creation of a more cumbersome process.

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Panel: Randy Lane, Vice Chair

Introduction

The worker, a firefighter, has appealed a September 30, 2005 decision (*Review Decisions #R0051147* and *#R0051148*) of a review officer of the Review Division of the Workers' Compensation Board (Board) to the Workers' Compensation Appeal Tribunal (WCAT). (Review officers' decisions may be viewed on the Internet at the Board's website at www.worksafebc.com.)

The review officer confirmed Board decisions dated February 24, 2005 and May 4, 2005. He considered that the initial acceptance of the worker's claim for a sprain/strain of the chest wall did not prevent the Board from adjudicating whether the worker's coronary artery disease was due to his work activities. He found that the worker's coronary artery disease did not arise out of and in the course of his employment and was not due to the nature of his employment. Further, there was no evidence to support a conclusion that the worker's pre-existing coronary artery disease was significantly aggravated or accelerated by his employment.

With the assistance of Mr. Guenther, a lawyer, the worker filed an October 12, 2005 notice of appeal which was followed by a February 9, 2006 submission from Ms. Patterson, an associate of Mr. Guenther. The worker's employer was notified of the appeal, but it did not indicate that it wished to participate.

By letter of January 6, 2006 the worker was advised that the appeal would proceed by way of written submissions. That decision does not bind me if I consider that an oral hearing is necessary. I have considered the rule regarding the holding of an oral hearing set out in item #8.90 of WCAT's *Manual of Rules of Practice and Procedure* and the other criteria set out in that item. 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 October 26, 2004 and November 14, 2004 incidents were injuries arising out of and in the course of his employment. A related issue is the effect of a November 24, 2004 letter regarding the worker's October 26, 2004 incident sent by the Board to the worker, and a December 15, 2004 claim log entry which sought to reconsider that November 24, 2004 letter. A further issue is whether the worker's coronary artery disease and need for surgery was due to the nature of his employment or was significantly aggravated or accelerated by his October 26, 2004 and November 14, 2004 incidents.

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Jurisdiction

WCAT has exclusive jurisdiction to inquire into, hear and determine all those matters and questions of fact, law, and discretion arising or required to be determined in an appeal before it (section 254 of the *Workers Compensation Act* (Act)). It 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 of directors of the Board that is applicable in the case.

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.

Background

On November 18, 2004 the worker's employer completed two reports of injury or occupational disease. The first report concerned an October 26, 2004 incident in which the worker became short of breath and experienced "crushing pain" in his chest which radiated down his arms while extracting a person from a vehicle. The second report concerned a November 14, 2004 incident in which the worker felt a tightness and minor pain behind his sternum after climbing up and down an extended ladder. The pain subsided within minutes.

On November 23, 2004 the worker completed two applications for compensation and reports of injury or occupational disease. The first report concerned the October 26, 2004 incident. He indicated that the pain subsided with completion of work and a few minutes of rest. He noted that he underwent stress testing on November 15, 2004. He gave the name of the specialist who assessed him with respect to that testing, Dr. Lalani (a cardiologist), and he gave the name of his family physician, Dr. Miki. The second report concerned the November 14, 2004 incident. He indicated that the pain behind his sternum subsided within a few minutes. There was a slight shortness of breath but no radiation of pain or sweating beyond normal sweating. He noted that on October 29, 2004 he underwent heart tests, and the physician present at that testing felt that he had not had a heart attack on October 26, 2004 and that the pain on that day was not heart-related. The worker indicated that he saw his family physician later, who also told him that the blood work suggested that the pain on October 26, 2004 was not "cardio-related."

Initially, the Board established two claims for the two incidents. The sequence of relevant events on the two claims was as follows.

October 2004 Claim

A November 24, 2004 claim log entry on the Board's electronic file (e-file) by a customer service representative indicated that a claim decision had been rendered. The decision was "health care only." The Board issued a November 24, 2004 letter in which it advised the worker that the Board had accepted his claim for compensation benefits for his work injury. The claim detail screen on the e-file indicates under the heading "Decision" that on November 24, 2004 the claim was accepted for health care benefits only. At that point, no medical information had been received on file.

A December 2, 2004 claim log entry by the customer services representative indicated that the claim decision on the file was "info only." A second December 2, 2004 claim log entry by the customer service representative indicated the decision was "health care only." A third December 2, 2004 claim log entry by the customer service representative indicated that the claim was routed to the service delivery location with respect to reconsideration. A December 2, 2004 entry on the claim detail screen by the customer service representative refers to "Info only" under the heading "Decision." Of interest is the fact that a December 2, 2004 entry under the heading "Injury Decision" indicates that the claim was "denied" with respect to "sprains, strains."

The December 3, 2004 claim log entry of a case manager indicated that there was no medical information to consider at that time. She noted that the worker was on modified duties and that the client services representative indicated that the worker was recently sent for stress tests and did have evidence of blockages in his heart. She noted that the Medical Services Plan had been billed with respect to the worker's treatment. Her claim log entry concluded with the following comments of note:

> At this time I have nothing to consider. The claim came to me already accepted for Health Care Benefits, but I may have to reconsider if time is allowed (<75days), if we should get medical suggesting a pre-existing heart problem, vs, an acute injury.
>
> [all quotations in this decision are reproduced as written, save for changes noted]

A second December 3, 2004 claim log entry by the case manager entitled "E-file closure" consisted of the entry "Health care only."

The case manager's December 15, 2004 claim log entry reads as follows:

> **REGARDING: Memo to file/ claim status will be changed to Information only.**
> Since it is now December 15, 2004, still have no medical on file. A decision by the Client Service Representative to accept this claim for

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> Health Care Benefits I now believe is incorrect. I have still 54 days left from that decision to change the decision status to Info Only.
>
> I note a pending claim by the Entitlement Officer, and again the issue is no medical, and the workers' speculation that his heart blockages are causally related to this claim, perhaps exacerbated by a new lifting incident on a roof (lifting an air conditioner).
>
> The workers' own attending physician has not submitted any medical in support of any work place trauma since the creation of this claim. Now nearly 2 months.
>
> Should any medical come to the claim file, under this claim or the new claim for November I will make a decision then.

The case manager's second December 15, 2004 claim log entry, entitled "Claim Decision", provides as follows: "Claim decision marked in error. Decision was :health care only."

A December 15, 2004 entry on the Claim Detail screen under the heading "Injury Decision" indicates that the decision was "denied" with respect to "sprains, strains."

A January 6, 2005 claim log entry noted that the worker had submitted several prescription accounts for reimbursement. In her January 6, 2005 claim log entry the case manager commented that the "RX [prescriptions] are probably for a 'vacular' heart condition."

By letter of February 24, 2005 a second case manager noted that the Board had received several prescriptions. She indicated that no medical information had been received under the claim and, as a result, the claim had been filed for information purposes only. She commented that, as there was no medical information relating to any injury, a decision was never made on the claim and therefore she could not accept the prescriptions.

In her March 11, 2005 claim log entry a third case manager noted that the worker called that day to discuss the status of his claim. She indicated that she advised the worker that his claim had been denied. He was very surprised to hear that. She observed that a letter had never been sent to the worker. The worker indicated that when he spoke to an entitlement officer on December 15, 2004 regarding his November 2004 claim he had been advised that both claims would be consolidated. The case manager noted that consolidation had not been undertaken.

The case manager noted the worker's advice that he had been diagnosed with blockages and had undergone an angiogram on January 12, 2005. He had not suffered a heart attack; however, he had been on light/alternate duties for preventative reasons. The case manager advised that she would look into the matter, as the decision to deny the claim was made more than 75 days earlier. Despite the worker not having been advised of the decision, the denial was not a decision she could change.

In her March 21, 2005 claim log entry a claims adjudicator noted that the claim had been initially accepted for health care costs only and then had been accepted for information only. No medical information had been received; it did not appear that any medical information had been requested by the Board. While both claims had been established for "information only" as no medical information was requested, the related letters sent to the worker did not constitute appealable decisions. The October 2004 claim would be consolidated into the November 2004 claim, as they represented two closely related episodes of chest pain. Medical information would be requested following the gathering of further information from the worker. A decision would then be made as to whether there was evidence to support that the worker developed a heart condition as a result of his employment.

November 2004 Claim

A November 29, 2004 claim log entry by an entitlement officer contained the following information:

> The claimant is a 56 year old male, 5'10" tall and weighing approximately 195 lbs. This claim relates to chest pain noted at work on Nov 14, 2004. The claimant has a prior claim – [WCB claim number] - for chest pain noted at work on Oct 26, 2004. The current claim involves a Nov 14 incident, where after accessing the roof of a warehouse, by climbing up and down the extended ladder on firetruck # [number], the claimant felt a tightness and minor pain behind his sternum. The pain subsided after a few minutes. The complaint was reported right away. There is no protest and no indication of time loss. The claimant may not have sought medical attention with regards to this incident.
>
> **Prior Claim:**
>
> On Oct 26, the claimant was extricating a very heavy patient at an auto accident. He experienced a shortness of breath, along with chest pain which radiated down both arms. He worked through the pain, as the patient was critically injured. The pain subsided with completion of the work and a few moments rest. The claimant phoned his gp, Dr Miki and made an appointment. He was seen Oct 29 and sent to Royal Columbian Hospital for a heart test/stress test. He saw Dr Miki again on Nov 5. The claimant either underwent further tests at Royal Columbian on Nov 15 - or

went over the results with a Dr Lalani on Nov 15. I note that this claim was accepted for a "chest strain", although there is no medical evidence on file. The claim is accepted for Health Care Benefits only.

Issues:

There is no medical evidence on either claim. The clmt's statements indicate that a cardiac problem was ruled out. The claimant may not have sought medical attention specifically for the Nov 14 complaint; he may have seen a Dr Lalani on the 15th, to go over the results of tests conducted under the prior claim. If so, there is nothing for the Board to consider under the Nov 14 claim - no time loss, no medical evidence.

Action Plan:

I will contact the claimant to go over the history of complaints and medical attention. If necessary, I will request medical records for treatment under the current claim - to confirm diagnosis. The claim would then be adjudicated under Sec 5 of the Act.

In her December 15, 2004 claim log entry a second entitlement officer observed that the worker had not lost any time from work "under this claim." As well, there was no medical evidence to consider on the claim. The claim would be filed for information only, "as there is nothing to consider." Her decision had been discussed with the case manager assigned to the worker's October 2004 claim, which had also been filed "For Information Only" because there is "nothing to consider under it."

That entitlement officer then issued a December 16, 2004 letter in which she advised that the claim file with respect to work activities on November 14, 2004 had been filed for information purposes only. There was no medical evidence received on this claim, and the worker had confirmed that he had not lost time from work. If medical evidence was received by the Board from physicians who had seen the worker, such medical evidence would be reviewed by the Board.

Consolidated Claim

In her March 23, 2005 claim log entry the claims adjudicator documented the results of her March 21, 2005 conversation with the worker regarding the history of his cardiac concerns. She noted that the worker had been diagnosed with coronary artery disease and was scheduled for bypass surgery on April 12, 2005. He had not experienced a heart attack.

The claims adjudicator noted the worker's advice that, subsequent to the October 26, 2004 incident, he had undergone blood work on October 29, 2004. The day after the November 14, 2004 incident, the worker undertook a pre-booked stress test performed

by Dr. Lalani which revealed one or more blockages in his arteries. Dr. Lalani indicated that there was no evidence that the worker had suffered a cardiac event.

The claims adjudicator noted the worker's advice that he had no prior symptoms or treatment for cardiac disease before October 2004. Routine electrocardiograms required for work had been normal. He described himself as healthy; he did not have diabetes or any other medical condition. He had a previous history of hypertension which did not require medication. His blood pressure was at the high-end of the normal range. He had been diagnosed with elevated cholesterol which had been treated with diet, until the diagnosis of coronary artery disease. The worker indicated that he had no family history of cardiovascular problems, although his grandfather had suffered a stroke at a late age. The worker stopped smoking in 1974 and, prior to that date, he was a light smoker who smoked approximately one package of cigarettes per week.

The claims adjudicator noted the worker's belief that the nature of his job caused his coronary artery disease. It was the worker's view that the incidents in October and November 2004 contributed to his condition. He had been off work since December 16, 2004 and was in receipt of sick benefits, pending a decision on his claim. He had been undertaking a light duty program which involved fire inspections, as well as attending with a fire chief on "walk-arounds" and other activities when called out to attend a fire. He considered that work sufficiently stressful that it would be in his best interests to remain off work, pending the surgery and subsequent recovery.

In April 2005 the Board received medical reports which included Dr. Miki's office chart which, in turn, included entries dated October 29, 2004 and November 5, 2004; the worker's October 29, 2004 blood test and ECG results; Dr. Lalani's November 16, 2004 consultation report; the January 12, 2005 cardiac catheterization report of Dr. Lalani; the February 14, 2005 consultation report of Dr. Latham (a specialist in cardiac surgery); Dr. Lalani's consultation report of April 4, 2005; and Dr. Latham's April 12, 2005 operative report.

In his April 27, 2005 claim log entry a case manager requested a medical opinion. He noted the worker's assertion that the work incidents of October 26, 2004 and November 14, 2004 contributed to his condition and his need for surgery. The claims adjudicator noted that the worker's medical history was significant for hypertension, elevated serum cholesterol, and smoking. He queried whether the worker's diagnosis was related to his October 26, 2004 and November 14, 2004 incidents and whether those symptoms represented a disease, condition or disability. He also queried whether the work incidents caused the worker's coronary artery disease, whether the incidents significantly accelerated, activated or advanced a pre-existing condition, and whether the incidents simply brought the worker's attention to the presence of a pre-existing heart condition.

In her April 28, 2005 claim log entry Dr. D, a Board occupational physician with a diploma in industrial hygiene and the holder of an MFOM which I understand refers to Membership of the Faculty of Occupational Medicine, offered the following opinion:

> This 56 year old firefighter of many years, experienced chest pain on two occasions while physically exerting himself at work. The pain was transient and cardiac enzymes remained normal. On further investigation he was diagnosed as suffering from unstable angina due to three vessel disease. He at no time had evidence of having suffered a myocardial infarction.
>
> The worker is noted to have risk factors for coronary vessel disease which include hypertension, hyperlipidemia, mild obesity and a past history of smoking.
>
> In summary, the worker experienced two episodes of angina (lack of sufficient blood reaching the heart muscle for a short period of time, but not causing muscle damage). He did not suffer a myocardial infarction (heart attack).
>
> I have already listed the risk factors for coronary artery disease which are not occupationally related. The two work incidents described on file did not significantly accelerate, activate or advance the worker's pre-existing condition, but merely brought to the worker's attention the presence of an underlying pre-existing heart condition.

In his May 4, 2005 claim log entry the case manager indicated that he had contacted the worker that day. The worker contended that his initial five years as a firefighter had exposed him to more smoke than his previous years of cigarette smoking.

In his May 4, 2005 decision the case manager reviewed the incidents of October 26, 2004 and November 14, 2004 and subsequent medical treatment. He indicated that he accepted Dr. D's opinion and determined that he was unable to accept the worker's claim. He indicated that coronary artery disease is a progressive condition which develops as result of many factors, and there was no evidence to link the worker's heart condition to his work. The work incidents of October 26, 2004 and November 14, 2004 resulted in symptoms which brought the worker's pre-existing coronary condition to his attention. The worker's medical history was significant for risk factors including hypertension, hyperlipidemia, mild obesity, and smoking, all of which were not work-related.

The worker requested reviews of the February 24, 2005 and May 4, 2005 decisions. In his July 14, 2005 submission Mr. Guenther indicated that a decision was made on November 24, 2004 to accept the worker's claim, and it did not matter whether that decision was made prematurely or incorrectly. What mattered was that the decision

had been made. There was no tenable argument that no decision was made at that time; the effect of the decision was that the worker's condition was compensable.

Mr. Guenther argued that the case manager who made the claim log entries of December 3, 2004 and December 15, 2004 regarding the worker's October 26, 2004 claim correctly assessed the previous decision of November 24, 2004 as one that had to be corrected within 75 days, that is, by February 7, 2005. He argued that such a correction had not been undertaken.

Mr. Guenther contended that the February 24, 2005 decision which denied payment for prescription costs did not "assist the Board", as it had been specifically decided by the earlier November 24, 2004 decision that health care costs would be accepted. He stated that the Board's declaration that there had been no decision made did not mean that no decision had been made. Further, telling the worker on March 11, 2005 that his claim had been denied, when it had not, did not mean that either no decision had been made or that an adverse decision had been made. He asserted that the March 11, 2005 claim log entry looked like an attempt to "rewrite history on this claim, something specifically precluded by the statute itself."

Mr. Guenther commented that it might seem unfair, unjust, or inappropriate that a claim decision that may well have been made incorrectly or without satisfactory (or any) evidence could have the effect of becoming binding on the Board. He observed that the 2002 amendments to the Act had the stated purpose of bringing finality to claims decisions and had precluded many workers, in many situations, from challenging decisions that may have been equally incorrect or contrary to evidence (or without evidence). Speculation or a conclusion that a mistake has been made was no longer sufficient to alter a Board decision, except within 75 days of the decision.

Mr. Guenther contended that the incident of October 26, 2004 was caused by the worker's coronary artery condition which had been accepted by the Board. The November 24, 2004 decision now governed the worker's entitlement to benefits, and the worker's request for reimbursement for medication for his coronary artery condition should have been allowed, consistent with the November 24, 2004 decision. The February 24, 2005 decision should be reversed. The May 4, 2005 decision which purported to deny the worker's claim should also be reversed, as that decision was precluded by operation of sections 96 and 96.2 of the Act.

Mr. Guenther advised that the worker's alternate argument was that his coronary artery disease was properly accepted and should remain accepted. The Board's policy at item #15.15 of the *Rehabilitation Services and Claims Manual*, *Volume II* (RSCM II) gave rise to "an evidentiary inference in favour of the worker, in light of his symptoms of chest pain." He noted that Dr. Latham observed in his February 14, 2005 report that as a result of "being a firefighter [the worker] had been exposed to smoke on many occasions." Mr. Guenther submitted that Dr. D's "cursory review is cursory and insubstantial in its analysis, to the extent any analysis is documented at all."

In his September 30, 2005 decision the review officer reviewed the history of the two claims. He observed that "[i]nexplicably" a log entry dated November 24, 2004 indicated that the October 26, 2004 claim had been accepted for health care benefits only. At that point, the only document on file was the employer's report of the incident. He noted that the Board sent a form letter to the worker confirming acceptance of the claim. He commented that in a December 3, 2004 claim log entry a case manager noted that she might have to reconsider the decision to accept the claim for health care benefits if medical information was received which confirmed the existence of a pre-existing heart problem. He considered that an electronic summary screen attached to the claim showed that the status of the claim had changed from health care only to information only on the day prior to the December 3, 2004 claim log entry.

The review officer cited subsections 5(1), 6(1), 96(4), and 96(5) of the Act. He also referred to Board policy found at items #15.10, #15.15, #26.55, #30.70, and #C14-101.01 of the RSCM II. He provided the following analysis in support of his determination that the November 24, 2004 decision did not involve acceptance of the worker's coronary artery disease:

> I have first considered the matter of whether the Board was precluded from making these two decisions by the provisions of section 96(5). Technically, the initial letter sent to the worker on November 24, 2004 was a decision. It advised him that his claim had been accepted for health care benefits. This is despite the fact that there is no indication of what condition had been accepted or even whether the person who issued this letter had considered this. The fact that there was no evidence on the claim file at that time regarding the nature of the worker's injury or disease would lead me to conclude that the claim was not accepted or even considered for coronary artery disease. According to the claim summary attached to the Board's electronic file system, the claim was initially accepted for a sprain/strain to the chest wall.
>
> Medical information received subsequent to the decision to accept the claim for health care benefits confirmed that the worker's condition had been diagnosed as CAD [coronary artery disease]. This constituted a new medical condition that had not previously been considered by the Board. Therefore, as per the provisions of policy item #C14-101.01,

> I find that the Board had jurisdiction to render a new decision on the acceptability of the worker's CAD which was a new matter not previously decided upon.

With regard to the merits of the claim, the review officer determined that the facts surrounding the events of October 26, 2004 and November 14, 2004 were not in dispute. He accepted that the worker was a firefighter who had engaged in strenuous physical activity on both dates. He acknowledged a close temporal relationship between the events on those dates and the onset of transient chest pain. He found there was no dispute with respect to the diagnosis of coronary artery blockage which resulted in the need for bypass surgery.

The review officer found that item #15.15 was not applicable to the worker's claim:

> I find that the circumstances of the claim do not meet the requirements for acceptance under policy item #15.15. Although the worker is a firefighter and was engaged in a rescue operation involving strenuous physical activity on October 24, 2004, his symptoms did not arise as a result of myocardial infarction or cardiac arrhythmia. Rather, his symptoms arose as a result of the blockage of his coronary arteries. I find no evidence that the CAD was caused by his employment as a firefighter. Contrary to the assertion of the worker's lawyer, neither of the specialists whom the worker has seen has suggested such a link. This is a pre-existing, deteriorating condition that had become symptomatic but did not become disabling as a result of a specific work activity. In fact, the worker continued to work well beyond either event and finally stopped on December 16, 2004 for preventative reasons.

He found that the worker's employment did not significantly aggravate or accelerate his pre-existing condition:

> I have lastly considered whether there is evidence to support a conclusion that the worker's pre-existing CAD was significantly aggravated or accelerated by his employment. I find that it was not. There is no contrary opinion to that of the Medical Advisor who stated that the physical exertion at work in October/November had the effect of drawing to the worker's attention the existence of the disease. Further support for the Advisor's opinion is the fact that the worker continued to experience chest pain during exertion after he had stopped working altogether. The evidence supports that the worker experienced the transient effects of the artery blockage following exertion at work in October/November 2004. There is nothing to suggest that the exertion materially aggravated or accelerated the pre-existing condition.

The review officer determined that the worker's claim did not satisfy the requirements for acceptance under either sections 5 or 6 of the Act.

Reasons and Findings

Nature of The November 24, 2004 Letter

A copy of the November 24, 2004 letter is not on file. A copy was supplied by the worker. The letter is designated as a "25W42." It is produced by the Board's mainframe computer. The e-file lists all the mainframe letters issued by the Board on a claim, and a 25W42 is listed on this claim as having been sent to the worker and his employer. I consider it might be appropriate for such letters to be scanned to the Board's e-file, as they constitute relevant evidence. I appreciate that the Board may not wish to scan every document to the e-file; it may consider that those familiar with the claim file and the parties to the claim will be aware that such a mainframe letter was issued.

I find that the November 24, 2004 letter was a decision. The letter stated that the Board had accepted the worker's claim for compensation benefits for his work injury. That the claim was accepted for health care benefits only does not affect its status as a decision. Health care benefits cannot be accepted unless the Board accepts the condition for which health care is provided to a worker.

What Condition Was Accepted By The November 24, 2004 Decision?

The more critical issue is the nature of the condition accepted by the Board. There were no medical reports on file at the time the November 24, 2004 decision was issued. As well, there is no suggestion that a Board officer spoke to the worker prior to, or at the time of, the November 24, 2004 decision to confirm the nature of the worker's injury or disease. While the worker's November 23, 2004 applications for compensation had been received by the Board on November 24, 2004 (they are date-stamped as having been received on November 24, 2004), they were not scanned to the claim files when the November 24, 2004 decision was issued. That portion of the file which documents all log entries notes that the capture date for the worker's application for the October 26, 2004 incident was November 25, 2004.

The only documents on the Board's e-files at the time of the November 24, 2004 decision were the employer's two reports of injury or occupational disease. Those reports described the October 26, 2004 incident as involving shortness of breath and chest pain that radiated down the worker's arms. I accept that it is possible that the entitlement officer was aware of the contents of the worker's applications when she issued her November 24, 2004 decision, but the evidence does not resolve the matter one way or the other.

I do not consider that acceptance by the Board of symptoms reported on October 26, 2004 must automatically mean that the Board accepted a cardiac injury to the exclusion of any other injury that might have caused such symptoms. That such symptoms might not have been due to a cardiac injury is clear from the worker's observations on the second page of his application regarding his November 14, 2004 incident. He notes that the attending physician at the hospital on October 29, 2004 advised that he had not suffered a heart attack and his family physician indicated that the blood work suggested that the pain on October 26, 2004 was not cardio-related. If physicians did not consider that the worker's symptoms were cardio-related, they must have thought that the symptoms could be due to some other condition.

I agree with Ms. Patterson's comment on page 5 of her February 9, 2006 submission that the letter of November 24, 2004 was clearly a decision to accept the worker's claim arising from the October 26, 2004 incident regarding "chest pains."

Ms. Patterson also submits that the November 24, 2004 decision was a decision to accept the worker's heart condition - coronary artery disease. She submits that, while it was true that the entitlement officer initially understood the worker's claim to be for chest pain, it was clear from the application forms that the worker "never suggested or applied for 'chest strain' and there was no medical evidence diagnosing 'chest strain' at the time of the Board application." It appears that she may consider that the entitlement officer was in possession of the worker's applications at the time of her November 24, 2004 decision. I do not consider that the evidence on file resolves this issue. I accept that acceptance of chest sprain/strain would not be inconsistent with the notion that the entitlement officer had the, as yet, un-scanned applications in her possession when she issued her November 24, 2004 decision. I accept Ms. Patterson's assertion that the worker never applied for "chest strain"; his applications contain no reference to chest strain.

If the entitlement officer possessed the worker's applications when she issued the decision, was her decision to accept a claim for sprain/strain a result of a misreading of those applications, as contended by Ms. Patterson? She notes that the worker's application regarding his October 26, 2004 incident does not contain the words "coronary artery disease." She submits that the worker identified that Dr. Lalani had made a "firm diagnosis" based on the October 29, 2004 stress test. (Neither of the worker's applications referred to Dr. Lalani having made a "firm diagnosis." The application regarding the October 26, 2004 incident indicated that Dr. Lalani "diagnosed the results of the stress test" done on November 15, 2004.) Ms. Patterson indicates that the worker deferred to the medical diagnosis of Dr. Lalani. While that may be true, the worker's application for the October 26, 2004 incident does not refer to coronary artery disease.

Ms. Patterson indicates that on November 15, 2004 Dr. Lalani verbally cautioned the worker about recognizing "unstable angina" and the need to seek immediate medical attention from either Dr. Miki or the emergency department, in the event of chest pain. She submits that in his application with respect to the November 14, 2004 incident the worker explained that he did not seek medical attention on November 14, 2004 because at that time he believed his condition was not cardio-related, based on earlier information from both Dr. Miki and the emergency physician who treated his October 26, 2004 episode.

Ms. Patterson contends that the entitlement officer misunderstood the worker's application regarding the November 14, 2004 incident to mean that Dr. Miki's diagnosis of "no cardio condition" was the working diagnosis. She submits that the entitlement officer had a "serious misunderstanding" of the worker's applications, particularly of his application for the first episode, "…which provided detailed and complete information regarding his cardiac condition."

I question whether the worker's application regarding the October 26, 2004 incident can be fairly categorized in such a manner. If the worker had been told about unstable angina on November 15, 2004, his applications which he would have completed over a week later fall far short of providing detailed information regarding his cardiac condition. His application regarding his November 14, 2004 incident certainly suggests that his symptoms on October 26, 2004 were not cardiac in origin. I question the extent to which the entitlement officer could be faulted for acting on information passed on by the worker which suggested that his symptoms were not cardio-related. An understanding that a diagnosis of "no cardio condition" was the working diagnosis would be consistent with the worker's applications which contained no suggestion that he had received medical advice from Dr. Lalani contrary to that of Dr. Miki and to that of the emergency room physician.

Ms. Patterson seeks to classify the nature of the November 24, 2004 decision with regard to events that happened after that decision was issued. She contends that, while the initial acceptance was on the basis of a misunderstanding, the Board continued to accept the claim after the case manager knew of the worker's heart condition. She draws attention to the December 3, 2004 claim log entry which noted that the worker had been sent for cardiac tests and there was evidence of blockages in his heart. The case manager observed that she would reconsider the claim if the medical evidence supported the existence of a pre-existing heart problem. However, the case manager chose not to reconsider the claim at that point, and did not seek further medical evidence to confirm or deny whether the heart problem was pre-existing. Ms. Patterson submits that the case manager received information regarding the worker's heart condition and chose not to reconsider the acceptance decision.

Ms. Patterson contends that there are reasons in policy and natural justice as to why the case manager's decision to continue to accept the claim after she had realized

that the claim was not for a "chest strain", should be determined to be "a *de facto* adjudication of [the worker's] application for his CAD condition." I have summarized the remainder of her arguments in this regard in the following bullet-point format:

- The worker applied for acceptance of his coronary artery disease condition, and only his coronary artery disease condition.

- The Board's acceptance letter was not specific (as per requirements found in policy item #99.20 of the RSCM II), and the worker reasonably understood that the letter was an acceptance of the condition for which he applied.

- Had the worker been informed that his claim had been accepted for a condition for which he had not applied, he would have had an opportunity to respond and to supply supporting medical information.

- As the worker never applied for, or heard of, "chest strain" as his compensable condition, it would be unfair and prejudicial to have a chest strain condition be the basis of the Board's acceptance decision. Such a basis would be contrary to the guidelines for notice of adverse decisions found in item #99.20.

- The worker thought that his claim had been accepted for his coronary artery disease; he proceeded exactly as advised in the November 24, 2004 letter, when he contacted the Board when health care expenses arose and when he expected wage loss benefits with respect to his surgery.

- The case manager "clearly knew" that the Board had accepted a heart condition and that there was a time-frame for a reconsideration of its acceptance.

- Item #93.26 of the RSCM II requires the Board to make reasonable efforts to obtain medical information; while the worker provided Board officers with Dr. Lalani's address and phone number, they made no such effort.

- Given that the claim had been accepted, the case manager's decision to "do nothing", rather than to exercise inquiry powers, was, in effect, a decision to continue to accept the worker's claim "for the condition on his application" and to wait and see if any medical reports arrived at the Board.

- The case manager was aware that the Board's decision to accept the claim could be reconsidered based on future medical evidence within 75 days; she was also aware that the worker had disclosed the existence of his medical

information and that a detailed and accurate diagnosis of the worker's condition was easily available; however, the case manager chose not act and not to make a reasonable effort to obtain medical information.

- It would be unfair, in these circumstances, to find that the Board's decision of November 24, 2004 constituted an acceptance of a chest strain.

- The November 24, 2004 decision can only be reasonably interpreted as the Board's acceptance of the condition for which the worker applied. This is the "common sense meaning of a general acceptance", and one which a reasonable person would understand as being involved. That was certainly the worker's understanding.

- While the Board initially accepted the claim in error, it continued to accept the claim after it knew that the worker applied for a heart-related condition, and that the worker had been sent a general acceptance decision. In this context, the Board's continued acceptance of the worker's claim is effectively an acceptance of the claim for the heart condition, until there was a timely reconsideration otherwise.

I accept that the December 3, 2004 claim log entry by the case manager indicated that she was aware that the worker had blockages in his heart. The final paragraph of that claim log entry strongly suggests that the case manager considered that the initial acceptance of the claim involved an acute heart injury. This is so, despite the fact that the "Injury Decision" of December 2, 2004 suggests that the claim had been considered on the basis of "sprains, strains".

It is noteworthy, though, that there is no "Injury Decision" associated with the November 24, 2004 decision to accept the claim. The entries on the e-file do not establish, in any reliable manner, what the customer service representative accepted in her November 24, 2004 decision. The first "Injury Decision" was created on December 2, 2004, several days after November 24, 2004. As noted above, that injury decision which suggests a denial of a claim for "sprains, strains" seems to have been superseded by a December 2, 2004 claim log entry by the customer service representative who indicated that the claim had been accepted for health care only. Further, I consider it significant that the case manager's December 3, 2004 claim log entry indicated that the claim was accepted. That would not have been the case if the December 2, 2004 "Injury Decision" entry was in effect; that is, if the claim had, in fact, been denied.

The claim was still accepted as of December 3, 2004. The claim continued to be accepted as of December 15, 2004. That, as of that date, the case manager appeared to consider that the claim had been accepted for a heart-related injury is established

by her first December 15, 2004 claim log entry. I consider that that claim log entry purported to change the status of the claim from accepted for health care benefits only to information only.

I do not read that first December 15, 2004 claim log entry as indicating that the case manager put off the making of a decision. I consider that the caption line of that claim log entry and the case manager's second December 15, 2004 claim log entry clearly establish an intention to change the status of the claim. The reference in the final line of the first December 15, 2004 claim log entry to the making of a decision referred to the making of a decision with respect to the merits of the claim after it had been changed from health care only to information only. Such a decision could be rendered after the change in status, because a decision after the receipt of medical evidence would not involve a reconsideration of a decision regarding the merits of the claim.

Aside from the issue of the whether the December 15, 2004 claim log entry successfully changed the status of the claim (a matter which will be discussed further in this decision), does the case manager's belief that she needed to undertake a reconsideration of the claim within 75 days of the November 24, 2004 decision, should she wish to change the status of the claim, mean that the November 24, 2004 decision involved acceptance of a heart-related injury? I question whether her impression as to the nature of the decision is determinative of the nature of any injury accepted by the November 24, 2004 decision. I do accept that her impression is relevant.

Also of relevance is the nature of the condition for which the worker thought he had applied for compensation. In that regard, I question Ms. Patterson's assertion that "the condition on [the worker's] application" was coronary artery disease. The applications make no reference to such a condition.

While the applications make no reference to coronary artery disease, I accept that the worker applied for such a condition. This is so, because Dr. Lalani's November 16, 2004 report indicates that he spoke to the worker on November 15, 2004 about recognizing unstable angina. That report makes no reference to chest sprains/strains; there is little basis to find that the worker thought he had applied for compensation for sprains/strains. This is so, even though his application for his November 14, 2004 incident might suggest that he had not been told that he had a cardiac condition and, in fact, had been told that he did not have a cardiac condition.

Thus, the worker applied for compensation for a cardiac condition. Regardless of whether the customer service representative was aware of the contents of the worker's applications for compensation when she issued her decision, the worker would have been aware that he signed those applications and submitted them to the Board. The Board's November 24, 2004 decision was issued on the day that his applications were received by the Board. The November 24, 2004 decision indicated that the claim had

been accepted. The decision did not specify the nature of the acceptance and did not impose any limitations on the terms of acceptance. By that, I mean that the decision did not indicate that the claim had been accepted for chest sprains/strains.

Does a worker's belief as to what had been accepted by the Board mean that the Board had, in fact, accepted what the worker had applied for? I do not consider that statements can be made that are applicable to claims in general. The facts of a specific case are key. In the case before me, the worker applied for a cardiac condition, yet his application was not specific with respect to such a condition. However, the application made no reference to sprains and strains, and neither did any of the medical reports prepared at the time of the worker's treatment prior to his completing the applications on November 23, 2004, keeping in mind that the Board did not have any medical reports as of November 24, 2004.

While a sprain/strain would not be inconsistent with the worker's symptoms reported on October 26, 2004 and November 14, 2004, the simple fact is that there is no persuasive indication that the November 24, 2004 decision accepted sprains/strains. As noted above, there is no injury decision which indicates that sprains/strains were accepted on November 24, 2004. It is not clear what condition the customer service representative thought she was accepting on November 24, 2004 when her acceptance letter was issued.

Given the open-ended, general nature of the acceptance letter, I find that it was reasonable for subsequent Board officers to have considered the November 24, 2004 letter to have accepted that the worker's pain on October 26, 2004 was associated with his heart. The comments by the case manager indicated she considered the earlier letter to have accepted such a heart-related injury. Her analysis of the effect of that letter, perhaps generated in light of information which the Board received subsequent to November 24, 2004, was not unreasonable.

I find that the November 24, 2004 decision accepted that the worker's October 26, 2004 incident was of causative significance with respect to his pain associated with his heart. The worker did not suffer a heart attack. The pain was due to an extraction incident that occurred against the backdrop of the worker's pre-existing coronary artery disease. That the Board accepted such pain does not amount to an acceptance of the underlying coronary artery disease. Given the comments of Dr. Lalani and Dr. D, the most likely diagnosis of the worker's pain on October 26, 2004 is angina which, as per Dr. D, did not cause muscle damage. Acceptance of an attack of angina does not amount to an acceptance of the underlying condition.

I appreciate that the worker may have thought that he was applying for compensation for his coronary artery disease. He may even have thought that the Board accepted his coronary artery disease as compensable. I find, however, that his intention or his belief does not establish the basis of the Board's acceptance of a claim. There was no reference to coronary artery disease in the worker's applications or in the

November 24, 2004 decision. I find that coronary artery disease was not accepted by the November 24, 2004 decision. I do not consider that a common sense meaning of a general acceptance would mean that the Board must have been understood to have accepted the worker's coronary artery disease.

The Board accepted pain associated with the worker's heart. I do not consider that, as asserted by Ms. Patterson, the Board accepted a "heart condition", which I interpret to be a reference to something more than the worker's pain on October 26, 2004 associated with his heart. Further, that the Board later learned that the worker had blockages in his heart and did not seek medical evidence in a timely manner would not turn the November 24, 2004 decision into an acceptance of the worker's coronary artery disease.

The Effect of the December 15, 2004 Claim Log Entry

At this juncture, the next critical question is the effect of the first December 15, 2004 claim log entry which purported to change the status of the claim. There are no submissions of any significance from Mr. Guenther or Ms. Patterson as to the effect of the first December 15, 2004 claim log entry. Ms. Patterson's submissions tend to indicate she thought that the case manager's December 15, 2004 claim log entry indicated that the case manager thought that she might render a decision in the future, as opposed to the case manager having actually rendered a decision in her December 15, 2004 claim log entry. As noted above, I consider that the case manager, in her first December 15, 2004 claim log entry, purported to change the status of the claim.

As of the date of that first December 15, 2004 claim log entry, the claim has been accepted for health care benefits; this is so, despite the December 2, 2004 "Injury Decision" log entry noted above which indicated that the claim had been denied or the December 2, 2004 "Decision" entry which indicated the claim was filed for "info only." That December 15, 2004 claim log entry was made within 75 days of the November 24, 2004 decision. The February 24, 2005 letter and the May 4, 2005 decision were issued more than 75 days after the November 24, 2004 decision. The 75-day period is critical, given the terms of subsections 96(4) and 96(5) of the Act which provide that the Board may not reconsider a decision if more than 75 days have passed, save for cases where the decision resulted from fraud or misrepresentation.

In reviewing the issue of whether a claim log entry documented within 75 days of a decision is sufficient to reconsider that decision, I have taken into account the analysis found in *WCAT Decision #2006-02121,* issued on May 17, 2006.[1] Given the result of

[1] That decision, as well as other WCAT decisions cited in this decision, may be viewed on the Internet at WCAT's website at http://www.wcat.bc.ca/.

my analysis, I did not provide the worker with a copy of that decision (which was issued after the close of submissions in the case before me) and give him an opportunity to make a submission.[2]

In *WCAT Decision #2006-02121* the Board issued a decision which accepted a worker's injury; a claim log entry on the 75th day following that initial decision reconsidered the acceptance of the claim. A decision letter was issued on the 77th day after the initial decision.

I consider that the following bulleted summary of the panel's findings in *WCAT Decision #2006-02121* is of assistance in adjudicating the matter before me:

- Given the terms of the *Interpretation Act,* for the purposes of calculating the relevant time period, the date the original decision was made is excluded and the 75th day is included.

- None of the Board's published policies addresses when a decision is made, either generally, or for the purposes of a reconsideration decision under section 96 of the Act.

- Although policy item #C14-103.01 of RSCM II does not expressly address when a decision is made for the purposes of calculating when the 75-day time period begins and ends, it requires the Board to communicate the reconsidered decision to the affected parties.

- While various policies seem to make a distinction between the making of a decision and the activity of communicating and explaining a decision to the affected parties, the reconsideration process set out in policy #C14-103.01 assumes that a decision letter is issued at the same time a decision is made.

- The *Core Services Review of the Workers' Compensation Board*[3] (the Winter Report) proposed that the 75-day reconsideration period, the 90-day period to request a review by the Review Division, and the 30-day period to appeal to the appeal tribunal all run from the date the disputed decision was communicated, in writing, to the affected party(ies).

- Although the *Workers Compensation Amendment Act (No. 2), 2002* (Bill 63) incorporated the 75-day time limit on the Board's reconsideration power recommended by the Winter Report, it did not require written communication of the disputed decision before the various statutory time limits began to run.

[2] By letter of June 7, 2006, Ms. Patterson asked that the decision be brought to the attention of the panel assigned to this appeal. That letter arrived during my drafting of this decision.
[3] This report is accessible on the Internet at the website of the Ministry of Labour and Citizens' Services

- The provisions in Bill 63 which establish time limits for reconsideration by the Board (subsection 96(5)) and by the Review Division (subsection 96.5(3)), and for filing a request for review to the Review Division (subsection 96.2(3)) or an appeal to WCAT (subsections 243(1) and (2)), are all expressed as beginning when the disputed decision "was made." Subsection 96(6) sets out a 150-day time limit in which a review officer "must make a decision on a review." None of these provisions specify when a decision is considered to be made.

- Various dictionary definitions of "decision" do not assist in pinpointing when an administrative body, such as the Board, makes a decision for the purpose of beginning or ending a statutory time limit. Only some of those definitions contemplate some form of communication of the content of the determination (i.e., the reference to pronouncement or delivery of a decision).

- One of the rules of statutory interpretation of particular relevance in this case is the presumption of consistent expression, which applies not only to individual words but also to patterns of expression.

- The reconsideration, review and appeal provisions added to the Act by Bill 63 all use the same formulation, to the effect that the relevant time limits run from when the disputed decision "was made." In the absence of clear language in the Act or published policy which would dictate such a result, there is no compelling reason to give a different interpretation to when a decision is "made" for the purpose of triggering/concluding the 75-day time limit on the Board's reconsideration authority and the 23-day limit on the Review Division's reconsideration authority, or triggering the 90-day time limit for a party to request a review.

- While the Legislature could easily have made such a distinction between the operation of these statutory time frames, it did not do so. It is therefore presumed that the Legislature did not intend to create inconsistent schemes for the counting of these time periods for the various reconsideration, review and appeal provisions.

- A panel in concluded *WCAT Decision #2004-03907* that an internal determination on the Board's file, which was not communicated to the affected party(ies), did not constitute a "decision" for the purpose of triggering the 75-day time limit on the Board's reconsideration authority in sections 96(4) and (5) of the Act.

- A number of subsequent WCAT panels have adopted the rationale in *WCAT Decision #2004-03907*, and similarly concluded that a Board decision which is not communicated is not a decision for the purpose of triggering the 75-day time limit on the Board's authority to reconsider a decision (see, for example, *WCAT Decisions #2004-06708* and *#2005-05996*). The panels in these cases all considered it significant that to adopt the Board's interpretation of "decision" in the context of sections 96(4) and (5) would effectively deprive the affected employer or

worker of their appeal rights under the Act, as the Board had never informed them of the decision at the time it was documented on the file, or provided them with a formal decision which they could appeal within the relevant statutory time frame.

- The panel in *WCAT Decision #2005-05996* acknowledged that this interpretation did not accord with the restrictive wording in *Best Practices Information Sheet #5* (effective March 31, 2005) to the effect that a decision is made when it is documented on the claim file. The panel noted: "Although it may be administratively more convenient, given the reasoning I have adopted from *WCAT-2004-03907*, and my conclusion that sections 96(4) and (5) cannot operate in the face of an uncommunicated decision, this guideline violates basic principles of procedural fairness and natural justice."

- In *WCAT Decision #2004-05849* a panel concluded that the Board exceeded its jurisdiction in making a reconsideration decision outside the 75-day period. The panel treated the decision letter, rather than the claim log decision memo (which was made within the 75-day period), as the reconsideration decision.

- There is ambiguity in the Act with respect to when a decision is made.

- The panel in *WCAT Decision #2005-04638* stated that the timeline that is triggered for a right to a review or an appeal is separate and different from the timeline in which the Board may reconsider a decision. Other WCAT decisions cited above concluded that the 75-day reconsideration period starts at the same time as the time period to initiate a review or an appeal; both require a decision that is communicated.

- Different considerations may apply to the timeline that is triggered for an affected party's right to review or appeal, as distinct from the timeline which governs the Board's jurisdiction to reconsider one of its own decisions. In the former case, there are strong natural justice arguments for importing a communication requirement before a decision is considered "made" so as to trigger the running of the review/appeal period. It is obvious that affected parties cannot exercise their statutory appeal rights if they are not aware of the existence of a decision. This rationale underlies the conclusion in the WCAT decisions cited above that the 75-day reconsideration period is not triggered until the decision is communicated to the affected party.

- An argument could be made that, for the purposes of the Board's statutory authority to reconsider its decision, a decision could be considered to have been made within the 75-day period when it is documented in the claim file (as set out in *Best Practices Information Sheet #5*), even though the appeal period related to that decision would only begin to run when the decision is communicated in a decision letter. Adopting such an approach to the Board's reconsideration authority would not

affect a party's substantive appeal rights. Even though the reconsideration decision letter in *WCAT Decision #2006-02121* was issued two days after the claim log entry recording that decision, the worker did not lose two days from the 90-day period in which to seek a review of that decision. The 90-day period is counted from the date of the decision letter, not the claim log entry.

- The panel in *WCAT Decision #2006-02121* concurred with the following comments found in *WCAT Decision #2005-00570* with respect to the importance of developing a common understanding of the term "decision" for all purposes under the Act:

  > For example, in considering whether the Board's prior determination constituted a decision to which the 75 day time limit on the Board's reconsideration might apply, it may be helpful to consider whether the prior determination was a reviewable decision. In considering whether a decision is reviewable by the Review Division, it may be helpful to consider whether it was a determination to which the 75 day time limit on the Board's reconsideration authority would apply. Focussing exclusively on a single context in which a term is being used, and not having regard to other contexts under the Act in which the term is used, is likely to lead to error through applying too narrow a focus.

- Absent a specific statutory provision which mandates different interpretations, decision-makers in the workers' compensation system should adopt a consistent interpretation of "decision" which does not vary depending on the context.

- The panel in *WCAT Decision #2006-02121* did not accept the Board's interpretation in *Best Practices Information Sheet #5* that, for the purpose of determining the 75-day reconsideration period, a decision is made when it is documented in the claim file. While the panel acknowledged it would be administratively more convenient for the Board to use the date of the claim log entry or other internal file note as the date of the decision, such an approach would result in inconsistent schemes for counting the time periods for the reconsideration, review and appeal provisions in the Act. It also noted that such an approach runs counter to transparency in administrative decision-making.

- In the absence of specific direction in the Act or the Board's published policy on this matter, a reconsideration decision is not "made" for the purpose of the 75-day time limit in section 96(5) until the final decision resulting from the reconsideration process has been recorded in the file and communicated in some form to the affected party(ies). At that point the decision-making function is complete and the new decision has been "made", whether that decision simply confirms, varies or reverses the prior decision. Communication of the decision is not simply an administrative task, but is an integral component of the decision-making process involved in a reconsideration under sections 96(4) and (5).

- The panel in *WCAT Decision #2006-02121* concluded that its interpretation of when a decision is made in the context of the reconsideration provisions best fits with the legislative intention of promoting finality and certainty in the workers' compensation system, in that it gives the same interpretation to the same words which the Legislature has used to establish the statutory time limits for reconsideration, review and appeal.

The panel in *WCAT Decision #2006-02121* did not address the fact that, prior to the coming into force of Bill 63, communication requirements existed in the statute in connection with appeal remedies.

The current Act provides as follows, with respect to requesting a review by the Review Division:

> 96.2(3) A request for review must be filed **within 90 days after the Board's decision or order was made.**
>
> [emphasis added, above and in subsequent quotations]

Prior to March 3, 2003, the Act provided as follows regarding appeals to the Review Board:

> 90 (1) Where an officer of the Workers' Compensation Board makes a decision under this Act with respect to a worker, the worker, or, if deceased, the worker's dependants, or the worker's employer, or a person acting on behalf of the worker, the dependants or employer, may, not more than 90 days **from the day the decision is communicated to the worker,** dependants or employer, or within another time the review board allows, appeal the decision to the review board in the manner prescribed by the regulations.

The current Act provides as follows, regarding appeals to WCAT:

> 243 (1) A notice of appeal respecting a decision referred to in section 239 must be filed **within 30 days after the decision being appealed was made**.
>
> (2) A notice of appeal respecting a decision referred to in section 240 must be filed **within 90 days after the decision or order being appealed was made.**

Prior to March 3, 2003, the Act provided as follows, regarding appeals to the Appeal Division:

> 91 (1) Where the review board makes a finding under section 90, the worker, the worker's dependants, the worker's employer or the representative of any of them may, **not more than 30 days after the finding is sent out,** or within a longer period the chief appeal commissioner may allow, appeal the finding to the appeal division.

Despite the recommendations of the Winter Report that there be a communication component as part of the decision-making process, one can argue that such a communication component was removed from the statute when it was amended pursuant to Bill 63. Does the apparent removal of a communication component mean that the appeal period can run without communication of a decision? If this is so, and to the extent that reconsideration considerations should parallel decision-making considerations (after all, pursuant to section 1 of the Act, "reconsider" means to "make a new decision"), does this mean that a reconsideration decision may be rendered within the 75-day period without a communication component?

One can argue that, in the absence of any other good reason, the removal of a communication requirement was intentional. It is presumed that the Legislature intended something by the amendments.

I consider that, on their face, the amendments reflected a desire to have consistent language with regard to the commencement of appeal periods. I cannot ignore the fact that in the approximately 30 years prior to Bill 63 coming into force the Act was notable for varying provisions regarding the commencement of appeal periods with respect to the various appeal bodies. That point is illustrated by the statutory language (reproduced above) regarding appeals to the Review Board and Appeal Division. Another illustration is found in the former subsection 58(3) of the Act, with respect to appeals to Medical Review Panels:

> A worker is entitled to be examined by a medical review panel if, **not later than 90 clear days after the making of a medical finding** by the review board or a medical decision by the board, the worker….

Under the current version of the Act, there is no process analogous to an appeal to the Medical Review Panel.

Harmonization of the commencement language regarding appeal remedies resulted from the introduction of Bill 63. Can it be said that Bill 63 also intended the removal of a communication component from the decision-making process? While I appreciate that the amendments took place against the backdrop of the Winter Report which recommended a communication component, I do not find that the amendments involved a decision by the Legislature to reject a communication component. Bill 63 was

intended to bring finality to the workers' compensation system; I consider that a decision-making process that lacked a communication component would involve the creation of a more cumbersome process. By that, I mean that an orderly adjudication and appeal process leading to finality is hampered by a lack of communication. Parties do not know their status unless they are told of decisions that affect them. I do not consider that the revised language flowing from Bill 63 involved an intention to remove a communication component from decision-making.

I find that a decision is not made until the Board issues a decision via a letter or an oral communication. There is no requirement that the decision be issued in writing to be effective. I appreciate that policy at item #99.20 provides that decisions adverse to a worker are to be communicated in writing; however, I do not consider that policy means that an oral communication of a decision is void (see *WCAT Decision #2005-04638* cited in *WCAT Decision #2006-02121*).

Given that a decision is not made until it is issued by the Board to a party, I find that a new decision, as part of a reconsideration process, must be made, that is, issued, no later than the 75th day after the initial decision. In the case before me, no decision was issued to the worker within 75 days of the November 24, 2004 decision. That the Board had the capacity to issue a letter in December 2004 advising the worker that his claim for an October 26, 2004 incident was registered for information only is demonstrated by the fact that the Board issued such a letter dated December 16, 2004 to the worker regarding his claim for a November 14, 2004 incident. Had the Board issued such a letter in tandem with the December 15, 2004 claim log entry regarding his October 26, 2004 claim, it would have successfully reconsidered the November 24, 2004 decision to accept the worker's October 26, 2004 claim.

I find that 75 days after the November 24, 2004 decision the Board lost the capacity under section 96 of the Act to reconsider the acceptance of the worker's claim for an October 26, 2004 incident. That the Board consolidated the worker's claims did not affect the status of the November 24, 2004 letter as a decision. The Board lacked the capacity to issue the February 24, 2005 letter which advised that the October 26, 2004 claim had been filed for information only. I find that the letter is void. I direct the Board to cancel the February 24, 2005 letter. (A finding of voidness and a direction to cancel were the remedies reached by the panel in *WCAT Decision #2006-02121*.)

The Significance Of The October 26, 2004 Incident With Respect To The Worker's Coronary Artery Disease

My finding that the Board lacked the capacity to change the status of the worker's claim for his October 26, 2004 incident does not resolve the matter of the significance of that incident with respect to his coronary artery disease. The claims adjudicator addressed whether the worker's October 26, 2004 incident significantly aggravated or accelerated the worker's coronary artery disease. He also addressed whether the November 14,

2004 incident significantly aggravated or accelerated the worker's coronary artery disease.

I find that coronary artery disease was a new matter that had not been previously decided by the Board as part of its November 24, 2004 decision, and, as such, could be addressed (as suggested by the review officer) under item #C14-101.01 of the RSCM II. The Board initially adjudicated the issue of heart-related pain and the October 26, 2004 incident; later events on the claim file raised the issue of coronary artery disease for adjudication. While the Board purported to reconsider the status of the worker's claim, it was not permitted to do so. It was required to adjudicate the causative significance of the worker's October 26, 2004 incident with respect to his coronary artery disease on the basis that that incident did result in heart-related pain.

I find that the evidence does not support a conclusion that the worker's October 26, 2004 incident significantly aggravated or accelerated his coronary artery disease. There is no medical opinion in favour of the worker. While Mr. Guenther considered that Dr. D's opinion was cursory and insubstantial, I am not persuaded that is so. Dr. D's claim log entry provides persuasive reasoning as to why the October 26, 2004 incident did not significantly aggravate or accelerate the worker's coronary artery disease.

The November 14, 2004 Incident

I find that the Board did not lack the capacity to issue its May 4, 2005 decision with respect to the causative significance of the worker's November 14, 2004 incident. This is so, because the Board had not issued an earlier decision accepting a claim for an injury associated with that incident. Its December 16, 2004 letter advised that the worker's claim for a November 14, 2004 incident had been filed for information only.

It is necessary to consider whether the November 14, 2004 incident involved a heart-related injury. Ms. Patterson indicates that with respect to issues of aggravation and item #15.15 the worker relies on Mr. Guenther's submissions to the Review Division.

I consider that item #15.15 is of little assistance to the worker, owing to the fact that the evidence does not support a conclusion that the worker had a heart attack or acute cardiac arrhythmia on November 14, 2004. The inference set out in item #15.15 is not applicable to simple chest pain; the chest pain must be due to a heart attack or acute cardiac arrhythmia, before the inference becomes applicable.

Dr. Latham's February 14, 2005 report does not assist the worker either. Dr. Latham's observation that the worker had been exposed to smoke on many occasions falls far short of an opinion regarding the worker's November 14, 2004 incident. Later in his report, Dr. Latham indicated that, because of the worker's exposure to smoke and gases, it was necessary to undertake pulmonary function tests. Dr. Webster, a

specialist in internal medicine, performed pulmonary function tests on March 10, 2005 which confirmed mild obstructive lung disease. Thus, the concern with the worker's exposure to smoke did not involve his heart condition.

While Mr. Guenther considered that Dr. D's opinion was cursory and insubstantial, I am not persuaded that is so. Dr. D's claim log entry provides persuasive reasoning as to why the November 14, 2004 incident was not of causative significance.

I find that the evidence does not support a conclusion that the worker's November 14, 2004 incident involved an injury arising out of and in the course of his employment or that the incident significantly aggravated or accelerated the worker's coronary artery disease.

Significance Of The Worker's Employment Generally

The case manager and the review officer addressed whether the worker's coronary artery disease and need for surgery were due to his work. I consider that they addressed whether the worker's coronary artery disease was due to the nature of his employment under section 6 of the Act. That issue is different from the question, under section 5 of the Act, of whether the symptoms on October 26, 2004 and November 14, 2004 were injuries arising out of and in the course of the worker's employment.

After reviewing the matter, I find that the worker's coronary artery disease and need for surgery were not due to the nature of his employment. There is no medical opinion which favours such a link. Dr. D's opinion points away from any conclusion favouring such a link.

Effect of My Variance of The September 30, 2005 Decision With Respect To The Worker's October 26, 2004 Incident

As the February 24, 2005 letter is void, the November 24, 2004 decision governs the initial adjudication of the worker's claim regarding his October 26, 2004 incident. As the November 24, 2004 decision determined that the worker's October 26, 2004 incident was of causative significance with respect to his heart-related pain, I find that it falls to the Board to address the worker's prescriptions which he submitted to the Board.

Conclusion

The worker's appeal is allowed, in part. I vary the review officer's September 30, 2005 decision. I find that worker's October 26, 2004 incident involved an injury (angina) arising out of and in the course of his employment. This is so, because a November 24, 2004 decision accepted that the incident of October 26, 2004 was of causative significance with respect to the worker's heart-related pain, and the December 15, 2004 claim log entry which sought to reconsider that November 24, 2004 letter was not

sufficient to result in reconsideration of that decision. The Board's February 24, 2005 letter, which purported to advise the worker that his October 26, 2004 claim had been filed for information only, is void and is to be cancelled.

The worker's November 14, 2004 incident did not result in an injury arising out of and in the course of his employment. The worker's coronary artery disease and need for surgery were not due to the nature of his employment, and the worker's coronary artery disease was not significantly aggravated or accelerated by his October 26, 2004 and November 14, 2004 incidents.

Reimbursement of expenses has not been requested. As no expenses are apparent, I make no order regarding expenses of this appeal.

Randy Lane
Vice Chair

RL/jy