

Noteworthy Decision Summary

Decision: WCAT-2007-01419 **Panel:** Andrew Waldichuk **Decision Date:** May 3, 2007

Expenses associated with attendance of Orthopaedic Surgeon at oral hearing – Item #13.23 of WCAT’s Manual of Rules of Practices and Procedures – BCMA Fee Schedule

This decision is noteworthy as it determines what expenses associated with the attendance of an orthopaedic surgeon as an expert witness at an oral hearing may be reimbursed.

The worker sought acceptance of a claim for bilateral forearm complaints. The worker requested his orthopaedic surgeon to attend at an oral hearing to give evidence as an expert witness and sought reimbursement of this expense. The worker also submitted a written report from the orthopaedic surgeon.

The panel considered the orthopaedic surgeon’s attendance at the oral hearing to be useful, since it provided him with an opportunity to question the surgeon about certain aspects of his opinion, which were not addressed in the written report. Accordingly, the panel found that the worker should be reimbursed for any expenses that she may have incurred in relation to the surgeon’s attendance at the oral hearing. Because the Worker’s Compensation Board’s, operating as WorkSafeBC (Board), schedule of fees did not specifically address the reimbursement of these expenses, the panel looked to the British Columbia Medical Association (BCMA) fee guide. The BCMA fee guide addresses medical-legal matters, which include the preparation of medical reports and physicians’ attendance in court to provide expert testimony. It is used in civil litigation matters.

The panel found the worker entitled to be reimbursed for the orthopaedic surgeon’s fee for his preparation time and attendance at the oral hearing, as calculated under the BCMA fee guide. The panel allowed for one hour of preparation time, since much of the medical and factual information that the surgeon had to review in preparation for his testimony was contained within his written report. The panel allowed an expense of up to \$1,423.00 for the surgeon’s providing half a day or less of expert testimony, since he attended the oral hearing for approximately one hour. The surgeon’s fee for preparation time and attending the oral hearing was to be reduced by 4.35% to be consistent with the discount in the Board’s fee schedule. The worker was also reimbursed for any return travel expenses that the surgeon might claim, provided that the distance the surgeon travelled from his office to the oral hearing location satisfied the Board’s policy in this regard.

WCAT Decision Number : WCAT-2007-01419
WCAT Decision Date: May 03, 2007
Panel: Andrew Waldichuk, Vice Chair

Introduction

The worker, an environmental consultant, completed an application for compensation on March 23, 2005 with respect to elbow, hand, and shoulder symptoms she attributed to computer use.

By decision dated April 15, 2005, a case manager at the Workers' Compensation Board, operating as WorkSafeBC (Board), informed the worker that it was unlikely that her work activities were of causative significance in producing her condition, which had been diagnosed as right-sided lateral epicondylitis.

The worker submitted a request for review of the case manager's decision to the Board's Review Division. On November 8, 2005, a review officer considered the compensability of various conditions: ulnar neuropathy, epicondylitis, and tendonitis. The review officer found that there was insufficient evidence to establish work causation in regard to any of the conditions.

The worker, through her representative, Mr. Proudfoot, now appeals the review officer's decision to the Workers' Compensation Appeal Tribunal (WCAT).

The employer is participating in the appeal and is represented by Mr. A [not his real initial].

An oral hearing was held on April 19, 2007. Both parties' representatives attended, along with the worker and Dr. Fuller, an orthopaedic surgeon. The worker and Dr. Fuller testified under oath.

Preliminary Matter

The review officer recognized that the Board had considered the worker's bilateral forearm symptoms, but did not adjudicate their compensability owing to the absence of a diagnosis. Even though the review officer only considered the diagnosis of ulnar neuropathy in the worker's left arm, in addition to the other diagnoses that had been put forth, I accept that I have jurisdiction in this appeal to consider the compensability of the worker's bilateral forearm condition, since that was the issue in the worker's request for review.

Issue(s)

Are the worker's bilateral forearm complaints compensable?

Jurisdiction

This appeal was filed with WCAT under section 239(1) of the *Workers Compensation Act* (Act).

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

Background and Evidence

The worker has an accepted 2003 claim (healthcare benefits only) for a bilateral forearm condition that had been diagnosed as tendonitis. She attributed her condition to computer keyboard and mouse use.

The employer's report of injury under the worker's 2003 claim indicates that she had been a permanent full-time employee since January 1, 2000.

A December 15, 2003 medical report under the worker's 2003 claim shows that she had developed a progressing ache in both forearms up to the elbows in the past six months.

Medical information under the worker's 2005 claim shows that she presented to her new family physician, Dr. Elliot, on March 2, 2005 with a four-year history of bilateral forearm pain and tingling in the ulnar groove. Dr. Elliot noted that the worker was spending eight hours a day working on the computer. On examination, the worker had full neck and shoulder range of motion. As well, she had full range of motion and function in her wrists and fingers. However, there was point tenderness over her right lateral epicondyle. Dr. Elliot diagnosed bilateral forearm pain and right-sided lateral epicondylitis. In terms of treatment, she requisitioned a neck x-ray and recommended anti-inflammatories and physiotherapy for the worker, who was still at work.

A March 16, 2005 x-ray of the worker's cervical spine and right elbow was normal.

Dr. Elliot reported on March 23, 2005 that the worker continued to have tingling and numbness from the medial epicondyle to the fourth and fifth fingers (there was no indication of which hand), which was now bothering her while driving. She thought that the worker should have electromyography (EMG) studies.

The case manager conducted an ergonomic assessment on March 23, 2005, which the worker attended. Her report indicates that the worker's symptoms at the time of her 2003 claim occurred only when she was typing; however, they had persisted and progressed to the point that she was in constant pain. Her pain, which originated in both elbow joints, extended into the palms of both hands, as well as the fourth and fifth fingers. The worker complained of tingling in those fingers and was starting to feel pain in both shoulders. Furthermore, the worker indicated that her symptoms had worsened in September and October 2004, at which time there was an increase in her overtime work. They bothered her during and outside of work.

The case manager obtained photographs and video of the worker at her workstation during the ergonomic assessment. Her report contains the following information:

- The worker's duties as an environmental scientist/consultant involve reviewing information, data, and writing reports. She generally does not do any field work.
- Working either at her employer's premises, at a client's premises, or at home, the worker uses a computer to produce her reports. This involves obtaining information from the Internet or from binders.
- The worker generally works an 8-hour day, but may work up to 12 hours a day for a week.
- The worker's workstation consists of a desk in an office cubicle. She works on a laptop computer using an ergonomic keyboard, which had been obtained in the past year. The keyboard is situated on the desktop, whereas the laptop is elevated six inches by a stand. Her chair is equipped with armrests.
- The worker, who is right dominant, uses her right hand to manipulate the computer mouse, which is situated to the right of the keyboard on a mouse pad that is equipped with a wrist rest.
- When keying, the worker tends to rest her left wrist on the sloped edge of the keyboard or on the desktop. At times, she also rests her right forearm against the rounded desk edge when mousing or keying. The worker's right wrist was also observed to glide freely over the keyboard keys and mouse. Her elbows and shoulders were observed to be in neutral postures. She did not rest her arms on the armrests of the chair.

- The worker uses her laptop computer when working at a client's premises or at home. Everyday, she carries her laptop, which weighs 8 pounds, to work and home using a backpack. In addition, the worker carries a leather bag of binders, which weighs 23 pounds, to work and home every day. Lastly, approximately once a week, the worker carries two boxes of binders to home and work, which weigh a total of 54 pounds. She uses a car to transport them.
- The worker described her general health as good, with no history of arthritis, diabetes, gout, thyroid, or hormonal problems. She indicated that her activities outside of work include rock climbing for approximately one hour every two to three weeks (which she had not done since the summer of 2004 because of pain), approximately 10 days of skiing each year (which she had not done in the past year), approximately one week of kayaking during the summer (which was last done in July 2004), and walking her dog. Since Christmas 2004, the worker had been working at home, primarily on the computer, every weekend for five to eight hours per day.

The case manager accepted that the worker's duties met the definition for bilateral wrist repetition, given the small increments of movement other than when moving her right wrist between the computer keyboard and mouse. She did not, however, accept that the worker's finger movement met the definition of repetition, while adding that there was little movement of the worker's elbows and shoulders during her computer activities.

The case manager accepted that the worker's bilateral shoulder and elbow postures were well within neutral limits. She noted that the worker's bilateral wrist posture varied from approximately 25 to 35 degrees of extension when keying. As well, computer mousing required approximately 20 degrees of ulnar deviation, but was generally within neutral limits in terms of flexion and extension.

In terms of force, the case manager accepted that most of the worker's work duties required minimal force, while recognizing that she occasionally carried up to approximately 40 pounds. Additionally, the case manager noted the contact pressure between the worker's left wrist and the front of the keyboard or the desktop during her work activities, in addition to that between her right wrist and the desktop when using the keyboard or mousing.

Dr. Elliot maintained her diagnosis of bilateral forearm pain and right-sided lateral epicondylitis in her March 30, 2005 report.

Dr. Gibson, a neurologist, assessed the worker on April 12, 2005. In taking the worker's history, Dr. Gibson noted that she had been working 10 to 12 hours a day at a computer keyboard. Furthermore, the worker had a 6 to 12 month history of intermittent tingling in the medial two fingers of both hands, more frequently on the left

than the right. Activities such as typing or driving provoked her symptoms. As well, the worker complained that she had recently been experiencing aching in her shoulders, elbows, and both wrists.

On examination, Dr. Gibson found that the cubital groove of the worker's elbow was shallow bilaterally. She had a positive Tinel's sign on percussion over the left ulnar nerve at the elbow. Nerve conduction studies indicated that the left ulnar motor conduction velocity showed slowing of the left ulnar motor conduction velocity across the elbow. Furthermore, the right ulnar motor conduction study showed mild slowing of the ulnar motor conduction velocity in the forearm and across the elbow.

Dr. Gibson thought that the results of the neurophysiologic studies, which included an EMG, were consistent with a mild left ulnar neuropathy at the elbow. She suggested that the worker wear an elbow sleeve to protect the left ulnar nerve from compression and told her to avoid leaning on her elbow. Lastly, Dr. Gibson thought that the worker may have an idiopathic cubital tunnel syndrome. She recommended that the worker undergo repeat neurophysiologic studies in six months in the event that her symptoms persisted or progressed, with the view that consideration of a left ulnar nerve transposition may be necessary.

The worker's claim was discussed during an April 14, 2005 team meeting, specifically in regard to an accepted diagnosis of right-sided lateral epicondylitis and wrist tendonitis. The claim log entry concerning the team meeting indicates that Dr. D, a Board medical advisor, had reviewed the ergonomic assessment, as well as the photographs and the video of the worker's work activities and workstation.

Owing to the absence of force, the lack of repetitive finger movement and extreme wrist posture, along with the infrequent awkward posture of the worker's right wrist into ulnar deviation when mousing (which did not place any stress on the extensor tendons), Dr. D concluded that it was less than 50% likely from a medical perspective that there was an association between the worker's right-sided lateral epicondylitis and her work activities. In addition, noting that no diagnosis had been provided for the worker's bilateral forearm pain, Dr. D stated that the risk factors for forearm tendonitis, if that were ultimately found to be the diagnosis, were likely similar to those for epicondylitis.

The case manager's April 15, 2005 decision referred to the worker's indication that she had developed symptoms in her wrists, hands, forearms, elbows, and shoulders, which led to a diagnosis of bilateral forearm pain and right-sided lateral epicondylitis. The case manager adjudicated the issue of whether the worker's duties as an environmental scientist had caused her right-sided lateral epicondylitis. In doing so, she informed the worker that her bilateral forearm pain was not a diagnosis and merely a description of symptoms, and then went on to find that there were insufficient risk factors in her employment activities to have caused her condition, as supported by Dr. D's opinion.

A May 11, 2005 report from the worker's chiropractor, Dr. Grimmett, shows that she had been treated for bilateral forearm symptoms, along with back symptoms. Dr. Grimmett's working diagnosis was chronic bilateral forearm tendinosis with peripheral nerve entrapment resulting from a repetitive strain injury related to computer use.

A May 27, 2005 MRI of the worker's cervical spine was normal.

Dr. Willms, a specialist in physical medicine and rehabilitation, assessed the worker on August 23, 2005. As outlined in Dr. Willms' September 12, 2005 consultation report, the worker told her that she first noticed right hand and forearm pain near the wrist in approximately 2000, which improved with splinting. However, the worker told Dr. Willms that in the past year she had begun to experience pain in the medial and lateral aspects of her elbows, along with a "funny bone" feeling in both of her hands, especially in the evening. She further explained that her workload had increased in December 2004 to the point that she was keyboarding approximately 10 hours a day, which continued through March 2005. As for activities outside of work, the worker told Dr. Willms that she liked to kayak, climb, and windsurf, which she had been avoiding because of her pain.

In describing her symptoms, the worker told Dr. Willms that chiropractic treatment did not provide lasting relief; as soon as she returned to work, her symptoms flared again. She described a throbbing pain at the dorsal aspect of her forearm, which increased when carrying heavy items or trying to do sporting activities. Moreover, the worker told Dr. Willms that she experienced a dull pain in her elbow when sitting and driving. Activities requiring more force, such as a push up, intensified the pain and resulted in a "buzzing sensation" that extended into the palm of her hand and the fourth and fifth fingers. In addition, the worker complained of pain in the distal third of her dorsal forearm, which was aggravated by keyboarding. According to Dr. Willms, the worker had similar symptoms in her left arm. As well, she described how her neck felt tired with an occasional burning and pinching sensation.

Dr. Willms was of the impression that the worker had lateral epicondylitis, more so on the right than the left, tendonitis involving the distal third of the forearm, and mild bilateral ulnar neuropathy. Noting that keyboarding consistently aggravated the worker's symptoms, Dr. Willms supported her use of a voice recognition program to avoid some of the repetitive movements, which were perpetuating her symptoms.

In conducting his review, the review officer acknowledged the worker's argument that the Board had adjudicated her claim prior to receipt of all of the medical evidence. After indicating that Dr. Willms had put forth a diagnosis of bilateral ulnar neuropathy, the review officer acknowledged Dr. Gibson's diagnosis of mild left ulnar neuropathy, which had not been considered by the Board. As it was one of a number of conditions that

was affecting the worker's upper extremities, he chose to address the compensability of it, along with the diagnoses of epicondylitis and tendonitis.

As set out in the review officer's decision, he found that there were insufficient risk factors in the worker's employment activities for the onset of peripheral neuropathy, epicondylitis, or tendonitis. The review officer recognized that the worker's physicians supported a connection between her employment activities and the various diagnoses; however, he thought that this appeared to be based solely on the worker's reporting of a temporal relationship between her symptoms and her presence at work. Furthermore, the review officer preferred Dr. D's medical opinion on causation over any conclusions that the worker's physicians had reached, given the absence of any indication that they had observed the worker's workstation or analyzed the relevant risk factors.

Dr. Elliot reported on March 29, 2006 that the worker was experiencing constant bilateral forearm pain that was going into her hands and fingers (I assume her reference to the "H&5th" fingers should have read 4th and 5th fingers). Her pain was occasionally waking her. Dr. Elliot noted that the worker had been working eight hours a day on the computer. Her pain was increasing with work and not improving with rest. Clinical findings included brisk reflexes and normal range of motion and function. Dr. Elliot also referred to thenar or hypothenar atrophy, but I am unable to tell from her report if it was present or not. Nonetheless, Dr. Elliot diagnosed epicondylitis.

New Medical Evidence

In support of her appeal, the worker provided a September 13, 2006 consultation report from Dr. Fuller, an orthopaedic surgeon, to whom she had been referred by Dr. Elliot. At the time of Dr. Fuller's assessment, the worker presented with pain over the anterior shoulder and tenderness over the ulnar nerve at the cubital groove. There was also involvement of the radial forearm, hands, and fourth and fifth fingers.

Noting that the worker's pain occurred in the above-noted distribution, Dr. Fuller went on to describe the paresthesia in the worker's hands by stating that it occurred with no "easily definable cause and at no specific time." He added, however, that the worker's pain would tend to occur if she sat with her arms forward flexed at the shoulders, as she would when working at a computer keyboard, driving, or reading a book. The worker told Dr. Fuller that her pain was at its worst at the end of a day's work and it was not significantly impacting on her activities outside of work. Yet, she tended to wake up with numb fourth and fifth fingers and slightly swollen hands.

On testing the worker's range of motion, Dr. Fuller noted that there was a loss of radial pulse on abduction and external rotation of her shoulders. Moreover, he found on examining the worker's upper extremities that her deep reflexes were very brisk (as

they were in her lower extremities). In addition, the ulnar nerve was sensitive on palpation and she had some paresthesia in the fourth and fifth fingers.

Dr. Fuller was of the impression that the worker presented with “definitive evidence of ulnar nerve neuropathy, perhaps more significant on the right.” He also thought that the worker’s “mixed clinical picture” in terms of her upper extremities was more suggestive of a proximal lesion, such as thoracic outlet syndrome, which was suggested by the loss of the radial pulse. Dr. Fuller concluded that both of these conditions could be exacerbated by the worker’s activity on the computer with the elbows flexed and possible wrapping of the shoulders.

In terms of treatment, Dr. Fuller recommended that the worker modify her work activity by using voice activation software on her computer, which would remove the positional problems of the keyboard. He also suggested the use of a sheepskin pad at night to alleviate the pressure on the ulnar nerves while sleeping.

In addition, Mr. Proudfoot provided WCAT with a January 30, 2007 medical report from Dr. Fuller, which sets out his findings and recommendations at the time of his September 13, 2006 assessment of the worker and his subsequent assessment on January 17, 2007.

The worker told Dr. Fuller on January 17, 2007 that she had just returned from a three-week holiday, during which she had not used a computer. She had no anterior shoulder pain. Nor did she have any elbow pain or symptoms referable to the ulnar distribution in the forearm and hand. After assessing the range of motion of the worker’s neck, shoulders, elbows, and wrists, which had improved in some respects from the time of his previous assessment, Dr. Fuller went on to provide the following opinion:

It is clear that this patient’s primary concern refers to the ulnar nerves at the cubital groove and distally to the 4th and 5th fingers. There was no clear evidence on examination at the time I saw her of a musculoskeletal concern. It is also clear that the condition of the ulnar nerve is caused by sitting for prolonged periods with the elbow flexed, at which time greater traction and pressure is placed on the nerve at the cubital groove. Sitting for long hours at a computer keyboard would, therefore, be considered to cause the condition. Similarly, pressure on the elbow at night leads to the numbness of the 4th and 5th fingers which would be due to pressure on the ulnar nerve at the cubital groove. Clearly, this nerve is sensitive to any more pressure.

It is also of note that whenever this patient is on vacation and, therefore, away from spending long hours at a computer her symptoms resolve. In

my opinion, this would present further clear evidence that this condition is activity-related and caused by the said activity.

Oral Hearing

Dr. Fuller testified about his more than 30 years of experience as an orthopaedic surgeon, which includes serving on the former Medical Review Panel. As well, he described his familiarity with ulnar nerve problems, a condition that he sees maybe once every three months.

In recalling his assessments of the worker, Dr. Fuller said that he did not perform any specific tests beyond a physical examination. He commented that a diagnosis of thoracic outlet syndrome had crossed his mind upon initially assessing the worker; however, the worker's symptoms were not of significant import to make a firm diagnosis of that condition.

When asked to describe ulnar nerve neuropathy, Dr. Fuller explained how the ulnar nerve winds around the cubital groove in the elbow, much like a pulley, and travels up the ulnar aspect of the forearm into the fourth and fifth fingers. He explained that it supplies the muscles of the hand that are responsible for fine movement.

Dr. Fuller said that he had been provided with a copy of the worker's claim file, including the ergonomic assessment. He stated that his opinion was based on his understanding that the worker had been working 12-hour days with her elbows flexed as she typed on the computer keyboard. It was his impression that the worker did not rest her elbows on the armrests of her chair at work. He acknowledged, though, that he had not reviewed the videos and photographs that were obtained during the ergonomic assessment, but had recently observed the worker in her workplace.

Dr. Fuller stood by his opinion that the worker's computer work caused her bilateral ulnar neuropathy by putting pressure on the ulnar nerve. He explained that the worker's recovery "to a degree" during her three-week vacation in January 2007 pointed to her employment as the likely cause of her condition.

After describing how nerve transposition surgery moves the nerve so that it is behind bone, and how it should be avoided at this stage, Dr. Fuller indicated that the worker's symptoms should not be allowed to continue indefinitely. He encouraged the worker to try voice activation software on the computer.

I asked Dr. Fuller about cubital tunnel syndrome and he responded that it and ulnar neuropathy are "one and the same thing". Noting that cubital tunnel syndrome results from the development of fibrous tissue in the region of the cubital groove, he commented that the result of cubital tunnel syndrome is ulnar nerve neuropathy.

Furthermore, in response to my question whether the worker's symptoms had been brought to her attention because of her work activities, rather than her employment playing a causal role in the development of her ulnar neuropathy, Dr. Fuller said the worker's prolonged position in front of the computer would have increased the traction and pressure on the ulnar nerve. In other words, the flexion of her elbows stretched the ulnar nerve around the cubital groove. It is his evidence that the amount of reading or driving that the worker did would not have caused her condition. Nor did he think that the worker's ulnar neuropathy was related to her activities of rock climbing, skiing, windsurfing, or kayaking since those activities allowed her to change her elbow position or extend her arms.

It is Dr. Fuller's assumption that the worker was predisposed to developing ulnar neuropathy; however, he could not identify anything anatomical that was responsible for her, as opposed to someone else, developing ulnar neuropathy because of computer work. He stated that she did not have a pre-existing condition or disease when her condition began.

Lastly, Dr. Fuller provided a copy of Dr. Gibson's November 14, 2005 consultation report, to which he referred in his medical reports. Dr. Gibson mentioned in her report that the discomfort in the worker's forearms and hands seemed to be work-related because it was significantly less after she had been on a three-week summer vacation. As well, Dr. Fuller highlighted the objective evidence of ulnar neuropathy by pointing to the portion of Dr. Gibson's November 14, 2005 report where she mentioned that the right ulnar nerve conduction study was notable only for "mild slowing of the conduction velocity across the elbow", but the left hypothenar compound muscle action potential was still abnormal, despite the improvement in the left ulnar nerve conduction study.

After acknowledging that Dr. Gibson had only diagnosed left-sided ulnar neuropathy, Dr. Fuller explained that the clinical examination is more significant than nerve conduction studies, which are a "useful adjunct" when making such a diagnosis.

The worker described her educational background as a biologist. She went on to explain how she started working with the employer in January 2000, which was her first job that required her to type. She also testified that her level of responsibility at work increased over time so that she was eventually preparing reports, which increased the amount of writing she did (I assume on the computer keyboard).

It is the worker's evidence that between July 2004 and May 2005 she took on two projects that were beyond her normal expertise, which required her to work outside her normal hours of work. In addition to working eight hours in the office, she worked two to three hours at home, and put in a full day on the weekend.

Additionally, the worker explained that her symptoms in 2003 involved her forearms, whereas her symptoms in 2004 involved the anterior aspect of her shoulders, along

with her elbows, hands, and the fourth and fifth fingers. She said that physiotherapy and chiropractic treatments provided only temporary relief. Furthermore, as set out in the document that the worker prepared (exhibit #3), she testified that she took some time off work beginning in May 2005, which seemed to provide some relief only to have her symptoms return once she went back to work. As well, the worker said that she felt better after taking vacations from work in October 2005 and January 2007, while indicating that she had ten days of skiing during her last vacation.

The worker acknowledged that sleeping, driving, and holding a book can result in forearm discomfort. Yet, she downplayed her frequency of driving by explaining that she often caught a ride to work with neighbours prior to 2006, at which time her employer's premises changed location, and now tends to alternate between driving and taking the bus. She said that her husband does most of the driving on weekends. In addition, the worker testified that she did not have any forearm pain and discomfort prior to working with her employer. She denied sustaining any traumatic injuries to her elbows outside of work, while indicating that her activities outside of work, such as rock climbing and windsurfing, did not cause her any problems.

The worker expressed how her employer tried to modify her work station by providing her with an ergonomic keyboard, which worsened her symptoms. Additionally, she said that her arms are always positioned the same way when she is working on the computer, regardless of whether she is working at the employer's office or at other locations. The worker also stated that she would like to have voice activation software on her computer, and has sought out an estimate in this regard (exhibit #4). Lastly, in response to questioning from Mr. A, the worker acknowledged the support that she has received from her employer as she tries to overcome her condition, which persists to this day.

Reasons and Findings

The worker's entitlement in this case is adjudicated under the provisions of the Act as amended by the *Workers Compensation Amendment Act, 2002* (Bill 49). WCAT panels are bound by published policies of the Board pursuant to the *Workers Compensation Amendment Act (No. 2), 2002* (Bill 63). Policy relevant to this appeal is set out in the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II).

Section 6(1) of the Act provides that compensation is payable where a worker suffers from an occupational disease that is due to the nature of any employment in which the worker was employed.

Section 6(3) of the Act provides a rebuttable presumption of causation when the disease listed in the first column of Schedule B of the Act is followed by the process or industry in the second column.

I accept Dr. Fuller's diagnosis of bilateral ulnar nerve neuropathy. The worker has consistently reported tingling in the fourth and fifth fingers of her hands. I am mindful that Dr. Gibson only diagnosed mild left-sided ulnar neuropathy, based on the neurophysiologic studies that she conducted. However, I give weight to the fact that nerve conduction studies showed mild slowing of the right ulnar motor conduction velocity in the worker's forearm and across the elbow. Furthermore, Dr. Willms' diagnosis of bilateral ulnar neuropathy supports Dr. Fuller's diagnosis. Lastly, I give weight to Dr. Fuller's evidence about the importance of the clinical examination when diagnosing ulnar neuropathy.

Although Dr. Fuller raised the diagnosis of thoracic outlet syndrome, he admitted during the oral hearing that his diagnosis of that condition was not conclusive. Therefore, I have not considered it or the diagnoses of epicondylitis or tendonitis, none of which the worker is advancing in this appeal.

The Board recognizes cubital tunnel syndrome as an occupational disease by regulation. Consistent with Dr. Fuller's testimony about the similarity between cubital tunnel syndrome and ulnar neuropathy, policy item #27.33 of the RSCM II describes cubital tunnel syndrome as an ulnar nerve compression at the elbow. Noting that the review officer adjudicated the compensability of the worker's ulnar neuropathy, I accept that cubital tunnel syndrome and ulnar neuropathy are interchangeable for the purpose of this appeal. Since cubital tunnel syndrome/ulnar neuropathy is not found in Schedule B of the Act, there is no rebuttable presumption of causation. I must therefore determine whether the worker's bilateral ulnar neuropathy was due to the nature of her employment under section 6(1) of the Act.

Policy item #27.33 of the RSCM II states that cubital tunnel syndrome, radial tunnel syndrome, and thoracic outlet syndrome are syndromes which typically result in numbness and tingling, pain, and weakness of the upper limb(s). It explains that they may be caused or aggravated by occupational or non-occupational activities, "particularly in an individual who by virtue of their specific anatomical makeup is susceptible to these disorders." As medical research does not clearly relate any of these peripheral nerve entrapments to any particular employment, each claim must be considered on its own merits.

Mr. Proudfoot points to Dr. Fuller's qualifications and over 30 years of medical expertise. He submits that I should rely on Dr. Fuller's unequivocal opinion that the worker's bilateral ulnar neuropathy was caused by her employment activities.

Additionally, Mr. A, through his questioning of the worker and by submission, offers the employer's support for the worker as she deals with her condition and the appeal process. He does not take issue with Dr. Fuller's opinion. According to Mr. A, the worker is a valued employee who is in the middle of a good career with the company. As expressed in his September 16, 2005 letter to the Review Division (exhibit #1) (the

review officer referred to this letter, but I cannot locate it on the claim file), the employer does not contest the worker's claim and requests that the Board provide her with voice activation software and coverage for necessary treatment, among other things.

Turning now to the review officer's decision, I note that he relied on Dr. Gibson's indication the worker may have an idiopathic cubital tunnel syndrome, as expressed in her April 12, 2005 report, in addition to the lack of any explanation concerning an association between the worker's ulnar neuropathy and her employment. Yet, the review officer did not have the benefit of Dr. Gibson's November 14, 2005 report, where she mentioned that the worker's symptoms seemed to be work-related, since the discomfort in her forearms and hands was significantly less after a three-week summer vacation (the worker testified that her vacation was in October 2005).

As well, the worker's reported improvement during her vacation in January 2007 buttresses Dr. Fuller's opinion that the worker's bilateral ulnar neuropathy is causally related to the computer work that she performs in her employment.

I agree with Mr. Proudfoot that weight should be given to Dr. Fuller's opinion on this matter. Dr. Fuller is certainly qualified to provide an opinion, owing to his years of experience as an orthopaedic surgeon and familiarity with the worker's condition. Moreover, I accept his explanation that the worker's sitting for prolonged periods with her elbows in a flexed position would result in greater traction and pressure being placed on the nerve at the cubital groove.

Dr. Fuller's opinion that the worker's long hours of work on the computer keyboard caused her condition is, in my view, premised on an accurate understanding of the facts. This includes the worker's evidence about the change in her workload between July 2004 and May 2005, which resulted in more hours of completing reports on the computer. As Dr. Fuller recorded at page 2 of his January 30, 2007 report, it was his understanding that there had been an exacerbation of the worker's symptoms in December 2004, at which time there had been an increase in her work hours so that she was working 10 to 12 hours per day.

There is no compelling evidence that any of the worker's activities outside of work played a causal role in the onset of her condition. Nor is there any persuasive medical evidence that counters Dr. Fuller's opinion. Dr. D did not address the compensability of the worker's ulnar neuropathy because the diagnosis was not put forth during the April 14, 2005 team meeting. Moreover, Dr. Willms' impression that the worker's keyboarding was aggravating her symptoms, as well as her recommendation that the worker use a voice recognition program, weighs in favour of a finding that the worker's forearm condition was work-related.

Based on Dr. Fuller's response to my concern that the worker's employment was merely bringing her forearm symptoms to her attention, I am satisfied by his medical

opinion on this matter that the onset of the worker's bilateral forearm condition was not idiopathic, but rather one that was causally related to her employment.

I find that the weight of the evidence establishes that the worker's bilateral ulnar nerve neuropathy was due to the nature of her employment, in accordance with section 6(1) of the Act. As a result, I allow the worker's appeal.

Conclusion

I vary the Review Division's November 8, 2005 decision.

I find that the worker's bilateral ulnar nerve neuropathy was due to the nature of her employment, in accordance with section 6(1) of the Act. The Board will determine the nature, duration, and extent of any benefits that may be payable to the worker. I encourage the Board to consider coverage for the worker's use of speech recognition software, as recommended by Drs. Willms and Fuller.

Worker's oral hearing attendance

Section 7(1)(a) of the *Workers Compensation Act Appeal Regulation* (Appeal Regulation) provides that WCAT may order the Board to reimburse a party to an appeal for the expenses associated with attending an oral hearing if the party is required by WCAT to travel to the hearing.

Item #13.22 of WCAT's *Manual of Rules of Practice and Procedure* (MRPP) states that where a party has requested an oral hearing, WCAT will generally order reimbursement of the party's expenses to attend the oral hearing if the party was successful on the appeal.

Policy item #82.10 of the RSCM II discusses how transportation expenses are not normally paid in regard to the portion of any journey which takes place within a distance of 24 kilometres of the destination.

I direct that the worker be reimbursed for her travel expenses from her residence to attend the oral hearing, provided that her distance travelled satisfies the Board's policy in this regard. Owing to the proximity of the worker's workplace to the oral hearing location, this expense would only be for her travel to the oral hearing, and not on a return basis.

Additionally, I direct that the worker be reimbursed for her lost wages to attend the oral hearing in an amount not exceeding four hours of work, given the duration of the oral hearing.

Dr. Fuller's medical report

Section 7(1)(b) of the Appeal Regulation provides that WCAT may order the Board to reimburse a party to an appeal for the expenses associated with obtaining or producing evidence submitted to WCAT.

The worker is claiming an expense only in regard to Dr. Fuller's January 30, 2007 medical report. Dr. Fuller indicated during the oral hearing that he considered his report to be a medical-legal opinion.

As set out in item #13.23 of WCAT's MRPP, fee item 19933 (medical-legal opinion) under the Board's schedule of fees pertains only to specialists with relevant qualifications, or other physicians with recognized expert knowledge. The applicable fee includes the examination, review of records, and other processes leading to the completion of the written opinion/report. Fee item 19933 provides the following:

Medical-Legal Opinion: an opinion will usually include the information contained in the Medical-Legal Report and will differ from it primarily in the field of expert opinion. This may be an opinion as to the course of events when these cannot be known for sure. It can include an opinion as to long-term consequences and possible complications in the further development of the condition. All the known facts will probably be mentioned, but in addition there will be the extensive exercise of expert knowledge and judgment with respect to those facts with a detailed prognosis.

I am satisfied that Dr. Fuller's January 30, 2007 medical report can be characterized as a medical-legal opinion because the opinion contained within his report is premised on his understanding of the facts concerning the onset of the worker's condition, a review of the medical evidence, as well as an exercise of his expert knowledge and judgment derived from his years of experience as an orthopaedic surgeon. In my view, the absence of a detailed prognosis in Dr. Fuller's report is not fatal to my finding in this regard, since Dr. Fuller was asked to provide his opinion on causation. I therefore direct that the worker be reimbursed for Dr. Fuller's January 30, 2007 medical report in an amount that does not exceed the applicable fee for a medical-legal opinion under the Board's fee schedule. This amount includes any time that Dr. Fuller spent with the worker and/or Mr. Proudfoot in preparing his January 30, 2007 medical report.

Dr. Fuller's oral hearing attendance

The worker requested Dr. Fuller's attendance at the oral hearing. I considered Dr. Fuller's attendance to be useful, since it provided me with an opportunity to question him about certain aspects of his opinion, which were not addressed in his January 30,

2007 medical report. One such example is whether the worker's employment activities were only responsible for making her aware of her condition, as opposed to playing a causal role in producing it. Accordingly, I find that the worker should also be reimbursed for any expenses that she may incur in relation to Dr. Fuller's attendance at the oral hearing. These expenses are above and beyond the expense of his medical report, but subject to what I have to say below.

At the time of the oral hearing, Dr. Fuller had not prepared an account for his attendance. Therefore, it is my task to determine what expenses would be appropriate in this case.

A physician's attendance at a WCAT oral hearing is not a common occurrence. The amount of a physician's fee for attending an oral hearing was considered in *WCAT Decision #2006-01608* (available on WCAT's website at www.wcat.bc.ca), where the panel addressed the Board's implementation of the original panel's decision, namely, that the physician's fee for attending the oral hearing should be reimbursed to the worker in accordance with the Board's tariff for such matters.

As the panel in *WCAT Decision #2006-01608* explained, the tariff is properly known as the Board's schedule of fees, which is agreed upon between the Board and the British Columbia Medical Association (BCMA). It does not contain an item pertaining to a physician's attendance at an oral hearing. In the end, the panel in *WCAT Decision #2006-01608* decided that the appropriate fee for the physician's attendance at the oral hearing was equivalent to the fee for a general practitioner's medical-legal report, as per the Board's fee schedule.

Although not expressly stated, the panel in *WCAT Decision #2006-01608* was bound by the Board's fee schedule in deciding the appropriate fee for the physician's attendance at the oral hearing, owing to the original panel's decision. On that basis, I distinguish *WCAT Decision #2006-01608* from the matter before me.

The BCMA fee guide addresses medical-legal matters, which include the preparation of medical reports and physicians' attendance in court to provide expert testimony. It is used in civil litigation matters. The fees paid for medical reports under the BCMA fee guide exceed those paid for medical-legal matters under the Board's fee schedule. For instance, fee item 19933 (medical-legal opinion) under the Board's fee schedule currently allows for \$1,361.00, whereas \$1,423.00 is paid for a medico-legal opinion (A00073) under the current BCMA fee guide. This is a difference of 4.35%. A comparison of what is paid for a medical-legal report (fee item 19932) under the Board's fee schedule (\$815.00) and for a medico-legal report (A00072) under the BCMA fee guide (\$852.00) results in the same difference. I am unaware if a similar discount would be found throughout the Board's fee schedule. However, I am prepared to use the figure of 4.35% as an approximation of the difference between the fees in the Board's fee schedule and those in the BCMA fee guide.

Upon submitting Dr. Fuller's account, the worker is to be reimbursed for Dr. Fuller's fee concerning his preparation time and attendance at the oral hearing, as calculated under the BCMA fee guide.

With respect to Dr. Fuller's preparation time, I allow for an expense that does not exceed one hour of preparation, which is to be calculated using the hourly rate of \$339.00 under the BCMA fee guide. I consider this allotment of preparation time to be reasonable, since much of the medical and factual information that Dr. Fuller would have had to review in preparation for his testimony is contained within his January 30, 2007 medical report.

In terms of Dr. Fuller's attendance, I allow for an expense up to the flat fee of \$1,423.00 that Dr. Fuller could charge for providing half a day or less of expert testimony, since he attended the oral hearing for approximately one hour.

As well, I find that Dr. Fuller's fee for preparation time and attending the oral hearing, if any, should be reduced by 4.35% to be consistent with the discount in the Board's fee schedule.

Lastly, I direct that the worker be reimbursed for any return travel expenses that Dr. Fuller may claim, provided that the distance he travelled from his office to the oral hearing location satisfies the Board's policy in this regard.

Andrew Waldichuk
Vice Chair

AW/ec