Noteworthy Decision Summary

Decision: WCAT-2014-00679 **Panel**: Cathy Agnew **Decision Date:** March 3, 2014

Policy #31.00 of the Rehabilitation Services and Claims Manual, Volume II – Tinnitus as a compensable consequence – Conditions other than noise-induced hearing loss

This decision is noteworthy for its interpretation of policy item #31.00 (Hearing Loss) of the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II).

The worker complained of tinnitus which appeared shortly after he was prescribed medication to treat previously accepted psychological conditions. The worker claimed his tinnitus developed as a result of those psychological conditions or from their treatment, and should be compensable under item #C3-22.00 of the RSCM II.

The panel found that the wording of the policy does not limit the acceptance of tinnitus so that it is only compensable where it arises as a compensable consequence of an accepted claim for noise-induced hearing loss. Policy item #C3-22.00 of the RSCM II (Compensable Consequences) may still apply if a prior compensable injury or its treatment is of causative significance to the development of tinnitus.

Workers' Compensation Appeal Tribunal
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WCAT Decision Number: WCAT-2014-00679
WCAT Decision Date: March 03, 2014
Panel: Cathy Agnew, Vice Chair

Introduction

[1] These appeals to the Workers' Compensation Appeal Tribunal (WCAT) concern the worker's claim with the Workers' Compensation Board (Board), operating as WorkSafeBC, for injuries he sustained in a work incident on June 2, 2006. The worker has appealed a November 14, 2012 decision of a review officer in the Board's Review Division, which confirmed four Board decisions outlined below (Appeals C, D, E, and F).

[2] The Board provided the worker with a permanent partial disability award effective November 7, 2007 for his accepted L4/5 disc herniation, discectomy surgery on December 13, 2006 and chronic pain. The award was calculated on a loss of function based on 9.30% of total disability. It was effective from November 7, 2007 and would continue to the worker's 65th birthday on December 27, 2025.

[3] The worker's claim was reopened effective December 15, 2008 and after a further period of temporary disability benefits his permanent partial disability award was increased in a February 9, 2011 decision letter to 18.10% of total disability effective February 4, 2009. The matter of the percentage of impairment to be awarded for the worker's lumbar injury was confirmed in a July 21, 2011 decision of a review officer in the Board's Review Division and was further confirmed on appeal to WCAT on February 28, 2012.

[4] The matter of the duration of the increased permanent partial disability award effective February 4, 2009 was referred by the Review Division back to the Board for further investigation and a new decision was issued on April 13, 2012 by a disability awards officer who found that the increased portion of the worker's permanent partial disability award should also end on the worker's 65th birthday. This decision was confirmed in *Review Reference #R0146301* (Appeal C).

[5] On April 30, 2012, a disability awards officer advised the worker that he had been provided with an additional 25% of total disability for his permanent psychological conditions (Major Depressive Disorder and Pain Disorder Associated with both Psychological Factors and a General Medical Condition). This decision was confirmed in *Review Reference #R0146302* (Appeal D).

[6] On June 11, 2012, a health care payment officer advised the worker that he would be reimbursed in the amount of $873.12 for a February 21, 2011 medical-legal report from Dr. Parikh that had been submitted in support of the worker's February 28, 2012 appeal to WCAT. This decision was confirmed in *Review Reference #R0146608* (Appeal E).

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[7] On July 16, 2012, a case manager advised the worker that tinnitus would not be accepted as compensable. This decision was confirmed in *Review Reference #R0146765* (Appeal F).

[8] The worker asked for his appeals to be considered by reviewing the documentary evidence and written submissions. These appeals raise issues of law and policy which do not, in my view, require an oral hearing. In accordance with WCAT's *Manual of Rules of Practice and Procedure* (MRPP) item #7.5, I agree that an oral hearing is not required in order to fully and fairly address the issues in these appeals.

[9] The worker was represented by a lawyer who provided written submissions on his behalf. The employer did not participate in the worker's appeals, although invited to do so.

Issue(s)

[10] The issues are:

1. Should the worker's permanent partial disability award be provided beyond the worker's 65th birthday?

2. Should the worker be provided with more than 25% of total disability for his accepted permanent psychological condition?

3. Should tinnitus be accepted as compensable?

4. Is the worker entitled to be paid more than $873.12 for Dr. Parikh's February 21, 2011 medical-legal report?

Jurisdiction and Standard of Proof

[11] These appeals were filed with WCAT under subsection 239(1) of the *Workers Compensation Act* (Act). Section 254 of the Act gives WCAT exclusive jurisdiction to inquire into, hear, and determine all matters and questions of fact, law, and discretion arising or required to be determined in an appeal before it.

[12] Under subsection 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's board of directors that is applicable in the case. The *Rehabilitation Services and Claims Manual, Volume II* (RSCM II), contains the policy applicable to these appeals. All references to policy in this decision pertain to those contained in the RSCM II.

[13] The standard of proof that applies in these appeals is the balance of probabilities, subject to subsection 250(4) of the Act, which provides that if on an appeal respecting the compensation of a worker the evidence supporting different findings on an issue is evenly weighted, the issue must be resolved in favour of the worker.

Evidence, Reasons and Findings

[14] *Should the worker's permanent partial disability award be provided beyond the worker's 65th birthday?*

[15] Section 23.1 of the Act provides for the period of payment for total or partial disability benefits. Where, as here, a worker was less than 63 years of age on the date of injury, section 23.1(a) authorizes the Board to provide periodic payments to the worker until the later of:

> (i) the date the worker reaches 65 years of age;
> (ii) if the Board is satisfied the worker would retire after reaching 65 years of age, the date the worker would retire, as determined by the Board…

[16] This provision recognizes age 65 as the standard retirement age for workers.

[17] Section 23.1 of the Act permits the Board to continue to pay benefits where the Board is satisfied that the worker would have retired after the age of 65 if he or she had not been injured.

[18] Policy item #41.00 (Duration of Permanent Disability Periodic Payments) of the RSCM II provides that as age 65 is considered to be the standard retirement age, the Board requires evidence that is verified by an independent source to confirm the worker's subjective statement regarding his or her intent to work past age 65. Evidence is also required so that the Board can establish the worker's new retirement date for the purposes of concluding permanent disability award payments.

[19] The policy contains a non-exhaustive list of examples of the kinds of independent verifiable evidence that may support a worker's statement about the date he or she intended to retire. These examples primarily involve information that could be verified by an employer, union, or professional organization. This type of evidence is not always available to a worker who is not associated with a union or a professional organization, and it was not submitted in this case.

[20] The Board's policy provides that if the worker's statement is not independently verifiable, the Board will make a determination based on the evidence available, including information provided by the worker. The Board will consider any other relevant information in determining whether a worker would have worked past age 65 and at what date the worker would have retired.

[21] The Board's decision about the worker's initial permanent partial disability award was communicated to the worker on February 28, 2008. The Board determined that the award would be paid to age 65 and this is not a matter that is before me in the context of the present appeal.

[22] On February 9, 2011, the Board increased the worker's permanent partial disability award to 18.10% of total disability and decided that the increased portion of the award would also conclude at age 65. The effective date of this increased award was February 4, 2009, but on February 28, 2012 a WCAT panel found that the increase should be effective from December 15, 2008.

[23] As a result of a Review Division decision dated July 21, 2011, the matter of the duration of the increased portion of the worker's permanent partial disability award was referred back to the Board for further investigation and a new decision.

[24] On July 25, 2011, a disability awards officer wrote to the worker to request information about his intention to work past age 65. A copy of this letter was also forwarded to the worker's legal representative. A review of the claim file shows that neither the worker nor his representative provided any additional information in response to this letter.

[25] On April 13, 2012, the disability awards officer advised the worker that the increased portion of his permanent partial disability award would continue to age 65 and this was confirmed in the Review Division decision that is the subject of Appeal C.

[26] The worker's representative provided written submissions in support of the worker's contention that he did not intend to retire at age 65. She provided evidence of the worker's intentions and plans prior to his injury.

[27] I am not persuaded by the submission of the worker's representative that the worker's age of retirement should be established at age 72.

[28] I acknowledge the evidence provided by the worker's representative regarding the worker's intention to work beyond age 65. She submitted that the worker had demonstrated a strong work ethic and he had financial aspirations and obligations that would support a finding that he did not intend to retire at age 65 and would likely have continued to work beyond that date. She noted that the worker had anticipated ongoing good health and would have had the opportunity to continue to work for his pre-injury employer where he was a well-liked and valued employee.

[29] It is important to note that the Board's prior determination that the worker's initial permanent partial disability award would end at age 65 was not before the review officer who referred the matter back to the Board on July 21, 2011 and it is not before me. The review officer only referred the increased award that was effective from December 15, 2008 back to the Board for investigation and a new decision, noting that the worker's circumstances may have changed between the effective date of the initial permanent

partial disability award and the effective date of his increased award. Therefore, the worker's intentions and plans regarding his retirement prior to or at the time of his injury are not determinative of the matter I have to decide.

[30] The worker's representative noted that the worker and his wife had depleted their RRSPs totalling approximately $60,000 since the worker's injury. While this demonstrates a change in the worker's financial circumstances, I do not consider that it is sufficient to support a conclusion that the worker's intentions had changed since the original award was made.

[31] Therefore, I find that the Board has properly determined that the increase in the worker's permanent partial disability award for his back injury that was effective from December 15, 2008 should be paid to age 65.

[32] The need for this issue to be adjudicated arose from the July 21, 2011 Review Division decision to refer the matter of the duration of the increase in the worker's permanent partial disability back to the Board for investigation and a new decision. The scope of that referral and the decision that flowed from it is limited to that portion of the award for the worker's back injury that was effective from December 15, 2008. It does not affect the duration of the worker's award for his psychological injury. In any event, for the reasons already stated, I find insufficient evidence to conclude that the worker's intentions had changed and therefore find that this is not a basis to extend the permanent partial disability award for his psychological condition beyond the worker's 65th birthday.

[33] As already noted, the Board determined in a decision dated February 28, 2008 that, had the worker not been injured, he would have retired at age 65. My view is that this determination applies equally to the duration of the award for the worker's psychological injury as well as to the duration of the initial award for his physical injuries. Accordingly, the worker's award for psychological injury will also terminate at age 65.

Should the worker be provided with more than 25% of total disability for his accepted permanent psychological condition?[i]

[34] Under subsection 23(1) of the Act, where a permanent partial disability results from a worker's compensable injury, the Board must estimate the impairment of the worker's earning capacity from the nature and degree of the injury and pay the worker compensation based on the estimate of the loss of average net earnings resulting from the impairment.

[35] Under subsection 23(2) of the Act, the Board has established a Permanent Disability Evaluation Schedule (PDES). The PDES was amended on August 1, 2003. The version of the PDES in Appendix 4 of the RSCM II applies to the worker's permanent disability award since the subsection 23(1) assessment was undertaken after August 1, 2003.

[36] The PDES at item 80 sets out a range of percentages of disability for psychological impairment to be awarded for emotional (mental) and behavioural disturbances. The PDES contains categories and descriptions of psychological disability that are based on the American Medical Association *Guides to the Evaluation of Permanent Impairment (4th Edition)*. It assigns percentages of disability for various impairments categorized as mild, moderate, marked, or extreme.

[37] The impairment ratings in the PDES for emotional and behavioural disturbances such as depression relate to activities of daily living, social functioning, concentration, and adaptation. The ratings are not contiguous in that there are gaps of 5% between each of the categories. The PDES provides for an impairment rating between 5% and 25% for mild impairment compatible with most useful functioning, an impairment rating between 30% and 70% for moderate impairment compatible with some, but not all useful functioning, and between 75% and 95% for marked impairment that significantly impedes useful functioning.

[38] On November 17, 2011, the worker underwent a psychological assessment undertaken by registered psychologist, Dr. Chopra, who provided a report to the Board on December 8, 2011. Dr. Chopra provided the following diagnoses:

- Major Depressive Disorder, Single Episode, Moderate to Severe, with Melancholic Features, with Suicidal Ideations
- Pain Disorder Associated with Both Psychological Factors and a General Medical Condition

[39] In accordance with the Board's policy item #38.10, the Board's Psychological Disability Awards Committee (PDAC) is charged with responsibility for assessing the percentage of disability resulting from a permanent psychological impairment.

[40] The PDAC provided an April 19, 2012 memorandum, which contains general information regarding how a worker's psychological disability award is determined. The PDAC stated that they had reviewed the information on file including medical, psychological, and neurological examinations and assessments without identifying the specific documents that they relied upon when rating the worker's psychological impairment.

[41] The PDAC concluded that the worker's level of impairment was in the mild range of impairment specified in the PDES and rated the worker's compensable functional psychological impairment at 25% of total disability, which is the top of the range for mild impairment. According to the PDES, a range of 0 to 25% of total disability is provided when there is a mild level of impairment compatible with most useful functioning related to activities of daily living, social functioning, concentration, and adaptation.

[42] The PDAC has published guidelines that outline the behavioural descriptors and anchors on which the psychological disability percentages contained in the Board's PDES were developed. Although the guidelines do not form binding policy, they are intended to promote consistency of decision-making and the preamble to the guidelines emphasizes that the functional award must be based on the nature and degree of the injury as it impacts on the worker's vocational capacity.

[43] The PDAC guidelines provide for a rating of 20% to 25% where the worker has:

- mild residual symptoms
- moderate increased risk of decompensation under stressful situations
- accommodation or different job would not significantly attenuate psychological impairments
- continuing treatment and support likely

[44] I do not find support in the medical evidence for a conclusion that the worker's psychological impairment is in the mild range as described in the PDES or in the PDAC's guidelines.

[45] While the PDAC stated that an impairment rating of 25% was in keeping with the Board's PDES and the PDAC's guidelines, they did not provide any medical rationale for their rating of the worker as having mild residual symptoms or any explanation to reconcile their rating with Dr. Chopra's rating of the severity of the worker's depression as moderate to severe. Dr. Chopra's assessment is consistent with that of Dr. Sidhu, whose April 24, 2012 report was submitted in support of the worker's request for review.

[46] I also note Dr. Chopra's assessment of the worker as demonstrating a GAF (General Assessment of Function) of 45. GAF is a numeric scale (0 through 100) used by mental health clinicians and doctors to rate the social, occupational and psychological functioning of adults. It is included in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* as the Axis V assessment. The global rating takes place at the end of a diagnostic interview. A score is allocated by starting at the top level and moving down until the level of functioning is reached. A score of 41 to 50 indicates serious symptoms, with the individual experiencing serious impairment in social, occupational, or school functioning.

[47] In these circumstances, I have difficulty accepting the PDAC's rating of the worker's residual symptoms as mild Considering the whole of the medical evidence, I find that the worker's residual symptoms should be rated as moderate in severity. I find support for this conclusion in Dr. Chopra's report. Her assessment of the worker was undertaken with the express purpose of evaluating the extent of residual disability resulting from his psychological condition. I am satisfied by this medical evidence that the worker had moderate residual symptoms related to his accepted Major Depressive Disorder and Pain Disorder.

[48] I consider that the PDAC underestimated the extent of the worker's psychological disability. The rating they provided is not consistent with their guidelines and the explanation provided in their April 19, 2012 memorandum provides little analysis to assist me in understanding why they rated the worker's psychological impairment at 25% of total disability. Indeed, the memorandum does not even reference the criteria in the PDAC guidelines in relation to the medical opinions and findings that are on file.

[49] While I recognize the expertise and experience of the PDAC in matters pertaining to the assessment of psychological impairment, I find the PDAC memorandum to be of limited value when deciding the extent to which the worker's earning capacity has been impaired by his psychological injury as required by subsection 23(1) of the Act. I have therefore examined the evidence with detailed reference to the PDAC guidelines, which are especially useful when the PDAC has not articulated the basis for their decision. The PDAC guidelines are publicly available on the Board's website.

[50] The PDES provides that moderate impairment levels are compatible with some, but not all useful functioning. An impairment rating of 30% to 70% of total disability is assigned for this level of impairment.

[51] The PDAC guidelines provide for a rating of 30% to 35% of total disability where the following criteria are met:

- moderate residual symptoms
- capable of competitive work
- inadequate adaptation to impairment with or without accommodation
- moderate increased risk of decompensation under normal stress

[52] Dr. Chopra found the worker was at least at moderate increased risk of decompensation. This suggests that the worker's permanent psychological disability should be rated at least in the 30% to 35% range according to the PDAC guidelines**.**

[53] The PDAC guidelines provide for a rating of 40% to 45% where the following criteria are met:

- moderate residual symptoms
- capable of competitive work if provided significant support
- inadequate adaptation to impairment
- high increased risk of decompensation under normal stress

[54] The following criteria are listed for a rating of 50% to 60%:

- no significant competitive vocational capacity
- competitive vocational capacity only in exceptional circumstances
- may be capable of sheltered work
- none to mild activities of daily living problems or executive dysfunction

[55] I note the opinion of the vocational rehabilitation consultant as stated in his October 25, 2012 memorandum that the worker's psychological limitations/restrictions would prevent him from formal training or any job requiring multitasking, time pressure, complex activities or customer contact. The vocational rehabilitation consultant was unable to identify any kind of suitable employment for the worker.

[56] Considering the evidence as a whole, I agree with the worker's representative that the worker's psychological impairment should be rated at 50%. This rating is consistent with the PDES and the PDAC guidelines according to which a rating of 50% to 60% is provided when, as here, a worker has little to no competitive vocational capacity. I have established the worker's psychological impairment at the bottom end of that range since he was not assessed as being at high increased risk of decompensation, which is a criterion of the range immediately below the range in which I have placed him.

Should tinnitus be accepted as compensable?

[57] The Board's policy on tinnitus is addressed at item #31.00 of the RSCM II. The policy was changed on June 1, 2012 and the new policy applies to all decisions made after that date. As the Board's decision not to accept tinnitus as compensable was made on July 16, 2012, the new policy applies to this appeal. It provides as follows:

> Tinnitus is a symptom that is commonly associated with noise-induced hearing loss. Tinnitus is not a personal injury or occupational disease in and of itself. Tinnitus may be compensable where it is:
>
> - a compensable consequence of an accepted claim for noise-induced hearing loss (see Item C3-22.00, *Compensable Consequences*); and
>
> - confirmed based on evaluation by a qualified person, such as an audiologist.

[58] Board medical advisor, Dr. Chang, provided his opinion on June 19, 2012. He stated that as the worker does not have hearing loss, his tinnitus would not be a compensable condition. While this comment is adjudicative in nature and not related to Dr. Chang's expertise as a medical practitioner, I have considered whether policy item #31.00 limits acceptance of tinnitus to those circumstances where it is a compensable consequence of noise-induced hearing loss. I do not read policy item #31.00 as limiting the

acceptance of tinnitus in this manner. The policy provides that tinnitus "may" be compensable where it is a compensable consequence of noise-induced hearing loss, but it does not say that this is the only circumstance that tinnitus could be accepted as compensable.

[59] The Board's policy item #C3-22.00 provides that where a further injury arises as a consequence of a compensable injury or as a consequence of treatment for a compensable injury, it is sufficiently connected to the original employment-related injury as to form part of that injury. The further injury is therefore considered to arise out of and in the course of the worker's employment and is also compensable. Looking at the matter broadly and from a "common sense" point of view, the Board considers whether the compensable injury was of causative significance in the further injury.

[60] The worker seeks a finding that his tinnitus developed as a compensable consequence of his accepted psychological conditions or that it was caused by medication prescribed for his compensable psychological conditions.

[61] The worker's family physician, Dr. Parikh, referred the worker to a specialist, Dr. Nunez, in connection with the worker's complaints of bilateral tinnitus, which had appeared shortly after he was prescribed new medication (duloxetine and lorazepam) as treatment for his anxiety and depression.

[62] Otolaryngologist, Dr. Nunez, provided a May 16, 2012 consultation report in which he noted that the worker's tinnitus symptoms had started two months previously, which coincided with the time frame when the new medications had been started. Dr. Nunez also noted that the worker had asymmetric mild to moderate hearing loss with poorer thresholds on the right at 4 kHz. He did not express an opinion about whether the worker's tinnitus was related to this hearing loss.

[63] Dr. Nunez wondered whether the worker's tinnitus might be secondary to his anxiety disorder or whether it was an adverse response to the medication. Dr. Nunez stated that there was some published research suggesting that duloxetine and lorazepam were therapeutic for tinnitus. However, Dr. Nunez stated that the evidence tended to suggest the worker's tinnitus was more likely related to his anxiety disorder.

[64] I note that the worker's claim has been accepted for a Major Depressive Disorder and a Pain Disorder Associated with both Psychological Factors and a General Medical Condition. It has not been accepted for an "anxiety disorder", but I take Dr. Nunez's remarks to mean that the worker's tinnitus may be related to anxiety as a feature of the worker's accepted psychological conditions.

[65] Dr. Chang explained that tinnitus is a subjectively perceived noise in the ears such as ringing, blowing, roaring, or buzzing. Dr. Chang stated that the exact mechanism underlying tinnitus is largely unknown, but some possible causes include disorders of the outer, middle or inner ear, trauma to the head or neck such as concussion or

whiplash, or other rare causes such as an acoustic neuroma. He said that scientific evidence indicates that tinnitus is a symptom of an underlying condition. It is not an injury or disease in and of itself.

[66] Dr. Chang stated his opinion that the worker's tinnitus was not likely caused by the medication prescribed for his psychological conditions. Regarding lorazepam, he stated that this belongs to a class of benzodiazepines which has historically been prescribed for treatment in severe, intractable tinnitus, but he felt that the medical literature did not show that lorazepam could make a patient's tinnitus worse. Dr. Chang noted that there may be an association between patients with tinnitus and being on benzodiazepines, but he cautioned against establishing a causal relationship on this basis since association does not imply causation as the two conditions may simply co-exist in the same patient.

[67] Dr. Chang also noted that antidepressants such as duloxetine have been used to treat tinnitus, but he felt there was no medical literature to support tinnitus being aggravated by the use of duloxetine or being alleviated by it. Therefore, Dr. Chang felt that the probability of the worker's tinnitus having resulted from the anti-anxiety or antidepressant medications was less than 50%.

[68] Considering Dr. Nunez's expertise as a specialist in the study of ear, nose, and throat conditions and noting his opinion that the worker's tinnitus could have been caused by medication, I do not place significant weight on Dr. Chang's opinion that there was no medical literature to support tinnitus as a side effect of medications. I accept Dr. Nunez's opinion that the worker's prescribed anti-anxiety and/or antidepressant medication is a possible cause of his tinnitus.

[69] However, I consider that Dr. Nunez was speculating about possible causes of the worker's tinnitus. He did not state a clear opinion about what had caused the worker's tinnitus. He merely postulated that the worker's tinnitus might have been caused by the medications or might be related to his anxiety disorder. He did not provide a medical rationale that would lead me to conclude that the worker's tinnitus was caused by either of these conditions.

[70] I recognize the temporal connection between the onset of the worker's tinnitus symptoms and his use of duloxetine and lorazepam. However, this is an insufficient basis to conclude that the worker's tinnitus was caused by these medications.

[71] Dr. Nunez felt that the worker's tinnitus was more likely related to an anxiety disorder than to his medication. This tends to support a conclusion that the worker's tinnitus does not represent an adverse reaction to medication.

[72] For these reasons, I find that the worker's tinnitus was not caused by the medication prescribed as treatment for his psychological conditions. I will now proceed to consider whether the worker's tinnitus should be accepted as a compensable consequence of his psychological condition.

[73] Dr. Chang cited a website (www.actiononhearingloss.org.uk) for a national charity in the United Kingdom that provides support to people with hearing loss. As noted by the worker's representative, this is not a medical website and there are no references to scientific medical literature in support of the summary advice it contains. As the question of whether the worker's tinnitus is related to stress is a matter requiring medical expertise, Dr. Chang's reliance on this website leads me to place less weight on his opinion. However, it does not cause me to discount Dr. Chang's opinion entirely, given his medical expertise as a physician.

[74] Dr. Chang stated that stress may cause a person to be more aware of his/her tinnitus, but he felt that stress would not change or worsen the underlying pathology that leads to the symptom of tinnitus. This opinion is not inconsistent with Dr. Nunez's statement that the worker's tinnitus may be "related to" his anxiety disorder, which I do not interpret as an expression of likely causation. There may well be a relationship between the worker's anxiety and his tinnitus such as that described by Dr. Chang. However, I do not conclude from the evidence that the worker's anxiety related to his psychological condition had causative significance for his tinnitus. I conclude from the medical evidence as a whole that the worker may have been more aware of his tinnitus because of his anxiety, but I consider that it would be speculative to conclude that the worker's tinnitus was caused by his compensable psychological conditions.

Is the worker entitled to be paid more than $873.12 for Dr. Parikh's February 21, 2011 medical-legal report?

[75] In support of the worker's prior appeal to WCAT regarding the Board's decision not to reopen his claim, the worker's legal representative requested a report from the worker's family physician, Dr. Parikh. This report, together with the representative's written request for it and Dr. Parikh's invoice in the amount of $1,607.20, were submitted to WCAT. Dr, Parikh's invoice included the following specific items:

- $342.40 for extensive review of the clinic medical notes
- $342.40 for review of the Board's medical notes and consultation reports
- $917 for medical-legal report
- $5.40 for photocopying

[76] In a February 28, 2012 WCAT decision, a vice chair found that the worker was entitled to be reimbursed for "the expenses of Dr. Parikh's medical-legal report of February 21, 2011, subject to the Board's schedule of fees".

[77] The Board reimbursed the worker $873.12 which is the amount shown in the Board's schedule of fees, updated to 2011. The worker seeks full reimbursement of Dr. Parikh's invoice.

[78] It is important to note that the matter of the worker's entitlement to reimbursement of expenses was determined in the prior WCAT decision. It is not open to the worker to make arguments in the context of the present appeal in order to justify an order entitling the worker to more than the amount provided for in the fee schedule. Those arguments could have been made in the context of the worker's prior appeal, but are not relevant to the matter I have to decide, which is whether the payment of $873.12 accords with the order contained in the February 28, 2012 WCAT decision.

[79] In accordance with item #16.1.3.1 of WCAT's MRPP, WCAT will usually order reimbursement of expert opinions at the rate established by the Board for similar expenses. The balance is the responsibility of the party who obtained the report.

[80] Although a WCAT panel has the discretion to award reimbursement of an expert opinion in an amount greater than the fee schedule, the party seeking reimbursement of the full amount must explain the reasons the account exceeds the fee schedule and why the panel should order reimbursement of the full amount. In the absence of a request and a satisfactory explanation of the circumstances, WCAT will limit reimbursement to the fee schedule amount.

[81] There is no indication in the February 28, 2012 WCAT decision or in the written submissions provided by the worker's representative in support of that appeal to suggest that an amount in excess of the fee schedule was requested at that time. The WCAT panel had a copy of Dr. Parikh's invoice for an amount in excess of the fee schedule and yet he did not order reimbursement of an additional amount.

[82] WCAT's public website (www.wcat.bc.ca) provides a link to the fee schedule according to which a maximum of $873.12 may be paid for a medical-legal report, which is described in fee code 19932 as follows:

> Medical-Legal Report: a report which will recite symptoms, history and records and give diagnosis, treatment, results and present condition. This is a factual summary of all the information about when the Injured Worker will be able to return to work and might mention whether there will be a permanent disability.[ii]

[84] I find nothing in the wording of the February 28, 2012 WCAT decision to suggest that the worker is entitled to be reimbursed for more than $873.12. The vice chair specifically and clearly limited the worker's entitlement to that which is provided for in the Board's schedule of fees. Therefore, I find that the Board's payment of $873.12 was made in accordance with the order contained in the February 28, 2012 WCAT decision.

Conclusion

[85] I deny the worker's Appeal C and confirm *Review Reference #R0146301* by finding that the worker's permanent partial disability award should end on the worker's 65th birthday.

[86] I allow the worker's Appeal D and vary *Review Reference #R0146302* by finding that the worker's psychological disability should be established at 50%.

[87] I deny the worker's Appeal E and confirm *Review Reference #R0146608* by finding that the worker is not entitled to be reimbursed more than $873.12 for Dr. Parikh's February 21, 2011 medical-legal report.

[88] I deny the worker's Appeal F and confirm *Review Reference #R0146765* by finding that the worker's tinnitus is not compensable.

[89] No appeal expenses were requested and none are ordered.

Cathy Agnew
Vice Chair

CA/gl/rh

[i] Minor formatting correction made
[ii] Minor formatting correction made