WORKERS' COMPENSATION REPORTER

Volume 20, Number 1

2004

published by the

WORKERS' COMPENSATION BOARD

Province of British Columbia

WorkSafe™

WORKERS' COMPENSATION BOARD OF BC

The mandate of the WCB, in concert with workers and employers, is to:

- *Promote the prevention of workplace injury, illness, and disease*
- *Rehabilitate those who are injured and provide timely return to work*
- *Provide fair compensation to replace workers' loss of wages while recovering from injuries*
- *Ensure sound financial management for a viable workers' compensation system*

Sections and excerpts from the *Workers Compensation Act*, Revised Statutes of British Columbia 1996, Chapter 492 are provided for convenience and are to be used for informational purposes only.

For more information about the *Workers' Compensation Reporter*, please call Sheryl Wynne at 604 279-7594.

To order copies of the *Workers' Compensation Reporter*, please contact Jim McGowan at 604 276-3143.

Table of Contents

Publishing Criteria for Board of Director Decisions

Decisions of the WCB's Board of Directors are published in the *Workers' Compensation Reporter* where:

- The decision results in an amendment to a regulation made under the *Workers Compensation Act*. This includes amendments to the *Occupational Health and Safety Regulation, Regulations for Agricultural Operations, Industrial Health and Safety Regulation, Fishing Industry Regulations,* and the *Occupational Disease Recognition Regulation.*

- The decision results in substantive amendments to the published policies of the Board of Directors. A policy amendment may be considered substantive if it results in change to worker or dependant benefit levels or employer obligations. It may also be considered substantive where it results from a change in policy interpretation or new legislation. Consequential, housekeeping and other minor changes will not be published in the *Workers' Compensation Reporter*.

- The decision constitutes a policy decision but does not amend any of the published policy manuals of the WCB.

Publishing Criteria for Review Division Decisions

The Review Division applies the criteria outlined below to the selection of key decisions for publication:

Criteria

1. The decision will facilitate in the understanding of workers' compensation because it offers a thorough analysis of significant concepts or offers new insights including:

   - Summarizes the legislative history behind key statutory provisions
   - Sets out a thorough analysis of law and policy in relation to a key issue
   - Draws on relevant jurisprudence
   - Applies important principles of statutory interpretation
   - Discusses/analyzes changes in the law, policy, or practice

2. The decision signals to the workers' compensation community the direction that the Review Division is taking on certain issues in an effort to provide greater certainty, recognizing that the Review Division is not bound by precedent but that like cases are generally treated alike.

3. The decision will facilitate consistency and improved decision-making.

4. The decision will assist individuals in pursuing a remedy or providing representation on workers' compensation, assessment, prevention, and other matters by explaining in clear, plain language the criteria for considering or adjudicating particular issues, or the procedures for pursuing a remedy.

5. The decision assists in understanding important jurisdictional questions relating to the new legislation or to the new appellate structure.

6. The decision assists in interpreting new key statutory provisions.

---

* A decision that is a final decision of the Board with no further appeal rights, may, for that reason, in conjunction with the above noted criteria, have added value for publication as a decision of note.

Publishing Criteria for Workers' Compensation Appeal Tribunal Decisions

The Workers' Compensation Appeal Tribunal (WCAT) applies the criteria outlined below to the selection of key WCAT decisions for publication in the *Workers' Compensation Reporter*:

1. The decision will assist individuals in pursuing a remedy or providing representation on compensation, assessment, prevention, or other matters by explaining in clear, plain language the criteria for considering or adjudicating particular issues, or the procedures for pursuing a remedy.

2. The decision will aid in the understanding of workers' compensation by offering a thorough analysis of a significant concept or a new insight. The decision may:

   (a) Summarize the legislative history behind a key statutory provision

   (b) Set out a thorough analysis of law and policy in relation to a key issue

   (c) Draw on relevant jurisprudence

   (d) Apply important principles of statutory interpretation, or

   (e) Discuss/analyze a change in the law, policy, or practice

3. The decision signals the direction that WCAT is taking on certain issues to provide greater certainty and predictability:

   (a) While WCAT is generally not bound by precedent (except in the case of decisions by panels appointed under section 238(6)), recognizing that consistency and predictability are important values in decision-making, or

   (b) By providing a precedent which is binding on future WCAT decision-making, unless the circumstances are clearly distinguishable or a policy relied upon in the decision is changed (pursuant to section 238(6) and 250(3))

4. The decision assists in understanding important jurisdictional questions relating to the new legislation or to the new appellate structure.

5. The decision assists in interpreting new statutory provisions, regulations, or policies.

WCAT also assists in identifying key decisions of the courts on matters affecting the interpretation and administration of the Act or other matters of interest to the community.

Resolution of the Board of Directors

Number: 2004/01/20-01
Date: January 20, 2004
Subject: The Status of Treatment Injuries

WHEREAS:

Pursuant to section 82 of the *Workers Compensation Act,* RSBC 1996, Chapter 492 and amendments thereto ("Act"), the Board of Directors must set and revise as necessary the policies of the Board of Directors, including policies respecting compensation, assessment, rehabilitation, and occupational health and safety;

AND WHEREAS:

Section 5(1) of the Act provides that the Workers' Compensation Board ("WCB") must pay compensation out of the accident fund where personal injury or death arising out of and in the course of employment is caused to a worker;

AND WHEREAS:

Policy in the *Rehabilitation Services and Claims Manual* ("RSCM"), Volume II, provides that where a further injury arises as a direct consequence of treatment for a compensable injury, the further injury is also compensable;

AND WHEREAS:

Policy does not clearly indicate the basis upon which a further injury is compensable;

AND WHEREAS:

The Policy and Regulation Development Bureau ("Bureau") has consulted with stakeholders on this issue;

THE BOARD OF DIRECTORS RESOLVES THAT:

1. Amendments to policy items #22.00, #22.10, #22.11, #22.15, and #22.21 of the RSCM, Volume II, attached as Appendix A, are approved and apply to all decisions, including appellate decisions, made on or after February 1, 2004, regardless of the date of the original work injury or the further injury.

2. Policy item #74.11 is deleted and amendments to policy item #111.10 of the RSCM, Volume II, attached as Appendix B, are approved effective February 1, 2004.

3. Decision No. 152 of the *Workers' Compensation Reporter*, Volume II is retired effective February 1, 2004.

4. This resolution is effective February 1, 2004.

DATED at Richmond, British Columbia, January 20, 2004.

Appendix "A"

REHABILITATION SERVICES AND CLAIMS MANUAL, VOLUME II

Additions in **bold;** deletions in ~~strikethrough~~

#22.00 COMPENSABLE CONSEQUENCES OF WORK INJURIES

Once it is established that an injury arose out of and in the course of employment, the question arises as to what consequences of that injury are compensable. The minimum requirement before one event can be considered as the consequence of another is that it would not have happened but for the other.

Not all consequences of work injuries are compensable. A claim will not be reopened merely because a later injury would not have occurred but for the original injury. Looking at the matter broadly and from a "common sense" point of view, it should be considered whether the ~~previous~~ **work** injury was a significant cause of the later injury. **If the work injury was a significant cause of the further injury, then the further injury is sufficiently connected to the work injury so that it forms an inseparable part of the work injury. The further injury is therefore considered to arise out of and in the course of employment and is compensable.**

EFFECTIVE DATE: **February 1, 2004**
APPLICATION: **All decisions, including appellate decisions, made on or after February 1, 2004 regardless of the date of the original work injury or the further injury.**

#22.10 Further Injury or Increased Disablement Resulting from Treatment

Where a further injury **or increased disablement** arises as a direct consequence of treatment for a compensable injury, ~~the further injury is also compensable~~**it is sufficiently connected to the original work injury as to form part of that injury. The further injury is therefore considered to arise out of and in the course of employment and is compensable.**

Where a worker is undergoing treatment for a compensable injury, the place of treatment is analogous to a place of employment**.** ~~, and a~~ **A** further injury arising out of the place of treatment ~~would also be~~ **is** compensable **provided it is consistent with the worker being at the place of treatment for the purpose of treatment and does not result from activities of a personal nature**. **The further injury in these cases is compensable because it is sufficiently connected to the original work injury so that it forms part of that injury and is therefore considered to arise out of and in the course of employment.** For example, if a worker is undergoing treatment at a hospital for a compensable injury and sustains a further injury by stumbling down the stairs in the hospital **while en route to a treatment appointment**, **the further injury** ~~that~~ is also compensable.

EFFECTIVE DATE: **February 1, 2004**
APPLICATION: **All decisions, including appellate decisions, made on or after February 1, 2004 regardless of the date of the original work injury or the further injury.**

*#22.11 Disablement Caused by **Unauthorized** Surgery*

Compensation is not limited to the direct consequences of work accidents. Ordinarily, when a worker undertakes surgery for ~~the injuries sustained~~ **a work injury**, the consequences of the surgery are ~~accepted as consequences of the accident, and any~~ **considered to be sufficiently connected to the original work injury as to form part of that injury. Any** disablement resulting from the surgery is treated as compensable **on the basis that it arose out of and in the course of employment.**

~~No doubt an~~ **An** exception could be made if a worker recklessly undertook surgery, knowing that it was likely to do more harm than good. In that case, a worker might be viewed as having introduced a new cause of disablement **so that the further injury is not sufficiently connected to the original work injury so as to form part of that injury**. There may be other grounds for making an exception**.**~~, but there is no rational ground on which an exception can be made~~ **However, the connection between the original work injury and the further injury is not severed** simply because the surgery was not authorized by the Board.

~~In a Board decision, the worker had suffered a compensable injury at work, but had then become disabled following surgery carried out without the Board's authorization. The question was whether the disablement should be compensated as resulting from the injury or disallowed because it resulted from unauthorized surgery. Once it was determined that the worker's conduct in undertaking the unauthorized surgery was not unreasonable, the surgery was treated as having resulted from the work injury, and pursuant to the general rule, the consequences of the surgery were accepted as the consequences of the work accident.~~

Virtually all patients place complete faith in their physicians and, if a physician merely suggests the remote possibility of improvement in a patient's condition through surgery, it cannot be said to be "clearly unreasonable" for the patient to go along with that suggestion. It is irrelevant whether unauthorized surgery was successful or unsuccessful, whether or not the worker and/or the physician knew the Board was not prepared to authorize the surgery, nor that the surgery was purely exploratory in nature.

The only situation where it is foreseeable that the Board could reasonably refuse payment of benefits for unauthorized surgery is where a worker, in desperation and against the ~~advise~~ **advice** of every other physician consulted, deliberately seeks out surgery. **In such a situation, the connection between the original work injury and the further injury is considered to be severed. However,** ~~U~~**u**nless the worker can be shown to have acted foolishly, the worker should not be deprived of compensation because there happens to be a persuasive surgeon involved who has convinced the worker that, on balance, surgery is the best course of action. (9)

The above rules only apply where the surgery resulted from the injury. The Board accepts no responsibility for the cost of surgery or any resulting disability where the surgery was not a consequence of the injury.

EFFECTIVE DATE: **February 1, 2004**
APPLICATION: **All decisions, including appellate decisions, made on or after February 1, 2004 regardless of the date of the original work injury or the further injury.**

#22.15 Travelling To and From Treatment

The test for determining whether a further injury is compensable is whether the work injury was a significant cause of the further injury. Where this test is met, there is a sufficient connection between the work injury and the further injury to consider the further injury a part of the work injury. In considering whether this test has been met, the place of treatment is analogous to a place of employment.

Travel to the place of treatment is generally comparable to the ordinary commute to work. Injuries arising in the course of normal travel for subsequent~~ial~~ treatment are generally not compensable. For example, if a worker suffering from a compensable injury is subsequently injured in the course of travel in the following circumstances, it is not compensable:

(a) attending the office of the attending physician for advice, examination or treatment;

(b) attending for x-ray examinations or laboratory tests when associated with a visit to the office of the attending physician and not involving a special journey from home;

(c) attending the office of a medical specialist in connection with a course of treatments by such a specialist;

(d) attendances at the out-patient department of a hospital~~, the Board's Rehabilitation Centre~~ or a private physiotherapist for a course of therapy treatments;

(e) travel to a drugstore for the purchase of drugs or other medical supplies;

(f) travel to an optician or optometrist, prosthetist, shoemaker or hearing aid dealer in connection with medical supplies or the fulfillment of prescriptions.

The heading also includes any other types of visits or attendances which are part of a routine (analogous to travelling to and from work) or which are analogous to personal shopping.

Apart from routine travel in connection with subsequent~~ial~~ treatment, a worker may sometimes be injured in the course of a special and exceptional journey undertaken as a result of the compensable injury. The following headings illustrate the point.

1. Emergency Transportation

   Where a compensable injury has just occurred and a worker is being transported to a hospital or other place of emergency treatment, and a further injury occurs in the course of such transportation, the further injury is also compensable. This is so whether the worker is travelling on foot, by ambulance, by automobile, by aircraft, or by any kind of vehicle; and it is so regardless of the ownership of the vehicle, and regardless of whether the worker is driving the vehicle or being carried as a passenger.

2. Treatment-Related Vehicles

   If a worker is travelling to or from a place of treatment for a compensable injury and sustains a further injury while travelling in a vehicle that is provided for that purpose by an institution engaged in the provision of treatment, or in the provision of a vehicle for the conveyance of patients for treatment, the injury is compensable.

3. Exceptional Travel for Subsequent Treatment

   This heading relates to situations where a worker is travelling by prearranged appointment to a place of exceptional medical treatment, or for an exceptional examination. In these cases, an injury arising out of travel to or from that place of treatment is compensable. The following situations illustrate this point.

   (a) Travelling to a hospital for admittance as an inpatient, or travelling home following discharge from hospital as an inpatient.

   ~~(b) Travelling to Richmond from the Interior for a course of treatment at the Board's Rehabilitation Centre, with accommodation at the Board's Rehabilitation Residence~~.

   (~~c~~**b**) Travelling to any other place of special treatment that involves living away from home for the duration of the treatment.

   (~~d~~**c**) Travelling in relation to a referral by the attending physician to a specialist for a special examination or treatment.

   (~~e~~**d**) Travelling for x-ray examination or laboratory tests where this involves a special journey separate from any attendance for routine treatment.

   (~~f~~**e**) Travelling to a special place of paramedical attention, or a social or rehabilitation agency in connection with assistance in the diagnosis, handling, treatment or care of medical or rehabilitation problems related to the compensable injury on referral by the attending physician, or by the Board.

   (~~g~~**f**) Travelling on referral by a physician or qualified practitioner to another physician or qualified practitioner for a second opinion.

   (~~h~~**g**) Travelling for a medical examination at the Board by prearranged appointment with the Board, or for a medical examination elsewhere approved by the Board in connection with a compensable injury.

In the examples in items 1–3 above, the further injury is compensable because it is sufficiently connected to the original work injury as to form part of that injury. The further injury is therefore considered to arise out of and in the course of employment.

EFFECTIVE DATE: **February 1, 2004**
APPLICATION: **All decisions, including appellate decisions, made on or after February 1, 2004 regardless of the date of the original work injury or the further injury.**

#22.21 Activities on Board Premises or at Other Premises under Board Sponsorship

Where a worker is attending at the Board by prearranged appointment made with an officer of the Board for the purpose of an enquiry, interview or discussion in respect of a claim which has been accepted, or which is subsequently accepted, and where the worker suffers a further injury arising out of and in the course of travel to or from such an appointment, the further injury will be compensable.

The same rules apply where a worker is attending by prearranged appointment to meet with the Board's Review Division, the Workers' Compensation Appeal Tribunal or a Medical Review Panel.

Where an injured worker is reinjured while undergoing a course of rehabilitation training sponsored by the Board, the second injury may be regarded as a compensable consequence of the first injury. (11)

In all of these instances the place of treatment, appointment or rehabilitation is analogous to a place of employment. The further injury is compensable because it is sufficiently connected to the original injury as to form part of that injury and, therefore, is considered to arise out of and in the course of employment.

EFFECTIVE DATE: ~~March 3, 2003 (as to references to the Review Division and the Workers' Compensation Appeal Tribunal and deletion of references to the Board's Rehabilitation Residence)~~ **February 1, 2004**

APPLICATION: ~~Not applicable~~. **All decisions, including appellate decisions, made on or after February 1, 2004 regardless of the date of the original work injury or the further injury.**

Appendix "B"

REHABILITATION SERVICES AND CLAIMS MANUAL, VOLUME II

Additions in **bold;** deletions in ~~strikethrough~~

~~*#74.11 Medical Negligence or Malpractice*~~

~~During the progress of a worker's file, information may come to the attention of Board employees that would lead them to conclude that there was prima facie evidence of medical malpractice or negligence. This may come from the perusal of a single file or the perusal of a series of files where workers have been treated by the same physician. The following action should be taken in these cases:~~

~~1. Where this is brought to the attention of a Board employee or a Board physician, it shall be reported to the Executive Director, Health Care Services.~~

~~2. The Executive Director, Health Care Services will review the case, together with a committee composed of the following members:~~

~~(a) The Board's General Counsel, or nominee;~~

~~(b) The Director, Clinical Services Department;~~

~~(c) The Director, Rehabilitation Services.~~

~~3. The committee will forward to the President a recommendation for action in cases where it is felt that medical malpractice or negligence may have occurred. The President will determine whether to proceed with an action. The worker will be advised of the President's decision with reasons.~~

#111.10 Injury Caused by Worker or Employer

Section 10(1) of the *Act* provides that "The provisions of this Part are in lieu of any right and rights of action, statutory or otherwise, founded on a breach of duty of care or any other cause of action, whether that duty or cause of action is imposed by or arises by reason of law or contract, express or implied, to which a worker, dependant or member of the family of the worker is or may be entitled against the employer of the worker, or against any employer within the scope of this Part, or against any worker, in respect of any personal injury, disablement or death arising out of and in the course of employment and no action in respect of it lies. This provision applies only when the action or conduct of the employer, the employer's servant or agent, or the worker, which caused the breach of duty arose out of and in the course of employment within the scope of this Part."

This provision prohibits a law suit by an injured worker or a dependant of an injured worker against the employer of the worker or against any employer within the scope of Part 1 of the *Act*, or against any worker in respect of any personal injury, disablement, or death arising out

of and in the course of the employment. The worker or dependant has no choice but to claim compensation. In situations where the third party on a claim is reported to be a worker, it must also be established that the activities of this "worker" were arising out of and in the course of his or her employment.

~~Where an action is barred under section 10(1) in respect of a work injury, the same applies to any subsequent injury occurring in the course of treatment or rehabilitation which is accepted as a compensable consequence of that injury.~~

Resolution of the Board of Directors

Number: 2004/02/24-02
Date: February 24, 2004
Subject: Retirement of Old Reporter Decisions

WHEREAS:

Pursuant to section 82 of the *Workers Compensation Act*, RSBC 1996, Chapter 492 and amendments thereto ("Act"), the Board of Directors must set and revise as necessary the policies of the Board of Directors, including policies respecting compensation, assessment, rehabilitation, and occupational health and safety;

AND WHEREAS:

The *Workers' Compensation Reporter* Decisions No. 1−423 contained in Volumes 1−6 ("Old Reporter") were adopted as "policy" by the former governors in 1991. They consist of decisions of the former commissioners made between 1973 and 1991;

AND WHEREAS:

On February 11, 2003, the Board of Directors issued a bylaw identifying the policies of the Board of Directors under the Act. Among the policies listed in the bylaw are those Old Reporter Decisions that were not retired prior to February 11, 2003;

AND WHEREAS:

The workers' compensation system has gone through significant statutory and policy change since the Old Reporter Decisions were first issued;

AND WHEREAS:

The Old Reporter Decisions have become repetitive, outdated and/or contradictory to policy contained in the Policy Manuals;

AND WHEREAS:

While 380 of the 423 Old Reporter Decisions have been retired from policy status, 43 Decisions remained to be considered, creating potential complexity and confusion in the workers' compensation system;

AND WHEREAS:

The Policy and Regulation Development Bureau ("Policy Bureau") has presented to the Board of Directors a list of 39 Old Reporter Decisions that have been identified for retirement;

AND WHEREAS:

The Policy Bureau has presented to the Board of Directors a proposal to revise policy item #18.31, *Worker on Call*, of Volume II of the *Rehabilitation Services and Claims Manual,* to support the retirement of Old Reporter Decision No. 50 by remedying an ambiguity that exists between the decision and the policy item;

AND WHEREAS:

Arising from the development of the new *Assessment Manual,* Decision No. 225 was prematurely retired on January 1, 2003. The Board of Directors considers it appropriate to reinstate Decision No. 225 so that it can be considered as part of a 2004 project to review the *Fishing Regulations;*

AND WHEREAS:

With the retirement of 39 Decisions and reinstatement of Decision No. 225, a total of 418 Old Reporter Decisions will be retired from policy status. The remaining five Decisions (No. 99, 225, 231, 271 and 343) will be addressed in the near future as part of separate policy projects;

THE BOARD OF DIRECTORS RESOLVES THAT:

1. The 39 Old Reporter Decisions listed in the attached Appendix "A" are retired from the Board of Directors policies as of the effective date of this Resolution ("retirement date").

   As of the retirement date, the listed decisions are no longer "policy" under the Board of Directors' Bylaw re: Policies of the Board of Directors. However, the status of the listed decisions as "policy" prior to the retirement date remains unaffected by this Resolution. The listed decisions remain applicable in decision-making on historical issues to the extent they were applicable prior to the retirement date.

   Where a policy statement in an Old Reporter Decision retired under this Resolution also appears in a policy manual, the retirement of the Old Reporter Decision does not affect the applicability of the policy statement in the manual.

2. The amendment to policy item #18.31, *Worker on Call*, in Volume II of the RSCM, attached as Appendix "B" is approved.

3. Decision No. 225 is reinstated as policy of the Board of Directors, as if it had never been retired, pending a review of the *Fishing Regulations.*

This resolution is effective February 24, 2004.

DATED at Richmond, British Columbia, February 24, 2004.

Appendix "A"

WORKERS' COMPENSATION REPORTER DECISIONS 1–423 (VOLUMES 1–6)

PHASE FIVE:
DECISIONS PROPOSED FOR RETIREMENT, FEBRUARY 24, 2004
(39 Decisions)

No.	Title
2	An Injured Person
3	A Claim For Industrial Disease
10	A Claim for Dependents Benefits
17	Disablement Following Unauthorized Surgery
41	The Composition of a Medical Review Panel
48	The Coverage of Workers' Compensation
50	The Coverage of Workers' Compensation
65	Cost Shifting Between Classes
69	Legal Fees
77	Criminal Injuries Compensation
101	Contagious Diseases
102	Disablement Through Exhaustion
107	Termination Pay
108	The Violation of Safety Regulations by a Worker
121	Employment Injuries and Natural Causes
128	Bronchitis and Emphysema
129	Injuries and "Specific Incidents"
145	Employment Injuries and Natural Causes
172	*The Criminal Injury Compensation Act*

No.	Title
178	*The Criminal Injury Compensation Act*
182	The Course of Employment
194	Horseplay
195	Compensable Consequences of Work Injuries
198	*The Criminal Injury Compensation Act*
207	Bronchitis and Emphysema
214	Travelling Employees
219	Medical Review Panels
267	Section 7A: Compensation for Non-Traumatic Hearing Loss
270	Subsection 6(5) Proportionate Entitlement
286	Section 6(1): Injuries Arising out of Employment
318	Stress Testing
320	Continuity of Income and Assessment for Permanent Disability
324	Personal Care Allowances
330	Scope of Employment
333	Certain Industrial Diseases
348	Alcoholism
379	Time Limit on Application for Compensation
382	The Commutation of Pensions
407	Assessment of Permanent Disabilities

Appendix "B"

#18.31 Worker On Call

Workers are not covered while routinely travelling to and from work simply because as part of their contract of employment, they are liable to be called out from their homes at any time to deal with a matter connected with their employment. They are, however, covered if because of an emergency or some other reason they have to make a special journey from their homes to their employer's premises or to some other place where the job has to be done. **In this regard, they will be covered for compensation from leaving home until their return home, provided that they do not deviate from their route.**

EFFECTIVE DATE: **February 24, 2004 (to clarify that compensation will be provided to workers from leaving home until their return home. This revision supports the retirement of Decision No. 50 of the *Workers' Compensation Reporter* by remedying an ambiguity between that Decision and the policy item.)**

APPLICATION: **Applies to all decisions made on or after February 24, 2004.**

Decision of the Review Division

Number: **2069**
Date: **December 30, 2003**
Review Officer: **Guy Riecken**
Subject: **An Estate**

The worker requested a review of the decision of the Workers' Compensation Board (the "Board") dated March 6, 2003. The worker provided a written submission in support of his request. The employer was notified of this review but is not participating. The worker died on June 6, 2003, and his surviving spouse seeks to continue the review on behalf of the worker's estate.

Section 96(6) of the *Workers Compensation Act* (the "Act") gives a review officer authority to conduct this review.

Issues

There are two issues in this review:

1. The preliminary issue of whether the worker's estate has standing to continue the review after the worker's death.

2. The review of the Board's decision to grant the worker a disability award based on a permanent functional impairment of 2.07% of total disability effective from May 27, 2002.

Background

On September 21, 2001, the worker was employed as an ironworker when he caught his hand between some rebar and sustained an injury. The Board accepted the claim for a right hand crush injury.

The claim was referred to the Board's Disability Awards Department. In the decision under review the Board granted a functional impairment award of 2.07% of total disability for the worker's right wrist impairment.

The worker filed his request for review of the Board's decision on April 15, 2003. The worker died on June 6, 2003, before the review was completed. The worker's surviving spouse, TM, on behalf of the worker's estate, requests that the review continue to completion.

Facts and Evidence

The following are the relevant facts and evidence I have considered in conducting this review:

- The May 22, 2002 medical review memo from Dr. S, Board medical advisor, which indicates that, although the worker was not able to return to his full pre-injury heavy duties, he was capable of returning to moderate duties on a full-time basis.

- The May 23, 2002 memo from the Board case manager, which indicates that the worker's wage loss benefits would be terminated as of May 26, 2002, and that the worker would be referred to Vocational Rehabilitation Services.

- The February 10, 2002 memo from the case manager, which indicated that the worker had returned to work in a different job three weeks earlier.

- The November 12, 2002 permanent functional impairment ("PFI") evaluation conducted by Dr. K., PFI physician, which sets out the measurements of the restricted range of motion of the worker's right wrist. The PFI evaluation also indicates that the worker reported that he continued to experience intermittent pain and cracking in his right wrist when performing various activities.

- The November 14, 2002 ARCON impairment rating report, which indicates that the worker had a scheduled impairment of 2.07%, including 0.6% for abnormal right wrist flexion and extension, 1.08% for abnormal radial and ulnar deviation, and 0.39% for abnormal motion of pronation and supination.

- The March 4, 2003 PFI review (Form 24) by the disability awards officer ("DAO"), which reviewed the findings of the PFI evaluation and the ARCON calculation, and concluded that the 2.07% scheduled impairment calculation would be accepted. The DAO considered the worker's subjective complaints for pain and concluded that the scheduled percentage included the worker's subjective complaints. The DAO determined that the effective date of the pension would be May 27, 2002, the day after the worker's wage loss benefits concluded. The DAO applied an earnings rate for the one-year period before the worker's injury of $5,913.75. This was a monthly pre-injury earnings rate of $492.79. The worker's disability award was based on 2.07% of that amount. The DAO indicated that a loss of earnings assessment was not applicable.

- The worker's certificate of death.

- The June 28, 2003 statutory declaration of TM, which indicated that TM was the common-law spouse of the worker, that the worker died on 6 June, 2003 without a will, that with the exception of insurance policies payable to a named beneficiary and jointly registered assets, the total value of the worker's estate did not exceed $10,000, and that no other person was entitled to share in the estate of the deceased worker.

Submission

In the submission which the worker provided with his request for review, he argued that it was unfair to base his disability award on his one-year earnings prior to the date of injury because he had an uneven work history during that period due to his young age and relative inexperience in the workforce. The worker indicated in his submission that at the time of his injury he was close to moving to a better paying position with his employer and would have had future earnings that were much higher than the wage rate used in the decision by the Board. The worker also submitted that the functional impairment percentage was too low and that it did not reflect the extent of his pain in his wrist and did not reflect the effect on his reduced physical functioning and potential future earnings.

Law and Policy

The Act

The Act was amended, effective June 30, 2002, by the *Workers Compensation Amendment Act 2002*, (the "amendment"). As the worker's injury and permanent disability occurred before June 30, 2002, the provisions of law and policy as they read prior to the amendment (the "former" Act and policies respectively), apply to the substantive issue of the worker's disability award.

The Act was further amended, effective March 3, 2003 by the *Workers Compensation Amendment Act (No. 2), 2002,* (the "2003 amendment"). The current provisions of the Act as amended by the 2003 amendment, apply to the conduct of reviews by review officers.

Section 15 of the Act, which has not been changed by either of the aforementioned amendments, provides that a sum payable as compensation is not capable of being assigned, charged or attached, nor can it pass by operation of the law except to a personal representative.

Section 23(1) of the former Act provides that a worker with a permanent disability is eligible for a benefit that estimates the impairment of earning capacity based on the nature and degree of the injury.

Section 23(2) of the former Act allows the Board to compile a rating schedule of percentages of impairment of earning capacity for specified injuries, to be used as a guide in determining the compensation payable.

Policy

The following policies relating to the issues in this review are found in the *Rehabilitation Services and Claims Manual* (the "RSCM"), Volume I, Chapter 6, *Permanent Disability Awards*, Chapter 9, *Average Earnings*, and Chapter 12, *Claims Procedures*:

- Policy item #38.00, *Permanent Partial Disability*, identifies two methods for assessing permanent partial disabilities: the loss of function method and the projected loss of earnings method. These two methods are "considered in every case where applicable." The amount of the award is to be the higher of the two methods.

- Policy item #39.00, *Loss of Function/Physical Impairment Assessment*, identifies the physical impairment, or loss of function method, provided for under section 23(1) of the Act, as the primary one used for measuring permanent functional disabilities. The policy also specifies the calculation model to be used for determining a loss of function award.

- Policy item #39.01, *Chronic Pain,* which applies to Board decisions made on or after January 1, 2003, provides guidelines for the assessment of section 23(1) awards for workers who experience disproportionate disabling chronic pain as a compensable consequence of a work injury.

- Policy item #39.10, *Scheduled Awards Permanent Disability Evaluation Schedule*, refers to the permanent disability evaluation schedule as a rating schedule for percentages of impairment for specific injuries, as well as other variables, that may be considered by the Board officer in Disability Awards.

- Policy item #68.00, *Permanent Disability Pensions,* provides that the long-term earnings rate resulting from the eight-week review is normally the rate used for pension purposes. However, if there are valid reasons for doing so, a different rate may be used for pension purposes.

- Policy item #97.40, *Disability Awards*, identifies that the report of a disability awards medical advisor ("DAMA") or an external service provider takes the form of expert evidence which, in the absence of other expert evidence to the contrary, should not be disregarded.

Reasons and Decision

Issue #1 — Preliminary Matter — Standing of Worker's Estate to Continue Review

This review was requested by the worker, under subsections 96(6) and 96.3(1) of the Act, prior to his death. These circumstances raise the issue of whether the deceased worker's estate has standing, through the estate's representative, to continue the review after the worker's death.

As explained in a reported decision of the former Appeal Division of the Board (Appeal #95-0991), 11 *Workers' Compensation Reporter* 507, at common law the estate of a deceased person did not automatically inherit all the rights of the deceased. Generally, with some exceptions, the rights of the deceased were extinguished upon death. For example, at common law the estate of the deceased person could not maintain an action for damages for a personal injury suffered by the person during his life. Statutory law has given rights and obligations to the estates of deceased persons that did not exist at common law. The extent to which the rights of the deceased vest in the estate, and the standing of the estate to commence or continue an action or an appeal with respect to those rights, is a matter of statutory law. The extent to which the rights of deceased workers to compensation, for employment-related personal injuries, may vest in their estates is governed, in the circumstances of this case, by the Act and by the *Estate Administration Act* (the EAA).

In their decision in Appeal #95-0991, the panel of the Appeal Division reviewed the provisions of the former Act and the EAA and concluded that the estate of a deceased worker had standing to continue an appeal that had been initiated by the worker, where the worker was seeking

to have his entitlement to compensation benefits recognized or given full effect The Appeal Division panel also held that the estate of a deceased worker had standing to initiate an appeal of a decision concerning a claim for arrears of compensation.

The Appeal Division panel commented, however, that an estate may not be able to maintain a worker's claim for discretionary benefits, such as vocational rehabilitation benefits, because section 15 of the Act refers to "a sum payable as compensation" passing to a worker's personal representative. The panel found that the words "a sum payable as compensation" suggest some entitlement to compensation, as that term is defined in the Act, rather than discretionary benefits.

The 2003 amendment repealed sections 90 and 91 of the former provisions of the Act, which gave the former Workers' Compensation Review Board (the "Review Board") and the former Appeal Division, respectively, their jurisdiction.

The relevant provisions in the current Act with respect to the initiation of reviews, and the jurisdiction of review officers, are subsections 96(6), 96.3(1) and 96.4(2).

I find that the repeal of the former sections 90 and 91 has not diminished the standing of deceased workers' estates. I adopt the general approach of the Appeal Division in Appeal #95-0991. I also note that, as outlined in the passage quoted below, the Workers' Compensation Appeal Tribunal ("WCAT") has recognized the standing of estates of deceased workers to initiate and continue appeals. I conclude that the estate of the worker has standing, through the estate's personal representative, to continue this review.

This leads to the question of whether adequate documentation has been provided by TM to establish that she can act as the personal representative of the estate for the purpose of continuing this review. The issue of the documentation that is required for this purpose is not addressed in the legislation or the Review Division Practices and Procedures.

The Manual of Rules, Practices and Procedures of WCAT addresses the estates issue in the section 3.20 as follows:

> The estate of a deceased worker has the right both to initiate an appeal to the WCAT, and to continue an appeal on behalf of a deceased worker, concerning a claim for arrears of compensation up to the date of the worker's death. Documentation is required to establish the identity of the estate's representative. This may include the Letters of Administration or Letters Probate, or a copy of the will if the estate is small and probate is not required, or a statutory declaration or other form of evidence where there is no will and the estate is small or substantially held in joint tenancy.

I adopt the same approach with respect to documentation.

In this case TM, the worker's surviving spouse, has provided a statutory declaration which confirms that the worker died intestate, that the estate is small, and that no one else is entitled to claim as beneficiary of the estate. I accept this as sufficient documentation to establish the standing of TM to continue the review as the personal representative of the worker's estate.

Issue #2 — Substantive Issue

In his submission, the worker contended that the percentage of the PFI assessment did not adequately reflect his degree of impairment and did not properly take into account his pain and the effect of his disability on his potential earnings. The worker also contended that the Board should not have used his earnings from the one-year period prior to the date of injury to calculate his award. The worker did not dispute the effective date of the award.

Under policy item #97.40, the DAO was required to treat the PFI findings of Dr. K, an external service provider, as expert evidence. The worker has not provided any other expert evidence to the contrary, and the PFI evaluation cannot be disregarded. I have reviewed Dr. K's PFI evaluation and the calculations in the ARCON impairment rating report. I find that the measurements from the PFI evaluation were correctly entered into the Board's ARCON rating system. I concur with the DAO's determination that the resulting 2.07% scheduled award accurately reflects the worker's functional impairment.

Under policy item #39.01, in considering the worker's chronic pain as part of a section 23(1) assessment, the DAO is required to enquire carefully into all the circumstances of the worker's chronic pain, including the findings of any multidisciplinary assessments, information provided by the worker, the worker's conduct and activities, medical evidence, and in the case of specific chronic pain, whether the pain is in keeping with the particular permanent impairment.

I find from my review of the evidence, including the PFI evaluation, the medical evidence on the claim file, the information provided by the worker, and the Form 24 PFI review, that the DAO considered the relevant factors under policy item #39.01. I find that the DAO's determination, that the worker's continuing pain was adequately included in the scheduled PFI award, was consistent with the evidence and with the provisions of policy item #39.01.

In calculating the disability award, the DAO used the earnings rate established at the eight-week point of the claim, in accordance with policy item #68.00. I have reviewed the information submitted to the Board by the worker with respect to his earnings from 1995 through 2000. While the worker did have higher earnings in 1995 through 1998, his annual earnings in 1999 and 2000 were lower than during the one-year prior to his date of injury. Considering all of the available information about the worker's earnings, I concur with the determination of the DAO that using the worker's earnings in the one-year period prior to his injury best reflects the worker's long-term loss due to the injury.

In light of the worker's low pre-injury earnings of $492.79 per month, and the evidence that he had returned to work in a different job before the disability award was calculated, I concur with the determination of the DAO that a loss of earnings assessment is not applicable in this case.

As a result of this review the worker's request is denied.

Conclusion

As a result of this review, I confirm the Board's decision of March 6, 2003.

Decision of the Review Division

Number: **5089**
Date: **February 11, 2004**
Review Officer: **Nick Attewell**
Subject: **Sections 33.3 and 33.4 of the *Workers Compensation Act* and Section 15 of the *Canadian Charter of Rights and Freedoms***

The worker requests a review of the decision of the Workers' Compensation Board (the "Board") dated March 31, 2003. In support of this request for review, the worker's representative has provided a written submission. The employer was given notice of the review and did not respond.

Section 96(6) of the *Workers Compensation Act* (the "Act") gives a review officer authority to conduct this review.

Issue

The issue on this review is the Board's decision regarding the worker's average earnings after the initial 10 weeks of disability.

Background

The worker injured his upper back on January 15, 2003, in the course of his employment as a construction labourer. He had only been employed with that employer for two days. Temporary disability benefits were paid until November 16, 2003. After the initial 10 weeks of disability, the benefits were based on the earnings in the prior year of a similar worker in the same company.

Facts and Evidence

The following are the relevant facts and evidence I have considered in conducting this review:

- The worker was hired as a regular worker but had only been working for two days prior to the injury.

- The employer provided a T4 showing earnings of a similar worker who had been employed in the previous year. These earnings were in the amount of $28,071.69, giving a gross weekly rate of $538.36. The decision under review used these earnings.

- The case manager was advised by the employer during a site visit that the employer is in the house building business and normally employs only two or three workers.

- The employer provided an October 10, 2003, letter stating as follows:

  – the worker was being paid $15.00 an hour and would have been working six days a week and nine hours a day,

  – the worker would have been continued to be employed and have received wage increases over the following year if he had not been injured,

  – the T4 for the similar worker that he provided only covered nine months as the worker in question had been on employment insurance for the first three months of the year. If that worker had worked a full year, he would have earned between $36,000 and $39,000 or approximately $3,100 per month.

Law and Policy

The Act

The law that applies to this review is found in sections 33 to 33.7 of the Act. Section 33(1) states that "the Board must determine the amount of average earnings and the earning capacity of a worker with reference to the worker's average earnings and earning capacity at the time of the worker's injury." Under section 33(2), the Board must determine the amount of average earnings in accordance with section 33 and sections 33.1 to 33.7.

Section 33.1 sets out two general rules for determining a worker's average earnings. For the first 10 weeks of disability, the Board must determine the amount of average earnings of a worker based on the rate at which the worker was remunerated at the time of the injury. After the initial 10 weeks, the Board must determine the amount of average earnings based on the worker's gross earnings, as determined by the Board, for the "12-month period immediately preceding the date of injury."

These general rules are subject to exceptions. These include the following:

- Section 33.3 provides that "in the case of a worker employed, on other than a casual or temporary basis, by the employer for less than 12 months immediately preceding the date of the injury, the Board's determination of the amount of average earnings under section 33.1(2) must be based on the gross earnings, as determined by the Board, for the 12-month period immediately preceding the date of injury, of a person of similar status employed in the same type and classification of employment
  (a) by the same employer, or
  (b) if no person is so employed, by an employer in the same region."

- Section 33.4 of the Act contains a specific provision allowing the Board to calculate average earnings in a different way if there are exceptional circumstances causing an inequity. However, this section is expressed not to apply to workers covered by section 33.3.

Policy

The policy relating to this review is found in Chapter 9 of the *Rehabilitation Services and Claims Manual* ("RSCM"), Vol. II. In particular, Item #67.50 states as follows:

> To determine a worker's average earnings under section 33.3 of the *Act*, the Board will contact the injury employer to determine what the average earnings are or would be of a person of similar status employed in the same type and classification of employment. . . .

Reasons and Decision

The worker's lawyer makes two main arguments. The first is that sections 33.3 and 33.4 are contrary to section 15(1) of the *Canadian Charter of Rights and Freedoms* ("Charter"). The second is that section 33.3 was not correctly applied in this particular case. I will deal with these two arguments in turn, but will first set out some background to the sections of the Act governing average earnings, in particular sections 33.3 and 33.4.

Background to Average Earnings Provisions

The Act provides for the payment of compensation to workers suffering disabilities as a result of their employment. The compensation is intended to reflect the loss of earnings that workers suffer because of their disability and therefore compensation is generally based on their earnings prior to the injury. However, there is no intention to provide complete and individualized compensation for a worker's total loss of earnings. For various reasons, including the "historic compromise" that led to the founding of the workers' compensation system in 1917 and the need for an administratively efficient payment and adjudication system, the compensation payable is subject to certain rules and limits. For example, there is a maximum wage rate for which compensation can be paid and payments are limited to 90% of net earnings or a proportion of that in the case of a partial disability.

The current sections 33.1 to 33.9 relating to the determination of earnings are based on a March 2002 report entitled the "Core Services Review of the Workers' Compensation Board," at pages 134–144. This can be found on the internet at http://www.labour.gov.bc.ca/wcbreform/WinterReport-Complete.pdf. The report notes that under the prior system, section 33 gave the Board a very broad discretion to determine average earnings in any case. For the reasons set out in the report, the core reviewer considered that more specific rules should be set out in the statute that would reduce the amount of discretion. These included a general rule basing compensation on 12 months' earnings after the initial 10 weeks but also specific rules for the earnings to be used for certain types of workers, namely learners/apprentices and regular workers employed less than 12 months. These exceptions were enacted in section 33.2 and 33.3. The report does not explain these two exceptions but the reason behind them is apparent. In both cases, the actual earnings in the job at the time of injury averaged over 12 months would not normally be reflective of the worker's long-term loss. In the case of the regular worker employed less than 12 months, these earnings would not take account of such things as variations in work hours and temporary layoffs that might occur during a typical year. The loss in such cases would be better reflected by the earnings of a similar worker in the preceding 12 months.

The report recommended a third exception that would allow the Board "to deal with those extenuating circumstances when the calculation of the worker's average earnings, based on the preceding 12 month period, would, as determined by the WCB, produce an inequitable result." The examples given are of young workers and students. This exception resulted in section 33.4, which is expressed not to apply to either sections 33.2 or 33.3. This is presumably because the intent of the report was to deal with exceptional situations that might arise under the basic requirement for using 12 months' earnings. It was not intended to allow for exceptions to situations for which specific, exceptional rules were being separately created.

Application of the Charter

Section 15(1) of the Charter states as follows:

> Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The worker's lawyer refers to the Supreme Court of Canada decision in *Nova Scotia (Worker's Compensation Board) v. Martin* ("*Martin*") and argues that the reasoning would also apply in this case. His points include:

- The Review Division has jurisdiction to make determinations under the Charter.
- The worker gave up a job as an experienced truck driver making in excess of $40,000 per year to begin a new career in construction.
- New workers are particularly vulnerable given their lack of seniority, and are placed in a very prejudicial position with respect to workers who have more experience and have worked for more than a year.
- Section 33.3 explicitly excludes new workers from the general compensation provisions of the Act with respect to setting long-term average earnings.
- Section 33.4(2) of the Act prevents the Board from applying section 33.4(1) which allows the Board to provide compensation that best reflects the worker's actual losses if strict application of the rules of section 33 would be inequitable.
- *Martin* indicates that financial and budgetary considerations would not justify a violation under section 1 of the Charter. In addition, section 33 completely ignores the real needs of workers who are new on the job.

The Board of Directors of the Board have determined following *Martin* that the Review Division has jurisdiction to consider the application of the Charter in matters before it.

In deciding this review, I propose to apply the general guidelines for making decisions under section 15 of the Charter that are set out in the Supreme Court of Canada in *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 SCR 497 ("*Law*"). These guidelines were followed in *Martin*. The guidelines suggest that there are three central issues to be considered:

1. whether the law in question imposes a differential treatment between the claimant and others, in purpose and effect,

2. whether one or more enumerated or analogous grounds of discrimination are the basis for the differential treatment, and

3. whether the law in question has a purpose that is discriminatory within the meaning of the equality guarantee.

I will deal with each of these issues in turn

1. Does the law impose differential treatment?

I find that, as in the *Martin*, the appropriate comparator group is the group of workers who are eligible for compensation for their employment-related injuries other than the workers that are covered by section 33.3. I accept that the persons covered by section 33.3 are treated differently from the comparator group.

2. Are the enumerated or analogous grounds the basis for the different treatment?

The worker's lawyer does not clearly state the grounds of discrimination on which he is relying. With regard to the enumerated grounds set out in section 15(1), the only candidate appears to be "mental or physical disability." However, the ground on which the worker is treated differently in this case is his employment status at the time of and prior to the injury rather than his disability. Employment status is not one of the enumerated grounds in section 15(1).

The question remains whether the circumstances of this case involve a ground analogous to those set out in section 15(1). What is an analogous ground was considered by the Supreme Court of Canada in *Corbiere v. Canada (Minister of Indian and Northern Affairs)* [1999] 2 SCR 203 ("*Corbiere*"). The majority decision stated as follows:

> What then are the criteria by which we identify a ground of distinction as analogous? The obvious answer is that we look for grounds of distinction that are analogous or like the grounds enumerated in s. 15 — race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability. It seems to us that what these grounds have in common is the fact that they often serve as the basis for stereotypical decisions made not on the basis of merit but on the basis of a personal characteristic that is immutable or changeable only at unacceptable cost to personal identity. This suggests that the thrust of identification of analogous grounds . . . is to reveal grounds based on characteristics that we cannot change or that government has no legitimate interest in expecting us to change to receive equal treatment under the law. To put it another way, s. 15 targets the denial of treatment on grounds that are actually immutable, like

> race, or constructively immutable, like religion. Other factors identified in the cases as associated with the enumerated and analogous grounds, like the fact that the decision adversely impacts on a discrete and insular minority group that has been historically discriminated against, may be seen to flow from the central concept of immutable or constructively immutable personal characteristics, which too often have served as illegitimate and demeaning proxies for merit-based decision making.

I find that the situation in this case does not amount to an analogous ground. The status of being a new, regular employee in a workplace is not an immutable or constructively immutable condition that can be considered analogous to factors such as race or religion.

3. Is the purpose of the law discriminatory?

If I am wrong about this situation not involving an enumerated or analogous ground, I also consider that the differential treatment does not amount to discrimination for the purpose of section 15(1). *Law* elaborates on this issue as follows:

> Does the differential treatment discriminate, by imposing a burden upon or withholding a benefit from the claimant in a manner which reflects the stereotypical application of presumed group or personal characteristics, or which otherwise has the effect of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect and consideration?

The court set out some contextual factors to be considered in making this determination, notably

- The pre-existing disadvantage, stereotyping, prejudice, or vulnerability experienced by the individual or group at issue.

- The correspondence, or lack thereof, between the ground on which the claim is based and the actual need, capacity, or circumstances of the claimant or others.

- The ameliorative purpose of the law upon a more disadvantaged person or group.

- The nature and scope of the interest affected by the law.

With regard to the first of these factors, the worker's lawyer states that newly employed workers are particularly vulnerable given their lack of seniority, and are placed in a very prejudicial position with respect to workers who have more experience and have worked for more than a year. It is certainly true that new employees may in general be less secure than more senior employees. However, this in itself is not sufficient to support a finding of discrimination. There is no evidence of a history of disadvantage, stereotyping, prejudice or vulnerability for new employees of a type that section 15 is intended to cover.

With regard to the second of these factors, the lawyer argues that sections 33.3 and 33.4 are flawed in not giving the Board a discretion to determine what is equitable in the worker's particular case. For the reasons discussed in the next part of this decision, I find that the Board does in fact have some discretion, though perhaps not to the extent desired by the worker. Furthermore, section 33.3 is intended to deal with the particular needs and circumstances of new employees. It recognizes that the earnings with the injury employer would not provide an adequate basis for meeting the 12 months of earnings required by the general rule applicable to all workers and provides an alternative method of calculation that is reasonably reflective of the worker's situation. The Charter does not require that all laws must provide total discretion for decision makers to consider the individual circumstances of each person. A law may appropriately set rules of general application that permit no discretion.

The third factor would not apply to this case. With regard to the fourth factor, the interest of the worker at stake is significant in that it affects the amount of benefits paid to him. However, the interest is much less significant than that of the workers disabled by chronic pain in *Martin*. The effect of the special provision affecting them was to virtually create a separate regime of compensation which lacked a great many of the features of the normal system applicable to other disabled workers. In the present case, the worker is entitled to receive all the benefits of the system. The only difference is that a particular rule has been created for determining the earnings on which benefits are based.

I have concluded that section 33.3 and 33.4 are not contrary to section 15 of the Charter.

Application of Section 33.3 in this Case

The lawyer is arguing that, if his arguments regarding the Charter are not accepted, then the Board should take account of the fact that the similar worker whose earnings were used only worked for nine months. The Board should extrapolate the earnings of $28,071.69 over 12 months. This would produce an amount of $37.428.92 or approximately $3,100 per month.

Section 33.3 states that "average earnings under section 33.1 (2) must be based on the gross earnings, as determined by the Board, for the 12 month period immediately preceding the date of injury, of a person of similar status employed in the same type and classification of employment

(a) by the same employer, or
(b) if no person is so employed, by an employer in the same region."

The lawyer suggests that the phrase "based on the gross earnings, as determined by the Board" gives the Board authority to adjust the earnings of the similar worker so that they reflect the whole 12-month period.

The Compensation Services Division has created a Practice Directive that deals with this question (#33A, Initial and Long-Term Average Earnings). It states:

> When obtaining earnings information in these situations, it is not necessary for the "comparable'' person to have been employed for 12 months. This is because Policy items #67.40 and #67.50 allow Board officers to obtain a figure that represents what a comparable person earns or "would earn" in 12 months.

> However, neither law nor policy permits estimating the worker's earnings based on what the worker himself/herself would have earned working with the injury employer for 12 months.

The Practice Directive recognizes that section 33 allows the Board to adjust the earnings of the similar worker to reflect what a person in the particular type and classification of employment in question would normally earn over the 12 months.

A question may arise in this case whether the similar worker's unemployment for three months was an exceptional or normal part of the employer's business. If, for example, it was normal to lay off employees for three months at the beginning of each year, it would not be appropriate to adjust upward the worker's nine months' earnings. However, the evidence of the employer suggests that a three-month layoff is not normal. He indicates that the worker could have worked the whole year and earned between $36,000 and $39,000.

As a result, I allow the worker's request regarding the application of section 33.3. The worker's long-term average earnings will be set at $37,428.92 per year.

Conclusion

As a result of this review, I vary the Board's decision of March 31, 2003.

Decision of the Review Division

Number: **6807**
Date: **January 12, 2004**
Review Officer: **Kevin Rooney**
Subject: **Revised Premium Rate Notification Constitutes a Decision**

The employer requests a review of the decision of the Workers' Compensation Board (the "Board") dated July 24, 2003. In support of this request for review, the employer's representative has provided a written submission.

Section 96(6) of the *Workers Compensation Act* (the "Act") gives a review officer authority to conduct this review.

Issue

The issue on this review is the Board's decision not to reconsider an earlier decision.

Background

On June 1, 2001, the Board reached a settlement pursuant to a third party action, concerning the claim of a worker of the employer, and recovered $12,000. On November 4, 2002, the Assessment Department credited the employer's experiencing rating ("ER") with a portion of the funds recovered. The employer was notified of the adjustment to its ER on November 7, 2002.

Following a series of correspondence, the Board provided clarification as to the amounts credited to the employer's ER on May 28, 2003. On June 2, 2003 the employer requested the Board credit all funds recovered pursuant to the third party action, to the employer's ER. The Board refused to reconsider the November 2002 decision on the basis that more than 75 days had elapsed since the decision was made.

The employer is seeking to have the matter referred back to the Assessment Department for a decision on the basis the employer was not provided the reasons for the decision until May 28, 2003. In the alternative, the employer is applying to the Review Division for an extension of time to request a review of the original decision and for the Review Division to consider the merits of the decision.

Facts and Evidence

The following are the relevant facts and evidence I have considered in conducting this review:

- In 1997, one of the employer's workers was injured in a compensable workplace accident. On June 12, 2001, the Board recovered $12,000 as a result of a settlement with respect to a third party action in regards to the worker's accident. The manager of Accounting issued a memo on that date setting out how the monies recovered were to be credited.

- On November 4, 2002, the employer's ER was adjusted by the Assessment Department.

- On November 7, 2002, the Assessment Department sent to the employer a Notice of Revised Premiums for 1999. This document advised the employer that its ER for 1999 had been adjusted from a 2.1% discount to a 2.7% discount from the base premium rate. As a result of these changes, the employer's net premium rate decreased from $1.63 per $100 of assessable payroll, to $1.62 per $100 of assessable payroll. The revised premium rate form sent to the employer had "third party settlement" written on it. The form contained the name of the worker and the amount of claims costs, which had been deducted from the employer's ER account.

- On November 20, 2002, the employer's representative wrote to the Board and asked for an explanation.

- On November 29, 2002, the manager, Support advised the employer's representative that the recalculation sent to the employer on November 7, 2002 was due to a third party settlement.

- On April 28, 2003, the employer's representative wrote to the manager, Support asking for a breakdown of the recovery. The breakdown was supplied to the employer's representative on May 28, 2003.

- On June 2, 2003, the employer's representative wrote to the manager, Support seeking to have the full amount recovered pursuant to the third party settlement, credited to the employer's ER.

- On July 24, 2003, the manager, Support wrote to the employer advising she was statute barred from reviewing the underlying decision as more than 75 days had expired. The manager advised the employer's representative that their right of appeal lay to the Workers' Compensation Appeal Tribunal ("WCAT") as the decision had occurred prior to March 3, 2003.

- On September 26, 2003, the director of the Assessment Department wrote to the employer's representative confirming the manager, Support's decision. Attached to the letter was a memo from the manager, Assessment Policy. The manager, Assessment Policy provided the opinion that the Assessment Department was statute barred from reconsidering the November 4, 2002 decision under section 96(5)(a) as more than 75 days had elapsed since that decision was made. He stated that he believed the 75-day time limit ran from the date of the decision and not from the date that the reasons for the decision were provided. In addition, the manager now felt the department was barred from reconsidering the decision because a request for review had been filed.

Employer's Submission

The employer's representative submits that the rate notification document did not contain the rationale for the decision and that it is the rationale the employer is seeking to appeal. Further, the representative submits that the 75-day rule was not in effect at the time of the decision in November 2002. The representative also submits that he originally sought clarification of the notification on November 20, 2002, which was within 75 days of the date of the decision.

Law and Policy

The Act

Section 96(5)(a) sets out that the Board may not reconsider a decision or order if more than 75 days have elapsed since the decision or order was made.

Section 96.2(3) sets out that a request for review must be filed within 90 days after the Board's decision or order was made.

Reasons and Decision

There is no dispute the employer was notified of the changes to its ER, on November 7, 2002, when it was sent the revised Premium Rate Notification. The first question to be decided on this review is whether that document constitutes a decision under the Act. If it was a decision, the second question to be decided is whether the manager, Support was correct in determining that she was statute barred from reconsidering the original decision.

It should be noted that generally the Review Division does not consider refusal to reconsider a decision to be a reviewable decision under the Act. The matter is being reviewed in this case to determine whether an original decision was made.

The purpose of the Revised Premium Rate Notification was to communicate to the employer a Board decision with respect to the exclusion of claims costs, pursuant to section 42 of the Act, from the employer's ER. The information contained in the letter advises the employer there was a third party settlement, and that the settlement had resulted in certain costs for specific years being removed from the calculation of the employer's ER rate.

I agree with the employer's representative that the decision letter does not contain reasons; however, I find there is no requirement under the Act for every decision of the Board to contain reasons. It is possible that a Board decision may be made without an actual decision letter being issued. For instance, a decision could be communicated verbally or by other indirect means such as the issuing of a wage-loss cheque. Consequently, I find that the November 7, 2002 revised premium rate notification for 1999, sent to the employer on November 7, 2002 was the first communication to the employer of a Board decision and as such was a decision of the Board.

Section 96(5)(a) of the Act sets out that the Board may not reconsider a decision or order if more than 75 days has elapsed since the decision or order was made. This section clearly establishes that the time frame for reconsideration starts on the date the decision is made, it does not provide exceptions for a delay in providing reasons. The section also does not allow for the Board to reconsider a decision after 75 days on the basis that the request for reconsideration was made prior to the 75 days having elapsed.

The employer's representative has requested, as an alternative, that the Review Division grant an extension of time for the request for review of the original decision. As the original decision was with respect to an assessment matter and was made before March 3, 2003, it is not within the Review Division's jurisdiction to review that decision.

Based on the above, I deny the employer's request.

Conclusion

As a result of this review, I confirm the Board's decision of July 24, 2003.

Decision of the Review Division

Number: **8856**
Date: **February 25, 2004**
Review Officer: **Sidney G. Dennison**
Subject: **Provision of Vocational Rehabilitation Past Age 65**

The worker requests a review of the decision of the Workers' Compensation Board (the "Board") dated July 25, 2003. In support of this request for review, the worker has provided written submissions. The employer was given notice of the review and is participating. The employer has filed a submission with respect to this review, which has been cross-disclosed to the worker.

Section 96(6) of the *Workers Compensation Act* (the "Act") gives a review officer authority to conduct this review.

Issue

This is a review of the Board's decision to deny the worker vocational rehabilitation services after May 25, 2003.

Background

The worker, an appliance repairperson who is now 66 years old, injured his lower back and both knees on May 30, 2002, while repairing a stacked washer/drier unit for a home appliance repair service. The worker received short-term disability benefits from May 31, 2002 to December 1, 2002, and vocational rehabilitation benefits from December 2, 2002 to May 25, 2003. The worker fractured his left wrist on May 7, 2003. The wrist fracture was accepted under this claim, as the fall that caused the injury was due to the worker's compensable knee condition. Further short-term disability benefits were paid from May 26, 2003 to September 22, 2003. On October 28, 2003, a Board officer wrote to the worker advising that he had been assessed as having a permanent functional impairment equivalent to 12.48% of total disability. The worker began receiving a functional pension in the amount of $345.48 at the end of November 2003.

The worker's vocational rehabilitation benefits were concluded because the worker was unable to convince the Board officer that he had intended to work past the normal retirement age of 65. The worker asserts that it was his intention to work until he was 70 years old, and so continues to seek vocational rehabilitation services.

Facts and Evidence

The following are the relevant facts and evidence I have considered in conducting this review:

- On November 26, 2002, a Board officer wrote to the worker to arrange an interview on December 5, 2002, to begin the process of developing a vocational rehabilitation plan.

- The Initial Vocational Assessment ("IVA") was completed during the interview of December 5, 2002. The IVA notes that the worker held a $93,000.00 mortgage, and had just purchased a new car and a motor home. In documenting the worker's financial situation, the IVA noted that it was the worker's intention to continue working until age 70. The IVA indicates that if a return to the pre-injury employer is not possible, the vocational rehabilitation plan would focus on Phase III.

- On January 13, 2003, the Board officer telephoned the worker to ask if he could have his employer provide a letter verifying the worker's intention to work until he was 70 years old, as the worker said that he and his manager had specifically discussed this issue.

- On January 24, 2003, the worker reported that his manager had declined to provide the requested letter. The worker reported that the manager said such a letter would need to be issued "by personnel." The Board officer then telephoned the manager to explain what the Board required. The manager advised the Board officer that she remembered a casual conversation with the worker about working after age 65, but that the worker had referred to the fact that he had not yet reached the age of 65 and "you never know." The manager interpreted this to mean, "maybe I will and maybe I won't." The manager explained that she was not prepared to write a letter verifying the worker's intention to work to age 70 based on such a casual conversation.

- The Board officer met with the worker on February 4, 2003. The Board officer reviewed the manager's comments, and advised of the need to provide the Board with evidence of his intention to work to age 70.

- On February 17, 2003, Dr. M. wrote to the Board, stating that the worker had consistently and enthusiastically discussed his strong desire to return to work throughout his disability. Dr. M. said he had no doubt regarding the worker's ongoing and current wish to return to some form of employment.

- On February 20, 2003, the worker wrote to the Board officer, asserting that he had told the manager that he wanted to "stay with (his) job after 65" during the course of an employee evaluation. The worker submitted financial documentation regarding his mortgage and car loan, as well as statements from four individuals stating that the worker had told them of his intention to work beyond age 65.

- The documentation submitted by the worker was then considered by three Board officers on March 3, 2003. The Board officers concluded that the evidence offered by the worker was not convincing, noting that the worker had applied for Canada Pension Plan ("CPP") and Old Age Security ("OAS") benefits, had relocated, and had purchased a motor home. The Board officers considered that these actions suggested that the worker had been preparing for retirement. It was agreed that the Board officer would contact Dr. M., and request a

medical opinion as to whether the worker's medical condition would have allowed him to work until 70 years of age, had he not sustained his compensable injuries.

- Also on March 3, 2003, the Board officer contacted the worker who advised that he had applied for his CPP benefits at age 60 because he had been told that if he did not apply "there would likely be no money left in the fund." The worker said his OAS commenced on November 1, 2002, after he turned 65 in October 2002. The worker reiterated that he had never intended to quit working at age 65.

- In a letter dated March 5, 2003, Dr. M. advised the Board that it was his opinion that the worker would have been capable of working past the age of 65.

- A claims log entry for March 6, 2003, documents a telephone conversation between the Board officer and Dr. M., which apparently took place prior to Dr. M.'s drafting of the letter dated March 5, 2003. The Board officer explained the Board's need for evidence of the worker's pre-injury intention to work to age 70. Dr. M. agreed to write a letter confirming that the worker's general medical condition prior to the compensable injury was good, and that the worker would have been able to continue working at his pre-injury employment beyond age 65.

- On May 12, 2003, the Board officer met with the worker. The Board officer advised that the evidence the worker had submitted had been reviewed by the Disability Awards Department, and they too had concluded that the evidence was not sufficient to document the worker's pre-injury intention to work to age 70. The Board officer advised that vocational rehabilitation benefits would be concluded as of May 25, 2003. This decision was then confirmed by way of a letter dated July 25, 2003.

Submissions

The worker submits that he did, in fact, discuss the issue of working past age 65 with his manager, and that this conversation was not "casual." The worker submits that the manager had refused to confirm this conversation in writing, as she was not going to "sign her name to anything that might hold her or (the employer) liable." The worker submits that he has provided all the evidence requested by the Board, but that "nothing was good enough." The worker explained that he applied for early CPP at age 60 because he had been advised to. The worker also explained that when he turned 65 "the OAS was automatic," but that he did not intend to retire. The worker also states that he and his wife relocated because his wife was given an opportunity to become the office business manager for a moving company in the new community. The worker states that, in 2001, he and his wife extended their home mortgage by $30,000.00 in order to cover the cost of a motor home. This, the worker states, substantially increased his mortgage payment. The worker states that, in January 2002, he and his wife purchased a new car, financed over 48 months at $576.00 per month. The worker states that the purchase of the car and the motor home were made on the assumption that he and his wife would continue to enjoy two incomes. The worker states that it was necessary to sell both the motor home and the new car, due to the decrease in his income following his injury.

The employer submits that the Board's decision is correct, and asks the Review Division to uphold the decision.

Law and Policy

The Act

There were changes to the Act as a result of Bill 49 coming into force on June 30, 2002. Since the worker's injury occurred prior to that date, the Act, as it read immediately prior to June 30, 2002 (the "former Act"), applies to any entitlement to vocational rehabilitation services that the worker might have.

Section 16(1) of the former Act gives the Board the authority to provide vocational rehabilitation benefits.

Policy

The policy relating to this review is found in the *Rehabilitation Services and Claims Manual* ("RSCM"), Vol. I:

- Policy item #40.20, *Projected Loss of Earnings Pension*, states that Board considers age 65 years to be the standard retirement age. If the worker was at or above the age of 65 years at the time of injury, the worker's pension will usually be established by the physical impairment method, and that pension is payable for life. A projected loss of earnings pension is not awarded unless clear and objective evidence suggests that the worker would have continued to work past the age of 65 if the injury did not occur.

- Policy item #85.30, *Principles of Vocational Rehabilitation*, establish that the intent of vocational rehabilitation is to return the worker to gainful employment.

- Policy item #85.40, *Service Objectives*, sets out the objectives of vocational rehabilitation. These include assisting in returning workers to their pre-injury employment, or to an occupational category comparable in terms of earning capacity, and providing assistance to overcome the vocational impact of the compensable injury.

- Policy item #87.20, *Operational Process*, sets out the five phases of vocational rehabilitation. Phase II involves a return to a modified job, or other in-service placement, with the same employer. Phase III applies in cases where the employer is unable to accommodate the worker in any capacity. Vocational exploration then progresses to suitable occupational options in the same or in a related industrial sector, capitalizing on the worker's directly transferable skills.

Reasons and Decision

Vocational rehabilitation services are a discretionary benefit provided under the authority of s.16(1), to aid in returning injured workers back to work, and assisting in lessening or removing a resulting handicap. The exercise of this discretion is guided by the published policy of the Board of Directors, the RSCM. Policy items #85.30 and #85.40 reiterate the goal of returning injured workers to employment, while minimizing any loss of income arising from a compensable disability.

The issue of retirement is not expressly addressed in s.16(1). However, the RSCM does provide some guidance in this area. The issue of pension entitlement is not before me. However, in practice, a similar principle to that found in policy item #40.20 applies in that the Board generally considers 65 to be the standard retirement age, not only for pension entitlement, but also in relation to vocational rehabilitation. Thus, the Board does not normally offer vocational rehabilitation services to workers over the age of 65. Nevertheless, vocational rehabilitation services may be offered if there is evidence of the worker's intent to work beyond the standard retirement age. Thus, this review turns on whether there is sufficient evidence to support the worker's assertion that he intended to work past the age of 65.

During their first meeting, on December 5, 2002, the worker advised the Board officer that it was his intention to work until he was 70 years old. I consider this early statement of intent to add weight to the worker's assertion. Both CPP and OAS are benefits for which the worker qualified by virtue of his age, and are not related to the worker's employment status. While forgoing such income may be an indication of intent to continue working, I do not believe that acceptance of such income clearly demonstrates intent to retire. Consequently, I have not afforded great weight to the fact that the worker applied for CPP and OAS benefits. I consider that the fact that the worker financed the purchase of a motor home, and a new car, and then had to sell these vehicles as a result of the reduction in the worker's post-injury income, further indicates an intent to work beyond age 65. Finally, there is the evidence of the worker's physician, who has reported that the worker would have been medically able to work past the age of 65, had it not been for his compensable injury. The physician also reported that the worker had consistently expressed a desire to return to employment, and not to retire. I have concluded that the evidence supports the worker's assertion that he intended to work beyond the age of 65.

The IVA indicated that the intent of the worker's vocational rehabilitation plan was to move to Phase III if the pre-injury employer was unable to accommodate the worker in Phase II. The employer has been unable to accommodate the worker. Thus, any vocational rehabilitation services offered to the worker would now be in accordance with Phase III, as set out in policy item #87.20. In addition to the worker's transferable skills and physical limitations, the worker's vocational rehabilitation plan should give consideration to the fact that the worker is now in receipt of a pension award intended to compensate him for lost income arising from his compensable disability.

I find that the worker is entitled to vocational rehabilitation services in the form of eight weeks of job search allowances, with individualized assistance provided by an external job placement specialist. As a result, I allow the worker's request.

Conclusion

As a result of this review, I vary the Board's decision of July 25, 2003.

Decision of the Review Division

Number: **9803**
Date: **March 30, 2004**
Review Officer: **Jane Otto**
Subject: **Correction of Clerical Error Not Reconsideration**

The worker requests a review of the decision of the Workers' Compensation Board (the "Board") dated September 2, 2003. The worker has not provided a submission beyond the reasons contained in her request for review. The employer was given notice of the review and is participating. The employer filed a submission with respect to this review.

Section 96(6) of the *Workers Compensation Act* (the "Act") gives a review officer authority to conduct this review.

Issue

The issue on this review is the Board's decision that the worker was overpaid $2,686.21 as a result of an administrative error. The Board has also determined that the overpayment caused by its administrative error is recoverable.

Background

The worker is a part-time sales associate who is employed at a retail store. The worker's hours fluctuate each week. The worker's claim was accepted for a back strain that occurred at work on March 31, 2003. The Board officer determined that the worker's wage rate should be based on the worker's earnings for the three-month period immediately prior to her injury. The employer reported that during the three-month period prior to the date of injury, the worker earned $2,346.73 and in the one-year period prior to the date of injury, the worker earned $10,750.98. Due to a clerical error, the worker's wage loss benefits were calculated on the basis of earnings of $10,750.98 over a three-month period. The Board determined that an overpayment of $2,686.21 arose as a result of this clerical error. The worker disputes the amount of the overpayment.

Facts and Evidence

The following are the relevant facts and evidence I have considered in conducting this review:

- The worker's claim was accepted on May 14, 2003, and in a log entry of this date, the Board officer indicated that the worker was considered a regular worker for the purposes of establishing a wage rate. The worker's hours varied each week and the Board officer determined that the worker's wage rate would be based on the worker's earnings in the three-month period prior to her injury.

- An error was made inputting the correct earnings figure. The worker's one year earnings of $10, 750.98 were input as opposed to the worker's three-month earnings of $2,346.73.

- On June 2, 2003, a review of the worker's claim was undertaken and it was noted that the worker's three-month earnings were reported on the Employer's Report of Injury ("F7") as $2,346.73, not $10,750.98. An overpayment of $2,686.21 was calculated.

- On September 17, 2003, the worker indicated that the three-month earnings figure used to recalculate her wage rate was incorrect. The worker believed that she earned in excess of $2,346.73 in the three-month period prior to her injury. The Board officer contacted the employer. On October 8, 2003, the employer confirmed that the worker's three-month earnings as recorded on the F7 were correct. The employer indicated that during the three-month period prior to March 31, 2003, the worker missed eight shifts and was not paid for these shifts.

Law and Policy

The Act

The law that applies to this review is found in section 96 of the Act.

Section 96(4) provides that the Board may, on its own initiative, reconsider a decision that the Board or an officer or employee of the Board has made. The ability to reconsider decisions is limited. Section 96(5) states that the Board may not reconsider a decision if more than 75 days have lapsed since the decision was made. Section 96(7) provides for the Board to set aside a decision if the decision resulted from fraud or misrepresentation of the facts or circumstances upon which the decision was based.

Policy

The policy relating to this review is found in the *Rehabilitation Services and Claim Manual (*"RSCM"), Vol. ll.

- Policy item #48.41, *When does an Overpayment of Compensation Occur?*, confirms that an overpayment includes any money paid by the Board to a payee as a result of an administrative error, fraud or misrepresentation by the worker, or where the decision was not one within the statutory authority of the Board. Administrative errors are distinguished from "decisional errors." Administrative errors are computer, mechanical, mathematical, or an error in implementing a decision on a claim, as well as similar types of errors. A "decisional error" is a decision regarding entitlement, which is modified or reversed by a later decision, and does not result in an overpayment. Decisional errors include errors of policy and can include a situation where new information is received which initiates a judgment change in the original decision. Decisional errors can also include a situation where information was available but was overlooked. Decisional errors that involve actions outside the statutory authority of the Board, or are due to fraud or misrepresentation, are corrected retroactively to the date of the original decision, and result in an overpayment.

Reasons and Decision

Wage loss benefits were paid to the worker at a rate in excess of the worker's normal earnings. The worker was paid at an incorrect wage rate on the basis of a computer error in inputting her earnings. This error is a clerical one, and is administrative in nature, in accordance with policy item #48.41.

The worker submits that the Board incorrectly calculated the overpayment on her claim and maintains that her normal earnings are higher than those recorded by her employer. In this respect, the worker states that prior to her injury on March 31, 2003, she worked 25 hours a week and earned $10.00 per hour. The worker submits that her revised wage rate should be higher than the one used by the Board and submits that the resulting overpayment on her claim should be less. The worker provided a year-to-date statement of her earnings from January 1, 2003 to March 15, 2003. This statement confirmed that the worker's hourly rate of pay is $9.66 and that her year-to-date earnings total $2,337.08. The worker has not provided any evidence of her earnings from March 16 to 30, 2003.

The worker's hourly rate has been confirmed to be $9.66. The employer confirmed that the worker's earnings for the three-month period prior to her date of injury total $2,346.73. The employer indicated that the worker's earnings in this period reflect unpaid time off work.

I accept the employer's evidence. In the absence of confirmation of additional earnings in the three-month period prior to the date of injury under this claim, I conclude that the employer has provided correct information relating to the worker's earnings. The employer provided the worker's earnings on the Employer's Report of Injury and then, at the request of the Board, the employer subsequently confirmed that this amount was correct.

The Board determined that the worker's wage rate should be based on her earnings in the three-month period prior to her injury. The worker's three-month earnings total $2,346.73. The weekly equivalent of this amount is $180.27 net, and the daily amount, based on a seven-day week, is $25.75, net. The worker was paid wage loss benefits on the basis of $572.01 net per week, or $81.71 net per day. The worker received 48 days of benefits at a rate of $81.71 for a total of $3,922.35 when she was entitled to 48 days at $25.75, or $1,236.14. The difference between these amounts is $2,686.21, which is the amount of the overpayment declared.

As a result of the above, I conclude that the Board correctly determined the overpayment on this claim.

The overpayment resulted from a clerical or administrative error and, as such, it is recoverable. I find that the restrictions on the Board's ability to reconsider a decision, as referenced in section 96 of the Act, do not apply in this case. I find that by inputting an incorrect earnings figure, the Board officer did not make a "decision" within the meaning of the Act. The decision of the Board officer was clear; the worker's wage rate was to be based on the worker's three-month earnings. The wrong amount was input. The Board was provided with both the three-month and one-year earnings figures and simply input the wrong figure. This caused the worker to be overpaid. The Board error that caused the overpayment on the worker's claim did not result from a "decision." The decision to use three-month earnings remains unchanged; however, the overpayment arose from an error in inputting the correct earnings figure, or in implementing the decision to use the worker's three-month earnings, as referenced in policy item #48.41.

I find that the Board did not reconsider a decision when it corrected a clerical error with respect to the worker's earnings. In this case, the Board has the authority to correct its clerical error, without attracting the reconsideration requirements of section 96 of the Act.

The definition of "reconsideration" is provided in section 1 of the Act. It states that:

> Reconsideration means to make a new decision in a matter previously decided where the new decision confirms, varies or cancels the previous decision or order.

Bill 63 came into effect on March 3, 2003, and introduced the 75-day time limit for reconsiderations. Practice Directive #59 expanded on the application of the 75-day limit. The directive notes that the date of a "decision" normally refers to the date of the decision letter. The worker was issued a letter dated May 14, 2003 which indicated that the worker's wage rate would be based on her earnings at the time of her injury. The letter goes on to state that, at the time of the worker's injury, her earnings were $3,583.66 per month. The worker's earnings were clearly a mistake and the letter did not reflect the decision of the Board officer.

In terms of correcting its clerical or typographical errors, item B5.2 in the Review Division's *Practices and Procedures* allows for corrections to be made where a clerical or typographical error has been made and the text of the decision did not correctly reflect the officer's intent. Similarly, item 15.21 of the *Manual of Rules, Practices and Procedures* of the Workers' Compensation Appeal Tribunal ("WCAT") provides that a panel may issue an addendum to correct a clerical or typographical error in a decision where the text of the decision did not correctly reflect the intent of the panel. I find that these situations are analogous to one where a Board officer makes such a mistake and I find that it is reasonable to conclude that it is within the officer's authority, in these situations, to correct such an error providing the original decision remains unchanged.

It is my conclusion that the overpayment was correctly calculated and that the Board had the authority to correct the clerical error that caused the overpayment. As a result, I deny the worker's request.

Conclusion

As a result of this review, I confirm the Board's decision of September 2, 2003.

Decision of the Review Division

Number: **10472**
Date: **March 25, 2004**
Review Officer: **Sam Isaacs**
Subject: **Payment of Health Care Benefits**

The worker requests a review of the decision of the Workers' Compensation Board (the "Board") dated October 31, 2003. The worker has not provided any submissions with respect to this review. There is no respondent to this review as the employer is no longer active and the chief review officer has not deemed an employer for the purpose of this review.

Section 96(6) of the *Workers Compensation Act* (the "Act") gives a review officer authority to conduct this review.

Issue

This is a review of the Board's decision to not authorize payment for the use of Handy DART transportation services.

Background

The Board accepted this worker's claim for an injury that occurred on January 7, 1972. The injury has resulted in a permanent partial disability. The worker continues to receive medical attention relating to this injury, including periodic trips to a specialist whose office is located at UBC. In the decision under review, the Board officer advised the worker that he is not eligible for the payment of this transportation expense.

The worker, in his request for review, writes that the Board previously advised him, in November 2001, that transportation expenses would be covered. The worker writes that he is unable to use the local bus service.

Facts and Evidence

The following are the relevant facts and evidence I have considered in conducting this review:

- In a letter dated November 16, 2001 a Board officer reviewed various outstanding requests for reimbursement of expenses. The Board officer wrote that "transportation expenses regarding your visits to your attending physician will be paid under separate cover."

- The worker periodically submitted receipts for the use of Handy DART, when seeing Dr. T. at UBC.

- A log entry dated September 30, 2003 from a Board payment officer noted recent receipts requesting reimbursement. The payment officer requested clarification from the Board officer regarding the worker's entitlement to reimbursement.

- A response dated September 30, 2003 from the Board officer advised that he was unable to identify a reason to cover the transportation costs under the claim. This led to the decision under review.

Law and Policy

The Act

As there has been no recurrence of disability on or after June 30, 2002 related to this review, the law that applies to this review is found under the former Act. Section 21 provides that the Board may furnish or provide the injured worker with various medical aid benefits that might "cure and relieve from the effects of the injury or alleviate those effects." The Board may adopt rules or regulations regarding the payment of such medical aid. Any health care provided under this section must at all times be subject to the direction, supervision, and control of the Board. All questions as to the necessity, character, and sufficiency of this health care must be determined by the Board.

Policy

The policies relating to this review are found in the *Rehabilitation Services and Claims Manual* (the "RSCM"), Vol. I. Policy item #82.10, *Eligibility for Transportation*, provides direction on when the Board will pay costs associated with transportation to a place of medical examination or treatment. Transportation expenses are not normally paid for travel within the boundaries of a local bus service where the bus is a reasonable means of transportation for the worker. Trips within 24 km of the destination are also not eligible for the payment of transportation expenses, unless the worker's condition requires transportation by ambulance, or taxi. In the case of the latter, the worker must receive prior authorization from the Board.

Reasons and Decision

The worker has referenced, in his request for review, a letter from a Board officer dated November 16, 2001, which approved the payment of transportation expenses. I have considered whether this previous decision precluded the Board officer from providing a new and different decision, as explained in the letter of October 31, 2003. Legislative changes that came into effect on March 3, 2003 have significantly restricted the Board's authority to reconsider previous decisions. The legislative changes also confirm that the Board must apply a policy of the Board that is applicable for that case. This applies to the original decision maker as well as to reviews and appeals.

Eligibility for health care benefits under section 21 continues for as long as the worker experiences the effects of the injury. This results in continuing reviews of, and decisions on, a worker's eligibility for reasonably necessary health care benefits and entitlement. The decision as to what types of treatment and expenses might be appropriate will vary from time to time based on the worker's symptoms, circumstances, and medical evidence, as well as the Board's policies.

I do not conclude that the decision of October 31, 2003 represents a reconsideration of the Board's decision of November 16, 2001. The earlier decision reflected a retrospective review of various expenses submitted to the Board, which the Board officer, at that time, approved for payment. I do not read the letter of November 16, 2001 to mean that the Board will pay all future transportation expenses relating to visits to the worker's physician. As a result, I conclude that the decision of October 31, 2003 decides a new matter, based on newly submitted receipts not previously approved by the Board.

The Board officer considered policy item #82.10, and concluded that the worker was not eligible for reimbursement of Handy DART expenses. This policy advises that transportation expenses are not normally paid for travel within the boundaries of a local bus service and where the bus is a reasonable means of transportation for the worker. Handy DART reflects one of a variety of bus services provided in the Greater Vancouver Regional District. These various services have varying degrees of flexibility and accessibility. Handy DART is described by the transportation authority, TransLink, as a "custom transit service using mini-buses and share-ride taxis." The cost for Handy DART services within one or two zones is the same as that for regular bus service.

The worker resides within the boundaries of a local bus service that provides an accessible and reasonable means of transportation. In addition, the worker's journey is less than 24 km and does not require travel by ambulance or pre-authorized taxi.

The Board officer was required to apply an applicable policy of the Board. The Board officer has done so, with reference to policy item #82.10. I find that the Board officer's decision was consistent with this policy. As a result, I deny the worker's request.

Conclusion

As a result of this review, I confirm the Board's decision of October 31, 2003.

Decision of the Workers' Compensation Appeal Tribunal

Number: 2004-00222-RB
Date: January 6, 2004
Panel: J. Brassington
Subject: Inclusion of EI Benefits in Average Earnings

Introduction

The worker sustained a right knee injury on January 20, 1978. His claim was accepted and the injury and subsequent surgery were found to be compensable.

In the February 22, 2001 decision letter from a case manager at the Worker's Compensation Board (Board) the worker was advised that his left knee complaints were not accepted as being related to his right knee injury of 1978. His left knee had a diagnosis of osteoarthritis, which was not accepted under the claim. The case manager found that this condition is one that could affect the general population. The worker was advised that there had been no objective medical evidence supplied to his claim file since March 13, 1998 when he was provided with a decision regarding the non-acceptance of his left knee complaints. The worker appeals the decision on two counts; one on the basis that he believes his left knee problems are directly related to his right knee injury of 1978 and, two, that the medical evidence he submitted was new and objective evidence. This is Appeal B.

In Appeal C the worker is appealing the October 8, 2002 decision letter of a case manager in which he was advised that policy dictated that the case worker was required to use only the worker's earnings from his employment in the previous year to set the long-term wage rate. The case manager stated that when calculating the wage rate, he was not allowed to include the employment insurance benefits the worker had collected during that time period. The case manager noted that even though the industry of working in a golf course was clearly seasonal in nature, since there was no golfing in the region in the wintertime, this had not been recognized by Board policy. The worker appeals on the basis that golf course work in the area is seasonal and therefore his employment insurance benefits should have been included when calculating his average earnings.

Issue(s)

Appeal B

Did the worker submit the new evidence in 2001 that was significant enough to warrant a reconsideration of the March 13, 1998 decision? For example, were there new medical findings or was there a new opinion on previous findings, or did the worker call the Board's attention to critical evidence which had earlier been overlooked?

Appeal C

Was the worker's long-term wage rate correctly set? Is the worker a seasonal worker or a worker in a seasonal occupation; and, if yes, should his employment insurance benefits have been included when the Board calculated his long-term wage rate?

Jurisdiction

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

Under sections 250(1) and (2) of the *Workers Compensation Act* (Act) (effective March 3, 2003) WCAT may consider all questions of fact and law arising in an appeal, but is not bound by legal precedent. It must make its decision on the merits and justice of the case. It must apply policies of the Board's Board of Directors, which apply, to the case, except in exceptional circumstances outlined in section 251 of the Act.

Under section 254 of the Act (effective March 3, 2003), WCAT has exclusive jurisdiction to inquire into, hear, and determine all matters and questions of fact and law arising or required to be determined in an appeal before it. Thus, this appeal is a rehearing.

Background and Evidence

The worker was employed as a heavy duty mechanic when in January of 1978 he stepped in a hole and wrenched his right knee. He had a tear of the medial meniscus and had a medial meniscectomy performed in 1978. Subsequent investigations have revealed osteoarthritis of the medial compartment, which has been accepted under the claim as being secondary to the injuries and surgeries sustained.

The worker subsequently found employment as a small engine mechanic on a local golf course where he primarily works on domestic-sized equipment. He is in receipt of a permanent functional impairment pension for the right leg and knee assessed at 15 percent impairment equalling 7.5 percent total disability.

In 1996 the worker was examined by the disability awards medical advisor who in memo #42 recorded that the worker had moderately severe degenerative changes involving the medial compartment of the right knee, some anterior cruciate ligamentous laxity, some muscle atrophy of the right quadriceps complex with no loss of power of the flexors and extensors of the knees. There was a reduced range of motion in the right knee. On examination the medical advisor noted the worker walked with an antalgic gait, favouring his right leg.

In 1999 a disability awards medical advisor re-examined the worker for pension purposes. He found that the worker had evidence of ongoing active arthritis with acute and chronic synovitis. He noted that objectively there had been a further decrease in the range of movement of the right knee, and the range of movement in the left, non-compensable side had remained essentially the same.

The employability assessment completed in April of 1999 stated that:

> In relation to attempting to locate full-time employment as a golf course maintenance mechanic, this would only be available in the lower mainland (weather) and his physical restrictions would, in my opinion, prevent him from securing such employment in a highly competitive job market.

In memo #50, dated February 25, 1998 the Board medical advisor addressed the issue of the development of pain impairment in the left knee as a result of favouring a joint that had been injured in the past. He indicated that this was difficult to sort out, as there was no scientific support one way or the other. He felt it came down to speculation, along with taking into account all the aspects of each individual case. He noted:

> Certainly, if someone has got a significantly impaired gait or altered walking pattern and relies on the opposite leg for weight bearing then there is a potential for increased wear and tear, thus degeneration.
>
> In this particular case, that detailed information is not available and therefore, one would have to state that it's equivocal that he has developed some of his left knee problems as a result of favouring. It is also possible that he has developed a degenerative tear. This can occur with age, regardless of injury to the other knee. Even considering this factor; however, it still leave his current situation unbalanced in terms of possibilities.

In memo #63, dated June 27, 2000 the case manager noted that Dr. Gouws had conducted a PFI examination on August 16, 1999 and had indicated:

> . . . is experiencing more problems with his left knee because of the extra effort required in trying to save and take the weight off his right knee as much as possible.

The case manager indicated she was not clear whether this was Dr. Gouws' opinion or a statement provided by the worker or his wife and requested the Board medical advisor comment further on this matter.

Memo #64, dated September 12, 2000 outlines the Board medical advisor's response. He noted that Dr. Buchko's report of January 13, 1998 stated:

> [The worker] has a degenerative medial meniscus tear of the left knee. There is a possibility that this has developed through wear and tear over the years because he has been favouring his right knee. However, there is no way to prove or disprove this idea.

The Board medical advisor agreed with Dr. Buchko's comment that there was no way of stating whether the left knee problems would have arisen if the worker had not had a previous right knee surgery. He felt it would not be unreasonable to conclude that the degenerative changes that had occurred in the left knee had probably been accelerated by overuse and favouring of this knee as a result of his injury to the right knee.

The worker eventually had surgery on the left knee. The operative report of November 5, 1998 noted extensive Grade III chondromalacia patella involving the weight-bearing area of the medial femoral condyle. The surgeon noted that the medial meniscus was normal and there was Grade II chondromalacia involving medial tibial plateau. It appeared that there was relatively advanced osteoarthritis of the left knee.

In support of his belief that his left knee problems are the result of the problems with his right knee, the worker has submitted a letter from Dr. O'Brien dated August 13, 2003. Dr. O'Brien stated the worker now has osteoarthritis of the left knee that has been attributed to the over-compensation due to his right knee injury. She stated this could be so and it has been suggested by at least four other specialists that this could be so and she could not disagree.

In August of 2002 the worker's claim was reopened, as he was found to be temporarily totally disabled while awaiting a total right knee replacement. The worker had the total right knee replacement surgery on February 4, 2003.

The September 27, 2002 expedited consultation report completed by Dr. Driedger indicated that he felt that in the absence of a significant event or surgery of that side, that any arthritis in the left knee was aggravated if not directly secondary to the problems with the worker's right knee.

In the September 12, 2002 claim log the case manager noted that the reopening date was August 16, 2002. The log entry indicated that he asked the worker for information substantiating one year's prior earnings. The case manager noted that the reopening would fall under the current provisions and would therefore be subject to the new 90 percent rule. The worker advised the case manager he had been on employment insurance in January and February of that year.

In the September 16, 2002 claim log the case manager indicated that the worker's last day worked was July 12, 2002 and this date would be used as the reopening date. The case manager spoke to the employer's accounting department and was advised that the worker earned $15.00 per hour plus four percent vacation pay. He worked eight hours per day.

In calculating the initial wage rate the case manager determined that the worker was a regular worker and this was a reopening over three years of date of injury. The initial wage rate was calculated using hourly earnings. This wage rate was in effect for ten weeks after which the long-term wage rate was set.

In calculating the long-term wage rate, the case manger determined that this was a recurrence over three years from the date of injury; therefore the wage rate on reopening was based on current earnings. He determined that the worker was a regular worker with employment insurance, and noted the worker's job was actually seasonal in nature. Earnings of $20,312.92

as indicated by the employer, for the previous year, were used to calculate the long-term wage rate. The worker had been in receipt of employment insurance in the amount of $5,360.00 from November 18, 2001 to March 30, 2002. This amount was not considered in the calculation.

At the hearing the worker testified that the problems with his left knee started approximately ten years ago. He stated that due to the problems with his right knee, he used his left knee for everything. Over the years, he stated the more he used his left knee, the worse it became.

The worker testified that for the past 12 years he has worked on a local golf course repairing small equipment. He stated there was no hoist to lift the equipment onto a bench, so he was required to kneel down to do the repairs on the heavier equipment.

At the hearing the worker's representative submitted that in calculating the worker's wage rate, his employment insurance earnings should have been included. He submitted a copy of the worker's T4 slips indicating that from 1997 through to 2001 the worker was laid off by the employer in the fall and rehired in the spring.

The worker's representative noted that the Board's policy directive #35 indicated that employment insurance earnings could be included provided that the worker was employed in a seasonal industry or seasonal occupation and they have been with the employer more than two years. He submitted that the worker had worked for his employer for over ten years and that each year he was laid off in the winter when the golf course closed and was rehired in the spring when the golf course reopened. He indicated that Board policy provided a list of seasonal industries and occupations and that golf courses in the area were not on either list. However, he noted that agricultural workers were on the list. He stated that if you went to the National Occupational Classification put out by Human Resources Development Canada (on which the Board relies to determine work-related duties and classifications), that landscaping and grounds maintenance labourers and managers included workers on golf courses. Accordingly, he submits that the worker is a seasonal worker and as such should have had his employment earnings included in the calculation of his long-term wage rates.

Reasons and Findings

Appeal B

Was the new evidence submitted by the worker significant enough to warrant a reconsideration of the March 13, 1998 decision, i.e., were there new medical findings or was there a new opinion on previous findings, or did the worker call the Board's attention to critical evidence which had earlier been overlooked?

Section 96 of the Act allows the Board to reconsider an earlier decision, in this case, their decision being March 13, 1998.

Relevant Board policy in affect at the time of the February 22, 2001 decision was rendered as outlined in #108.11 of the RSCM (Volume I). It provided for two grounds for which a reconsideration could be undertaken, being significant new evidence or a mistake of evidence or law. In this case, the Board case manager concluded that there was no new medical evidence of a significant nature to change the decision.

The Board officer determined that the worker's left knee complaints were not related to his right knee injury of 1978. She stated that there had been no new objective medical evidence supplied to his claim file since March 13, 1998.

In reviewing the medical evidence supplied by the various physicians since 1998, I disagree with the Board officer. Dr. Gouws in the August 16, 1999 PFI examination indicated that the worker was experiencing more problems with his left knee because of the extra effort required in trying to save and take the weight off his right knee as much as possible. Dr. Buchko in his report of January 13, 1998 indicated that the worker had a degenerative medial meniscus tear of the left knee. He opined that there was a possibility that this had developed through wear and tear over the years because he was favouring his right knee. He noted there was no way to prove or disprove this idea. The Board medical advisor agreed and went on to state that he felt it would not be unreasonable to conclude that the degenerative changes that had occurred in the left knee had probably been accelerated by overuse and favouring of this knee as a result of the injury to the right knee.

In a paper published by the Ontario Workers' Compensation system titled, "Symptoms in the opposite or uninjured leg," Dr. W. Robert Harris, orthopaedic surgeon with supplemental information provided by Dr. Ian J. Harrington, orthopaedic surgeon indicated that to make a decision as to whether limping is or was affecting the normal leg, one needs to know:

a) Whether limping was or is present.

b) Was the limp mild or severe? A mild limp probably does not have a significant affect on the opposite leg.

c) What was the duration of the limp? If it was a few months, say up to a year, it probably did not significantly affect the opposite leg.

d) What sort of limp was it? A prolonged antalgic gait is more likely to affect the opposite leg than a paralytic limp. A short leg limp probably does not affect the opposite leg.

Dr. Harris stated that the easiest way to picture an antalgic gait is to imagine a stone in your shoe or a nail sticking through its sole. It hurts when you take weight on that foot and you lessen the discomfort by getting off it as quickly as you can. In other words, you shorten the duration of the stance phase on this side. This also produces a characteristic gait with uneven strides of different duration.

In reviewing all the medical information, I have determined that the worker's limping has and is affecting the other (left) leg. In the worker's situation, there is clear documentation that he does walk with a limp. The documentation goes back to 1996. In memo #42 the medical advisor described the worker's limp as an antalgic gait. Several of the specialists have indicated that it is possible that the worker's left knee problems could be a result of his right knee problems. The evidence is compelling and leads to the conclusion that the worker's left knee complaints are related to his right knee injury of 1978.

I allow the worker's appeal.

Appeal C

Was the worker's long-term wage rate correctly set? Was he a seasonal worker or a worker in a seasonal occupation and, if yes, should his employment insurance benefits have been included when the Board calculated his long-term wage rate?

As the worker's claim was reopened effective July 15, 2002, *Rehabilitation Services and Claims Manual, Volume II* (RSCM) is in effect and has therefore been referred to in determining this appeal.

#37.30 Reopening Claims (RSCM)

Where a claim involving a permanent total disability is reopened, no payments of wage loss can be made. Wage loss may, however, be payable where a worker receiving a permanent total disability award of less than the current maximum suffers a new injury at work. The amount payable would be the difference between the periodic payment being paid on the old claim and 90 percent of the long-term average net earnings on the new claim, limited by the current maximum.

Item #68.40 Employment Insurance Payments (RSCM)

Section 33(3.2) of the Act provides:

> The Board may include, in determining the amount of average earnings of a worker, income from employment benefits payable to the worker under the *Employment Insurance Act* (Canada) during the period for which average earnings are determined only if, in the Board's opinion, the worker's employment during that period was in an occupation or industry that results in recurring seasonal or recurring temporary interruptions of employment.

This is a discretionary provision and will be applied only where there is verified evidence from an independent source that the worker received employment insurance benefits due to the worker's employment in an occupation or industry that results in recurring seasonal or temporary interruptions of employment.

The Board may collect the necessary data to compile a list of industries and occupations that result in recurring seasonal or temporary interruptions of employment. The list must give regard to regional considerations and may adopt information from sources such as British Columbia Statistics, Statistics Canada, or Human Resources Development Canada.

In determining the long-term wage rate the case manager indicated that even though the industry of working in a golf course was clearly seasonal in nature, since there was no golfing in the winter in the area, this had not been recognized in Board policy. He quoted Practice Directive #35 and indicated that in order to determine whether an industry or occupation is seasonal, the policy provided lists of applicable industries and occupations that resulted in recurring seasonal interruptions of employment. In reviewing the lists, the case manager noted that neither golf courses nor mechanic work were included in either of the lists. Neither the industry nor the occupation were on the list, the Employment Insurance benefits could not be considered in determining the long-term wage rate.

The case manager explains that he consulted with the "policy group" and that it was explained to him that if the industry or occupation was not on the list of seasonal occupations listed by the Board, employment insurance benefits could not be added in the calculation of the worker's average earnings.

I find that the case manager was in error in describing the practice directive as part of Board policy. The establishment of lists of industries and occupations that result in recurring seasonal or temporary interruptions of employment is authorized by the policy, but the practice directive itself is not part of the policy. Item #2.20 of the RSCM concerns the application of the Act and policies, and concludes by noting:

> This policy item is not intended to comment on the application of practice directives, guidelines and other documents issued under the authority of the President/Chief Executive Officer of the Board. The application of those documents is a matter for the President/CEO to address.

Practice directives do not constitute policy — policy can only be provided by the Board of Directors under section 82 of the Act (see also #96.10 of the RSCM).

Policy must be applied by WCAT, as set out in section 250(2) of the Act. As stated in section 251(1), WCAT may refuse to apply a policy of the Board of Directors only if the policy is so patently unreasonable that it is not capable of being supported by the Act and its regulations. However, if the policy is ambiguous or unclear, it becomes necessary to interpret the policy under the Act.

The second paragraph of #68.40 indicates that section 33(3.2) is a discretionary provision. It states, as a mandatory requirement, that there be verified evidence from an independent source that the worker received employment insurance benefits due to the worker's employment in an occupation or industry that results in recurring seasonal or temporary interruptions of employment.

The third paragraph of #68.40 authorizes the Board to collect data to compile lists of industries and occupations that result in recurring seasonal or temporary interruptions of employment.

I attach no particular significance to the phrases in section 33(3.2) concerning "The Board may include" and "in the Board's opinion." These are points within the exclusive jurisdiction of the Board as set out in section 96(1) of the Act. However, the Act must be read as a whole. The Act has also created WCAT as an appeal body to hear appeals from such determinations. Section 254 similarly provides WCAT with exclusive jurisdiction to inquire into, hear, and determine all those matters and questions of fact and law arising or required to be determined under part 4. I do not read section 33(3.2) as giving the Board an authority which is insulated from scrutiny by way of appeal (in connection with WCAT's substitutional jurisdiction).

There is an ambiguity, in respect of the relationship between the second and third paragraphs of #68.40. One interpretation might be that the second paragraph concerns the discretionary authority of section 33(3.2) and the manner in which it is to be exercised. On this interpretation, the compilation of lists under the third paragraph may be viewed simply as a guide which would facilitate the exercise of this discretion. In other words, inclusion of an occupation or

industry on a list of industries or occupations subject to seasonal or temporary interruptions would facilitate, but not be a pre-requisite to, the exercise of discretion under the second paragraph.

An alternative interpretation is that a listing under the third paragraph is a pre-requisite to the exercise of discretion under the second paragraph. The difficulty with this interpretation is that the literal wording of the policy does not support such an interpretation. There is nothing in the actual wording of the policy to impose such a restriction. In fact, the Board has chosen to only create a listing of seasonal occupations, and has left industries or occupations that result in temporary interruptions of employment to be addressed on a case-by-case basis.

In my opinion, the exercise of the statutory discretion provided by section 33(3.2) should not be read as being so limited (i.e. as making listing of a seasonal occupation a prerequisite to consideration under section 33(3.2)), in the absence of clear wording in the policy to such an effect. In the absence of such clear wording, it is not necessary to address the issue as to whether such an interpretation would constitute an unlawful fettering of discretion.

Both the Act and policy authorize the inclusion of employment insurance benefits if the worker's employment was in an occupation or industry that results in "recurring seasonal **or recurring temporary** interruptions of employment" [emphasis added]. However, the Board has only created lists of "seasonal industries" and "seasonal occupations." Practice Directive #35 specifies:

> 2. A Board officer will determine on a case by case basis if a worker's employment is in an industry that results in recurring temporary interruptions of employment. (see "c" under "Eligibility".) Recurring temporary interruptions in employment show a repeating pattern but are not seasonal in nature. For example, workers employed in the field of education who are laid off and receive EI benefits on a regular annual basis.

It is evident from the different treatment of seasonal and temporary interruptions, with the creation of a list for the former and case-by-case consideration for the latter, that there is nothing in the wording of #68.40 which would require only one approach.

There is nothing in the literal wording of either the policy at #68.40, or Practice Directive #35, to indicate that a "listing" is a pre-requisite to consideration of a seasonal occupation or industry. Practice Directive #35 simply states:

> 1. With respect to determining whether an industry or occupation is seasonal (see "a" and "b" under "Eligibility"), policy provides for lists of applicable industries and occupations that result in recurring seasonal interruptions of employment. These lists will be available on BoardNET on the Policy and Practice homepage and will be amended periodically by the Board's Statistical Services Department.

There may be factual circumstances which clearly fit the intent of section 33(3.2), but which do not involve sufficient numbers of workers to have come to the attention of the Board for consideration of listing. The imperative of section 99 and section 250(2), that the Board and WCAT make decisions based on the merits and justice of the case, would seem to require consideration of such situations.

In my opinion, I am open to exercise the discretion contained in section 33(3.2) of the Act, and I am satisfied that there is "verified evidence from an independent source that the worker received employment insurance benefits due to the worker's employment in an occupation or industry that results in recurring seasonal interruptions of employment." Accordingly, I find that the worker's employment insurance benefits should have been included in the calculation of his average earnings.

Alternatively, if the approach that a "listing" is required for an industry or occupation to be considered seasonal, then Practice Directive #35 leaves open for consideration on a case-by-case basis whether there were recurring temporary interruptions in employment to support the inclusion of employment insurance benefits in the calculation of the worker's average earnings. In the alternative I find that there were recurring temporary interruptions in the worker's employment that support the inclusion of employment insurance benefits in the calculation of the worker's average earnings.

Conclusion

Appeal B is granted. I vary the February 22, 2001 decision letter and find that there was new significant medical information that, when read with the prior medical information on file, leads to the conclusion that the worker's left knee complaints are related to his right knee injury of 1978 and therefore compensable.

Appeal C is granted. I vary the October 8, 2002 decision of an officer of the Board and I find that the worker's employment insurance benefits should have been included in the calculation of his average earnings and return the file to the Board to implement this finding.

No costs were requested and none are awarded.

Decision of the Workers' Compensation Appeal Tribunal

Number: 2004-00638
Date: February 5, 2004
Panel: J. Callan, M. Gelfand, H. Morton
Subject: Refusal to Review — Reconsideration After 75 Days Denied

---

Introduction

The employer appeals the May 1, 2003 Review Division decision (Request for Review Reference #1249), to reject the employer's request for review. This concerned the March 18, 2003 letter from a case manager, which enclosed a copy of a decision letter dated August 28, 2000. The August 28, 2000 decision denied relief of claim costs under section 39(1)(e) of the *Workers Compensation Act* (Act).

The employer is represented by a consultant. References in this decision to the employer primarily refer to the submissions provided by the employer's representative. The initial decision letter of August 28, 2000 was sent directly to the employer, but subsequent correspondence was with the consultant representing the employer. The worker was notified of this appeal but is not participating.

Issue(s)

Did the review officer err in rejecting the employer's request for review? Does a refusal to provide a decision on an assessment matter constitute a reviewable decision? Did the case manager's letter, which enclosed a copy of a prior decision to deny relief of costs, constitute a reviewable decision?

Jurisdiction

Section 96.2 of the Act provides:

> 96.2 (1) Subject to subsection (2), a person referred to in section 96.3 may request a review officer to review the following in a specific case:
>
> (a) a Board decision respecting a compensation or rehabilitation matter under Part 1;
>
> (b) a Board decision under Part 1 respecting an assessment or classification matter, a monetary penalty or a payment under section 47 (2), 54 (8) or 73 (1) by an employer to the Board of compensation paid to a worker;

> (c) a Board order, a refusal to make a Board order, a variation of a Board order or a cancellation of a Board order respecting an occupational health or safety matter under Part 3.

Section 239(1) of the Act provides:

> Subject to subsection (2), a final decision made by a review officer in a review under section 96.2, including a decision declining to conduct a review under that section, may be appealed to the appeal tribunal.

Section 239(2) lists several categories of decisions which are not appealable to WCAT, which do not apply to this appeal.

Background and Evidence

The worker was employed as a nursing assistant at a hospital. On May 28, 2000, she hurt her right arm and shoulder while assisting a patient.

In a claim log entry dated August 28, 2000, the case manager noted:

> This claim is due for review with respect to relief of costs. At this time, there is no evidence to suggest that the claimant's recovery is being delayed or prolonged because of a pre-existing disability, disease or condition. Therefore, relief of costs will not be applied. A letter will be sent to the employer advising of my decision.

By decision letter dated August 28, 2000, the case manager advised the employer that relief of claim costs under section 39(1)(e) of the Act would not be granted. The decision letter stated in part:

> After reviewing the information on file, it is my decision that there is insufficient evidence to support the conclusion that the worker had a pre-existing disease, condition or disability.

The August 28, 2000 decision advised the employer that the decision could be appealed to the Appeal Division within 30 days. The employer did not appeal the August 28, 2000 decision.

Wage loss benefits were paid for 569 days (from May 30, 2000 until January 12, 2001, and from April 11, 2001 until March 17, 2002, with two graduated returns to work). The employer advises that an MRI on May 2, 2001 identified a pre-existing shoulder condition with propensity to enhance the disability (type II acromion). The employer further advises that on June 7, 2001 the worker underwent surgery where "significant bone spur formation" was noted.

By letter dated February 26, 2003, the consultant representing the employer wrote to the claims adjudicator, enclosing a direction of authorization from the employer. The consultant stated:

> From our records, it is unclear whether decisions pertaining to the application of Sections 39 and 42 of the WCB Act have been established on this claim.

> In this regard please advise whether the cost relief provisions of either Section 39(1)(e) or Section 42 may be applicable. If a decision was made at the 13-week point on the claim, please consider the issue with regard to medical evidence received since that time.

In a letter of reply dated March 18, 2003, the case manager advised (reproduced in full):

> Thank you for your letter dated February 26, 2003 requesting relief of costs under this claim.
>
> Enclosed for your convenience, is a copy of our decision letter dated August 28, 2000, concerning our review of this claim with respect to a relief of costs.
>
> As you can see from the enclosed, relief of costs was not applied as there is no evidence of any pre-existing disease condition, or disability which might have enhanced this injury or prolonged the period of this worker's disability under this claim.
>
> [reproduced as written]

On March 26, 2003, the employer submitted a request for review. By decision dated May 1, 2003, the review officer rejected the request for review. He explained:

> Section 96.2(1)(a) and (b) . . . state that a person may request a review of a "Board decision" respecting a compensation or assessment matter. No decision is made for the purpose of this section where a Board officer simply communicates a previously rendered decision. If you believe the Board has made a new decision, please explain why.

The review officer advised that the rejection of the request for review was appealable to WCAT. He further advised that the employer could apply to WCAT for an extension of time to appeal the August 28, 2000 decision to WCAT.

On May 7, 2003, the employer appealed the Review Division decision of May 1, 2003 to WCAT. By letter of July 2, 2003, the employer argued:

> The refusal to conduct a review is wrong because an employer has the right to question the costs utilized in their experience rating and to ask the Board if there are any circumstances under Section 42 (Policy #115.30) where such costs may be relieved. To refuse to provide a reply to that inquiry is contrary to the Board's inquiry mandate and demonstrates blatant disregard for client service.

A submission dated November 20, 2003 has been provided by the employer. The employer argues that the August 28, 2000 decision was of a conditional nature. He points to the August 28, 2000 log entry, which contained the phrase "At this time. . . ." He submits that the conditional nature of the August 28, 2000 decision, and "the natural justice requirement to adjudicate all salient evidence" required a new decision in connection with claim costs subsequent to the August 28, 2000 decision. He submits that the March 18, 2003 letter from the case manager constituted a new decision. In particular, he points to the use of the present tense in the March 18, 2003 letter, which stated:

> . . . relief of costs was not applied as there **is** no evidence of any pre-existing disease condition, or disability which might have enhanced this injury or prolonged the period of this worker's disability under this claim.
>
> [emphasis added by employer]

He argues that the use of the present tense in the word "is" demonstrates that the case manager had made a new decision. The employer concludes by requesting that if WCAT finds that the March 18, 2003 letter is indeed a decision, WCAT direct the Review Division to commence a review concerning the merits of applying section 39(1)(e) with respect to the obvious pre-existing condition in this case.

Law and Policy

On March 3, 2003, the Act was amended by the *Workers Compensation Amendment Act (No. 2), 2002* (Bill 63). Section 96(4) and (5) of the amended Act now provide:

> (4) Despite subsection (1), the Board may, on its own initiative, reconsider a decision or order that the Board or an officer or employee of the Board has made under this Part.
>
> (5) Despite subsection (4), the Board may not reconsider a decision or order if
>
> (a) more than 75 days have elapsed since that decision or order was made,
>
> (b) a review has been requested in respect of that decision or order under section 96.2, or
>
> (c) an appeal has been filed in respect of that decision or order under section 240.

Accordingly, there is a 75-day time limit on the Board's reconsideration authority (subject to the prior termination of this authority based on the filing of a request for review or appeal).

Section 1 of the Act defines the word "reconsider" as follows:

> **"reconsider"** means to make a new decision in a matter previously decided where the new decision confirms, varies or cancels the previous decision or order;

Item C14-103.01 of the policy in the *Rehabilitation Services and Claims Manual*, *Volume I*, is entitled *Changing Previous Decisions – Reconsiderations*. This policy provides:

> **(a) Definition of reconsideration**
>
> A reconsideration occurs when the Board considers the matters addressed in a previous decision anew to determine whether the conclusions reached were valid. Where the reconsideration results in the previous decision being varied or cancelled, it constitutes a redetermination of those matters.

(b) The purpose of sections 96(4) and (5)

The Board's authority to reconsider previous decisions and orders is found in section 96(4) and (5) of the *Act*. These provisions result from legislative amendments that came into effect on March 3, 2003. The purpose of these amendments is to promote finality and certainty within the workers' compensation system.

The same amendments establish a right to request a review by a review officer under sections 96.2 to 96.5, where a party disagrees with a decision or order made at the initial decision-making level. It is this review, rather than the application of the Board's reconsideration authority, which is intended to be the dispute resolution mechanism for initial decisions and orders of Board officers.

It is significant that section 96(4) only authorizes the Board to reconsider a decision or order "on its own initiative". This is to be contrasted with the Board's authority to reopen a matter "on its own initiative, or on application" under section 96(2). It is also to be contrasted with section 96.5 and section 256, which authorize a review officer and the appeal tribunal, respectively, to reconsider decisions on application in certain circumstances.

The use of the words "on own initiative" in section 96(4), with no provision for "on application", and the availability of a review mechanism under sections 96.2 to 96.5, indicate that the Board is not intended to set up a formal application for reconsideration process to resolve disputes that parties may have with decisions or orders.

Rather, the Board's reconsideration authority is intended to provide a quality assurance mechanism for the Board. The Board is given a time-limited opportunity to correct, on its own initiative, any errors it may have made.

Analysis

(a) What was the effect of the August 28, 2000 decision to deny relief of costs?

A preliminary issue arises as to whether the August 28, 2000 decision by the case manager to deny relief of claim costs was of a conditional nature, which was intended to be "time-limited" in its application. Was it limited to the issue as to whether, in terms of the claim costs to the date of the decision, the worker's disability had been prolonged or enhanced by reason of a pre-existing disease, condition, or disability? Such a decision would leave open for future consideration the question as to whether further periods of disability involved prolongation or enhancement on the basis of a pre-existing disease, condition, or disability.

Alternatively, did the August 28, 2000 decision provide a categorical denial as to the existence of any pre-existing disease, condition, or disability? If so, there would be no basis for a later new decision under section 39(1)(e). If there were no pre-existing disease, condition, or disability, the occurrence of further periods of disability would not give rise to a need for further consideration as to whether there had been a prolongation or enhancement by reason

of a pre-existing disease, condition or disability. Any further consideration under this section would necessarily involve a reconsideration of the earlier decision, which would be subject to the 75-day time limit on the Board's reconsideration authority.

The wording in the August 28, 2000 claim log entry is suggestive of the former approach, while the wording of the decision letter supports the latter interpretation. Given the conflicting interpretations possible from these documents, we consider it appropriate to view the determination actually provided to the employer in the formal decision letter as constituting the decision. The August 28, 2000 decision letter contained a categorical denial as to the presence of any pre-existing disease, condition or disability. Effective March 3, 2003, the Board's reconsideration authority became subject to a 75-day limit pursuant to section 96(4) and (5).

(b) Was the March 18, 2003 letter a further decision to deny relief of costs?

The employer has presented arguments as to why the March 18, 2003 letter from the case manager should be viewed as a new decision. We find, however, that the March 18, 2003 letter was an informational letter provided in response to the employer's inquiry, to show that the issue had previously been addressed. We are not persuaded that any significance attaches to the use of both the past and present tenses in the third (and final) sentence of that letter. The first sentence of the letter thanked the employer for the inquiry, the second sentence referred to the enclosed August 28, 2000 decision letter, and the third sentence noted: "As you can see from the enclosed. . . ." We read this letter as simply drawing attention to the prior decision, on an informational basis.

(c) Does the employer have a right to reconsideration based on new evidence?

The employer argues that natural justice creates a right to consideration of new evidence. The basis for this argument is not clear. In some general sense, there may be a perception of unfairness or injustice if there is no mechanism for consideration of new evidence. However, this is not a right accorded under the principles of natural justice. The Board previously had a broad discretion under the former section 96(2) of the Act, to "at any time at its discretion reopen, rehear and redetermine any matter, except a decision of the appeal division, which has been dealt with by it or by an officer of the board." However, this was based on the statute, rather than any common law authority. Even if there were common law authority to support a general right to reconsideration, such a common law right would be superseded by a specific statutory provision. The statutory limits on the Board's reconsideration authority under section 96(4) and (5) must prevail.

Apart from the primary avenues of review and appeal, additional avenues for seeking consideration of new evidence (i.e. which concern a previously determined matter) consist of the Board's reopening authority under section 96(2), the authority of the chief review officer to grant an extension of time to request review by the Review Division, the authority of the WCAT chair to grant an extension of time to appeal to WCAT, and the authority to reconsider Review Division or WCAT decisions on the basis of new evidence under section 96.5(1) or section 256 of the Act.

The Act and policy are clear with respect to the limits on the Board's reconsideration authority. One of the grounds for reconsideration, within 75 days, is that new evidence has been provided. The provision of new evidence does not by itself raise a new issue for adjudication, so as to give the Board authority to further address the matter as a new issue.

A request for reconsideration on the basis of new evidence cannot be made simply on the basis that natural justice requires it. The decision-maker must have jurisdiction under the Act to embark on such reconsideration, whether expressly set out in the Act or under common law principles. We are not persuaded that the Board had authority to accede to the employer's request for further consideration of relief of costs.

We further note that section 96(4) of the Act makes no provision for the Board to reconsider "on application." The Board's reconsideration authority is to be exercised on the Board's own initiative. As noted in policy, this situation may be contrasted with the wording of sections 96(2), 96.5(1)(b) and 256, which all provide for the making of decisions on application. As section 96(4) does not contemplate decisions being provided on application, we find that the Board had no obligation to furnish a decision concerning the employer's request for reconsideration. This further reinforces our view that the communication from the Board was strictly informational, considering the fact that the Board was not exercising its authority to reconsider within 75 days (as that time had long expired). The absence from section 96(4) of the phrase "or on application" seems to signify a legislative choice to limit the opportunities for review and appeal of a failure or refusal to embark on such reconsideration.

In the March 11, 2002 *Core Services Review of the Workers' Compensation Board* (accessible at: http://www.labour.gov.bc.ca/wcbreform/WinterReport-Complete.pdf), the core reviewer commented, at page 102:

> Accordingly, it is my recommendation that a party aggrieved by a decision rendered by an initial decision-maker should have the opportunity to request the WCB to reconsider the matter. **Whether or not the WCB agrees to conduct such a reconsideration should be left within the discretion of the WCB.**
>
> [emphasis added]

The inference from the wording of section 96(4), that the Board's refusal to embark on a reconsideration under this provision would not be reviewable or appealable, is consistent with the recommendation this authority be left within the Board's discretion. We would distinguish this situation from one where the Board in fact exercises its authority to act on its own initiative and provides a new decision on the merits (for example, in considering whether to reopen a claim under section 96(2) of the Act).

We find that the March 18, 2003 letter was simply an information letter, and that a copy of the August 28, 2000 decision was provided as a courtesy to the employer. No new decision was provided. Nor was it within the Board's authority to revisit the merits of the August 28, 2000 decision. Given the absence of any new decision contained in the March 18, 2003 letter, we are in agreement with the May 1, 2003 decision by the review officer declining to conduct a review.

(d) Request for Relief of Costs for Experience Rating Purposes under Section 42 and #115.30 — Absence of Specific Decisional Response

By letter of July 2, 2003, the employer submits they had the right to ask the Board if there were any circumstances under section 42 (policy #115.30) where relief of costs might be granted for experience rating purposes. The employer argues that a refusal to provide a reply is contrary to the Board's inquiry mandate and demonstrates blatant disregard for the employer.

WCAT has jurisdiction to hear an appeal from a "final decision made by a review officer in a review under section 96.2, including a decision declining to conduct a review under that section." This requires consideration of section 96.2(b), which provides that an employer may request a review officer to review the following in a specific case: "a Board decision under Part 1 respecting an assessment or classification matter."

Section 96.2(a) and (b) do not expressly grant a right to request review of a failure or refusal by the Board to make a decision concerning a compensation, rehabilitation, or assessment matter (or the other matters covered in (b)). This may be contrasted with section 96.2(c), which creates a right of review for:

> a Board order, **a refusal to make a Board order**, a variation of a Board order or a cancellation of a Board order respecting an occupational health or safety matter under Part 3.
>
> [emphasis added]

Other provisions in the Act creating a right of review or appeal with respect to a refusal to make an order, or to decline to conduct a review, include the following:

Section 239(1)

> Subject to subsection (2), a final decision made by a review officer in a review under section 96.2, including a decision declining to conduct a review under that section, may be appealed to the appeal tribunal.

Section 240(1)

> A determination, an order, a refusal to make an order or a cancellation of an order made under section 153 may be appealed to the appeal tribunal.

A contrary inference might be drawn from section 96.2(2), which enumerates matters for which no review may be requested. This includes matters for which a direct right of appeal to WCAT is provided (including under (b) "a determination, an order, a refusal to make an order or a cancellation of an order under section 153"). There is no provision expressly limiting the Review Division's authority to review the Board's failure to make a decision on a compensation, rehabilitation, or assessment matter.

However, having regard to both the express reference in section 96.2(c), which creates a right of review for a refusal to make a Board order respecting an occupational health or safety matter under Part 3 of the Act, and the other provisions (section 239(1) and section 240(1) of

the Act) creating a right of appeal to WCAT from a refusal to make an order under section 153 or a decision to decline to conduct a review, we find the absence of comparable language in section 96.2(a) and (b) significant.

One of the maxims of statutory interpretation is *expressio unius est exclusio alterius* (to express one thing is to exclude another). In *Sullivan and Driedger on the Construction of Statutes*, 4th ed. by R. Sullivan (Ontario: Butterworths, 2002), the author comments at pages 186−187):

> An implied exclusion argument lies whenever there is reason to believe that if the legislature had meant to include a particular thing within its legislation, it would have referred to that thing expressly. Because of this expectation, the legislature's failure to mention the thing becomes grounds for inferring that it was deliberately excluded. Although there is no express exclusion, exclusion is implied. The force of the implication depends on the strength and legitimacy of the expectation of express reference. The better the reason for anticipating express reference to a thing, the more telling the silence of the legislature.

Two common ways in which an expectation of express reference may arise involve a failure to mention comparable items, and a failure to follow an established pattern. With respect to the first, Professor Sullivan notes (at page 187):

> When a provision specifically mentions one or more items but is silent with respect to other items that are comparable, it is presumed that the silence is deliberate and reflects an intention to exclude the items that are not mentioned.

With respect to the second, Professor Sullivan explains (at page 189):

> . . . consistent expression is a basic convention of legislative drafting. As much as possible, drafters strive for uniform and consistent expression, so that once a pattern of words has been devised to express a particular purpose or meaning, it is presumed that the pattern is used for this purpose or meaning each time the occasion arises. This convention naturally creates expectations that may form the basis for an implied exclusion argument.

This maxim of statutory interpretation is one which must be applied with caution, as it may be rebutted or outweighed by other indicators of legislative intent.

To summarize, the legislature has granted express rights of review or appeal with respect to the following situations:

- a refusal to make a Board order respecting an occupational health or safety matter under Part 3;

- a refusal to make an order under section 153; and,

- a Review Division decision declining to conduct a review under section 96.2.

The legislature has provided a right of review concerning "a Board decision," "in a specific case," "respecting an assessment or classification matter." All three elements must be present. By logical inference, as set out above, the legislature did not intend to provide a right of review by the Review Division under section 96.2(b), with respect to the Board's failure to make a decision concerning an assessment matter. The practical impact of these provisions is to allow the Board discretion in assigning resources to various tasks and determining when and if decision letters are required.

We are not satisfied that the March 18, 2003 letter constituted a new "Board decision under Part 1 respecting an assessment or classification matter." Nor do we consider that the failure to provide a decision constitutes a reviewable decision under section 96.2(b) of the Act. Accordingly, we find no error in the May 1, 2003 decision by the review officer. The employer's appeal is denied.

Conclusion

The May 1, 2003 decision by the review officer, which declined to conduct a review of the March 18, 2003 letter (furnishing a copy of a prior decision to deny relief of claim costs under section 39(1)(e)), is confirmed.

Decision of the Workers' Compensation Appeal Tribunal

Number: 2004-01441-RB
Date: March 23, 2004
Panel: Cecil S. Memory, Vice Chair
Subject: Failure to Appear at Oral Hearing — Abandonment of Appeal

---

Introduction

The worker filed the above-noted appeal on October 23, 2002.

In a notice of hearing dated December 22, 2003 the Workers' Compensation Appeal Tribunal (WCAT) advised the worker that an oral hearing respecting the appeal would commence on Tuesday, February 17, 2004 at 9 a.m.

On the day and at the time set down for the hearing the worker did not appear.

By letter dated February 18, 2004 the registrar's office of WCAT invited the worker to provide reasons for his failure to attend the hearing.

The worker responded in a faxed letter dated February 17, 2004.

Issue(s)

Section 246 of the *Workers Compensation Act* (Act) states as follows:

> (1) Subject to any rules, practices or procedures established by the chair, the appeal tribunal may conduct an appeal in the manner it considers necessary, including conducting hearings in writing or orally . . .
>
> (5) If, in an appeal, a party fails to comply with the procedures of the appeal tribunal including any time limits specified for taking any actions, the tribunal may, after giving notice to that party,
>
> (a) continue with the proceedings and make a decision based upon the evidence before it, or
> (b) determine that the appeal has been abandoned.

The chair of WCAT approved a *Manual of Rules, Practices and Procedures* (MRPP) effective as of March 3, 2003, pursuant to her authority under section 234(2) of the Act. Item #9.23 of the MRPP sets out rules, practices, and procedures respecting the late appearance or failure of an appellant to appear for a hearing. It states as follows regarding the failure of the appellant to appear:

> The registrar's office will invite the appellant, within 14 days, to provide reasons for the failure to attend the hearing. The panel will then decide whether to [s.246(5)]:
>
> (a) reschedule the oral hearing;
> (b) continue the proceedings and make a decision based upon the written evidence before it;
> (c) determine that the appeal is deemed to have been abandoned.
>
> A failure to appear at an oral hearing without prior notice, would normally only be justified by a personal emergency and re-scheduling of a hearing may be considered in those circumstances.

The issue for determination is whether the oral hearing will be rescheduled, or whether the panel will continue the proceedings and make decisions based upon the written evidence before the panel, or whether the appeal is deemed to have been abandoned by the worker's failure to appear at the scheduled oral hearing.

Relevant Facts

On January 23, 2004 the worker telephoned WCAT and spoke with an appeal liaison officer. He requested a postponement of the oral hearing on February 17, 2004, stating that he was a student and had three exams in mid February. The appeal liaison approached the assigned vice chair for instructions.

The vice chair advised the appeal liaison that the worker must provide more than a telephone call and instructed that the worker be asked to supply a copy of the examination schedule on the basis that the oral hearing may fit between the exams.

The appeal liaison subsequently advised the vice chair that when the worker was asked for his examination schedule he advised that he had decided to proceed with his hearing on February 17, 2004.

WCAT arranged, as requested by the worker, for an Iranian interpreter to attend at the oral hearing on February 17, 2004.

At the appointed time on February 17, 2004 the interpreter appeared but the worker did not appear.

In a letter dated February 17, 2004, faxed to the WCAT on February 17, 2004, and received by WCAT on February 17, 2004, the worker stated,

> . . . could not make it to the hearing, because my wife is pregnant with our child and she is coming up to 6 month of her pregnancy. She has been through a very rough periods and unfortunately last night was one of those night and I was concern about my family that I totally forgot about the hearing.
>
> Please reconcider me for another hearing date.
>
> [reproduced as written]

Finding and Reasons

I find that the appeal is deemed to have been abandoned by the worker.

Item #9.23 of the MRPP sets out that a failure to appear at an oral hearing without prior notice will normally only be justified by a personal emergency.

The apparent rationale for a "personal emergency" as justification for rescheduling an oral hearing is that the emergency was not predictable by the appellant and not within the appellant's control. Examples would include an intervening family or medical emergency or a personal emergency of some kind. This worker's reasons for failing to appear by reason of forgetting about the hearing because of concern for his family are not outside of his control nor unpredictable by him. Accordingly, the worker does not qualify for the normal justification provided in item #9.23.

The use of the word "normally" in item #9.23 implies that there may be other justification for failing to appear for an oral hearing. There may be events which are predictable and not within the appellant's control, or vice versa, such as driving to the wrong address for the oral hearing, or getting lost and unable to find the hearing location, or being held up in traffic due to closure of a bridge or roadway by reason of an accident. In this worker's case, there is no evidence of this kind of event.

In summary, I find that there is no basis for rescheduling of a hearing by reason of a personal emergency or other justification as contemplated in item #9.23 of the MRPP.

In summary, I find that the appeal has been abandoned and will not be rescheduled or continued.

Decision of the Workers' Compensation Appeal Tribunal

Number: 2004-01842
Date: April 14, 2004
Panel: Luningning Alcuitas-Imperial, Vice Chair
Subject: Effective Date of New Chronic Pain Policy, #39.01 RSCM I

Introduction

The worker appeals a July 30, 2003 decision of the Review Division of the Workers' Compensation Board (Board). This decision concerned the worker's pension award under a 1998 bilateral elbow claim. In upholding the original decision of the Board, the review officer confirmed the 0.25 percentage of permanent functional impairment of the right elbow. She also confirmed that there was no measurable impairment of the worker's left elbow. Finally, she confirmed that no award should be granted on a projected loss of earnings basis, as the worker was fit to perform his regular duties as a storesman. She did not address the effective date of the pension or the average earnings used to calculate the award.

The worker argues that he is entitled to a pension award for his left elbow. He also disagrees that he is fit to perform his regular duties, as he says that he can only work four days per week.

Issue(s)

The worker did not dispute the pension's effective date or the average earnings used to calculate the award. Therefore, the issues arising from this appeal are:

1. What is the percentage of the worker's permanent functional impairment due to the condition of his left and right elbows?

2. Is the worker entitled to an assessment of his permanent partial disability award on a projected loss of earnings basis?

Jurisdiction

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

WCAT may consider all questions of fact and law arising in an appeal, but is not bound by legal precedent (section 250(1)). 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. WCAT has exclusive jurisdiction to inquire into, hear, and determine all those matters and questions of fact and law arising or required to be determined in an appeal before it (section 254).

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.

The worker's compensable injury and permanent disability occurred before June 30, 2002. Therefore changes contained in the *Workers Compensation Amendment Act, 2002* (Bill 49) do not apply to the adjudication of this appeal. I have therefore adjudicated it under the provisions of the Act that preceded changes contained in the *Workers Compensation Amendment Act, 2002* (Bill 49). Policy relevant to this appeal is set out in the *Rehabilitation Services and Claims Manual*, *Volume I* (RSCM I), which relates to the former (pre-Bill 49) provisions of the Act.

As well, I note the provisions of section 239(2)(c) concerning WCAT's jurisdiction over appeals involving the scheduled portion of the pension award. Having referred to the rating schedule compiled under section 23(2), which is the *Permanent Disability Evaluation Schedule* (published as Appendix 4 of the RSCM I), the specified ranges of impairment for the elbow exceed 5.0 percent. Therefore, I have jurisdiction over the scheduled portion of the pension award under appeal.

Background and Evidence

I reviewed the worker's claim file, as well as evidence presented by the worker and the employer at the oral hearing. Only the relevant information is outlined here.

The worker, a storesman, injured both his elbows on September 9, 1998 when lifting heavy items. He was diagnosed with bilateral extensor tendinitis. The Board accepted his claim for compensation. He received wage loss benefits from September 10, 1998 to March 12, 2000.

During the course of this claim, the worker underwent two surgeries for his right elbow (June 1999) and for his left elbow (October 1999). Dr. Favero, orthopaedic surgeon, performed both operations.

On Dr. Favero's recommendation, the worker returned to work on a part-time basis in January 2000. He did modified duties (avoiding lifting and gripping with the left hand) with no overtime hours. His treating physicians continued to monitor his progress after he returned to work. In July 2000, Dr. Favero noted the worker's left elbow pain when gripping and twisting. He thought the worker needed to be accommodated indefinitely for this left elbow pain.

On the basis of a medical advisor's opinion, the Board accepted in August 2000 that the worker's condition was permanent. His file was sent for assessment at the Disability Awards Department.

In September 2001, the employer contacted the Board to advise that the worker was working a nine-day fortnight, but only working four days per week on the alternate weeks. The worker later confirmed this information, explaining that he needed the day off due to his ongoing symptoms.

The worker was then examined by Dr. Parhar of CORE Medical Centre on November 28, 2001. The worker expressed concerns about switching to afternoon or evening shifts and about his ability to resume his pre-injury duties. The worker wanted to continue working four day shifts per week.

Dr. Parhar concluded that:

> In my opinion, [the worker's] anxiety about attempting shift work and resuming pre-injury duties is the biggest obstacle in his making a complete recovery.
>
> Given the nature of his condition any type of activity involving a forearm could conceivably cause an aggravation of his symptoms. Given his anxiety and resistance at working afternoons and evenings 4–5 days per week, it is unlikely that a durable and sustainable return to work is going to be possible at this time.
>
> [reproduced as written]

In April 2002, the pension assessment process began. Dr. Bland conducted a permanent functional impairment examination of the worker on April 15, 2002 at an external facility. In his report, Dr. Bland recorded the worker's reported functional tolerances. He reported limitations with carrying, climbing, fingering, handling, lifting, and reaching with weight involved. The worker also reported that both elbows were fatigued after a day's work. Both elbows ached after any prolonged activity.

Dr. Bland then reported the results of the series of tests conducted. These included grip strength and pinch strength tests which were done on both hands and elbows. The following results were also taken from extremity range of motion tests done on both elbows:

- Left elbow flexion = 143 degrees
- Right elbow flexion = 142 degrees
- Left elbow extension = 4 degrees
- Right elbow extension = 4 degrees
- Left elbow supination = 84 degrees
- Right elbow supination = 85 degrees
- Left elbow pronation = 70 degrees
- Right elbow pronation = 65 degrees

These results were placed into the ARCON Automated Impairment Rating Software (AIRS) system. A slight abnormal pronation of the right elbow was calculated to 0.25 percent of total disability. This percentage was calculated with reference to items #46 to #48 of the *Permanent Disability Evaluation Schedule*, published as appendix 4 of the RSCM I.

Prior to implementing the pension award, a Board officer in the Disability Awards Department reviewed the worker's claim file. In an April 23, 2002 memo, the officer first reviewed the ARCON results. The results of 0.25 percent for the right elbow and 0.0 percent for the left elbow were confirmed. The officer added 0.13 percent for the worker's subjective complaints, stating that:

> I have considered the worker's subjective complaints in determining his entitlement and find that these complaints are somewhat more significant than what would be considered consistent with the objective findings. Therefore, an additional award in recognition of same equal to half of what the objective degree of assessment was, would be appropriate, at 0.13%.
>
> [reproduced as written]

The effective date of the award (March 13, 2000), as well as the wage rate, were also confirmed. Finally, the Board officer asked for further information from the Vocational Rehabilitation Services Department about the worker's long-term employability.

The worker spoke to the Board in August 2002. He explained that he was still having pain, but was concerned about moving to an afternoon shift. He preferred the morning shift, as he was able to rotate duties with co-workers during that shift. A Board vocational rehabilitation consultant then contacted the employer in October 2002, who maintained that assistance would be available to the worker on the afternoon shift.

To further investigate this question, the Board conducted a worksite visit on October 31, 2002. Those present included a Board vocational rehabilitation consultant, a Board nurse advisor, the worker and the employer's representative. After a demonstration of the work duties, the vocational rehabilitation consultant analyzed the breakdown of those duties as follows:

- 40 percent making kits, which involves assembling and counting small pieces from shelves
- 25 to 30 percent putting light parts away on seven foot shelves
- 10 to 15 percent computer data entry
- 10 to 20 percent retrieving parts and bringing to the counter for co-workers

Six workers were in the stores on the day shift, while there were only two on the afternoon shift. The second worker on the afternoon shift was located at least 100 feet away from the worker.

At the job site visit, the worker expressed his concerns that his arms hurt with activity. The vocational rehabilitation consultant recorded that the worker did not have difficulty with his work duties, but that "home life combined with work proves to be too much."

At the end of the work site visit, the Board nurse advisor concluded that the worker should have a second person working on the afternoon shift to assist him if necessary.

The Board then contacted the employer to discuss implementation of the nurse advisor's recommendation. The employer's representative advised that a second worker was available to assist the worker on the afternoon shift, unless that second worker called in sick. In any event, the employer indicated that they were undergoing a work reorganization which would result in "extra" people available on the afternoon shift.

On January 2, 2003, the Board vocational rehabilitation consultant issued a letter advising the worker that he was not suffering any long-term loss of earnings because of his compensable injuries. The rehabilitation consultant considered the employer's information that assistance would be available. The rehabilitation consultant also characterized the nurse advisor's opinion as meaning that the worker's current position was physically suitable for the worker to complete on a full-time basis and that it was medically reasonable for the worker to work on afternoon shifts. An employability assessment outlining the same information, but with less detail, is also on file.

The worker reacted to the rehabilitation consultant's letter on January 7, 2003. He expressed to the Board that the question of a co-worker to assist him was not his main concern. He characterized his main concern as his ability to complete five day shifts.

The Board then issued the pension decision on January 22, 2003. The pension award was based on 0.41 percent of total disability, including a small percentage for age adaptability. No loss of earnings award was granted as the worker was considered capable of performing suitable employment over the long term.

In early 2003, Dr. Favero and Dr. Morrell (family physician) both filed reports with the Board. They stated that the worker should only work four days per week. In particular, Dr. Favero noted the worker's complaints in a January 7, 2003 letter. The worker reported a 75 percent improvement on the right side, but only a 50 percent improvement on the left. Dr. Favero thought the worker's scars well healed. He found tenderness on the lateral epicondyle of both elbows, with a full range of motion but pain on the extremes. Dr. Favero concluded that the worker had significant residual problems and needed to continue working four days per week. He noted that, from his clinical experience, significant improvement from chronic tennis elbow might take five to eight years.

The worker requested a review of the January 22, 2003 pension decision. In confirming the Board decision, the review officer first examined the issue of the worker's permanent functional impairment. She noted that the tests conducted by Dr. Bland reflected the Board's practice to compare restrictions for bilateral injuries against population norms. On the issue of the worker's ability to perform his job duties, the review officer preferred the conclusions of the vocational rehabilitation consultant to that of the worker on the issue of his ability to perform his job duties.

Oral Hearing Evidence and Submissions

At the oral hearing, the worker gave an update about the work reorganization and the shifts he worked. He confirmed that he has worked four shifts per week since returning to work after his September 1998 compensable injury. The only exception was three months he spent on the weekend shift in 2003. The weekend shift involves working Friday, Saturday, and Sunday for

12 hours. He confirmed that he can perform all the physical duties of his job, but he requires every second Friday off so he can rest for three days in a row. He has covered these missed shifts through his vacation entitlement.

The worker said he finds repetitive motions have the most impact on his endurance level. His symptoms are aggravated by activity, beginning with shooting pains and progressing to a dull ache in both elbows. He also briefly described the impact of his disability on his activities of daily living. He can no longer cook or golf.

In terms of a submission, the worker made oral comments to the panel. He submitted that he does not have the physical endurance to work full time. He argued that this fact is well documented in the medical evidence of his treating physicians and the employer's doctor. He submitted that this medical evidence should be preferred to that of the nurse advisor. He thought the Board missed this central question in adjudicating his loss of earnings pension. He also submitted that he still experiences residual symptoms in his left elbow and that these should be addressed in his pension. He asked for an increase in his functional award and an assessment for a loss of earnings award.

At the oral hearing, the employer's representative argued that the Review Division decision should be upheld. In support of her position, she submitted a March 8, 2002 letter from Dr. Morrell outlining the worker's restrictions with repetitive grasping and gripping. Dr. Morrell also stated that "[The worker] feels that his ability to work Monday, Tuesday, Thursday, Friday allows him one day off in the middle of the week as a recovery day and will allow him to work on a regular basis with this in mind. This program would be permanent."

The employer's representative also submitted a posting for positions in the "lean support group" created after the workplace reorganization.

In terms of a submission, the employer's representative made oral and written comments to the panel. She argued that Dr. Favero's January 2003 opinion was only based on the worker's subjective complaints. She also argued that there was no new medical evidence submitted to justify a change in the Review Division decision. She asked the panel to confirm the Review Division decision.

Following the oral hearing, I obtained further information from Dr. Morrell. This consisted largely of his chart notes. This material was disclosed to the worker and the employer's representative. They did not comment further on the material.

Reasons and Findings

Pension Award under Section 23(1) for Objective Impairment

Section 23(1) of the *Workers Compensation Act* (Act) provides in part that "Where permanent partial disability results from the injury, the impairment of earning capacity must be estimated from the nature and degree of the injury."

This is the "loss of function/physical impairment" method of assessing permanent partial disabilities. This is opposed to the "projected loss of earnings" method under section 23(3) of the Act. These are the Board's two basic methods of assessing permanent partial disabilities under the so-called dual system.

I will first deal with the percentage of the worker's functional award concerning his objective impairment. Item #39.30 of the RSCM I deals with restrictions of movement in the arms and legs. It provides in part that:

> Restrictions of movement in the joints of the body are measured and documented during the permanent functional impairment evaluation. The Disability Awards Officer or Adjudicator in Disability Awards then applies the measurement to the appropriate item in the Permanent Disability Evaluation Schedule.

Taking the results of Dr. Bland's examination, the Board entered the range of motion findings into the ARCON system. Normally, the ranges of motion for one limb are compared to the findings for the unaffected limb. Given that the worker has a bilateral condition, the ARCON system has built-in standards based on population norms. Those normal ranges of motion are now contained in the new version of the *Permanent Disability Evaluation Schedule*, published as appendix 4 of *Rehabilitation Services and Claims Manual*, *Volume II* (RSCM II).

Examining those population norms against the results of Dr. Bland's examination, I find that the award for 0.25 percent for loss of right elbow pronation is correct. The normal range of motion for pronation of the forearm is 71 degrees, whereas Dr. Bland recorded a right elbow pronation of 65 degrees. Dr. Bland recorded a left elbow pronation of 70 degrees, which is only slightly less than the normal range of motion.

I have also examined the worker's range of motion findings for flexion and extension in both elbows. These findings are slightly below the normal range of 146 degrees. However, I note that the correct figures were entered into the ARCON system. Applying item #97.40 of the RSCM I, I give weight to the findings of Dr. Bland. Item #97.40 of the RSCM I provides that the report of a disability awards medical advisor or external service provider takes the form of expert evidence which, in the absence of other expert evidence to the contrary, should not be disregarded. The worker has not provided any other medical evidence challenging the range of motion findings of Dr. Bland. While the worker states that he has symptoms in his left elbow, these do not appear to significantly interfere with his range of motion. Thus, I accept the Board's decision that the worker had no measurable objective impairment in his left elbow.

In summary, I confirm the worker's pension award for objective impairment in the right elbow at 0.25 percent of total disability. I deny the worker's appeal on this issue and confirm that portion of the July 30, 2003 decision of the Review Division.

Pension Award under Section 23(1) for Subjective, Chronic Pain

I will now examine the subjective complaints component of the worker's pension award. In this case, the Board awarded a small percentage of total disability to recognize the worker's subjective complaints. It is not clear from the Board file whether the additional percentage for subjective complaints addressed the symptoms in both elbows.

An issue arises as to which version of item #39.01 of the RSCM I applies in this case.

The previous version of the policy dealt with "subjective complaints" and outlined that both objective physical findings and the subjective complaints of pain were considered in a section 23(1) determination. I imply from the evidence that the Board officer applied this previous version of the policy in reaching the decision under appeal.

However, this policy item was amended by the Board's Panel of Administrators by Resolution 2002/11/19-04. The new version of the policy is entitled "Chronic Pain" and sets out guidelines for assessment of section 23(1) awards for "workers who experience disproportionate disabling chronic pain as a compensable consequence of a physical or psychological work injury." If the worker is found to have chronic pain that is disproportionate to the permanent impairment, an award of 2.5 percent of total disability will be granted. The preamble to the panel resolution provides reasons for the policy change, including the need to reflect current scientific and clinical information regarding chronic pain and the need to provide clarity for stakeholders about pension awards for chronic pain.

The body of the resolution of the Panel of Administrators also deals with the effective date of the policy change. Point #3 of the resolution states that:

> This resolution applies to new claims received and all active claims that are currently awaiting an initial adjudication.

Point #4 in the Panel of Administrators resolution states that it is effective on January 1, 2003.

There is ambiguity in the language of the Panel of Administrators resolution referring to an "initial adjudication." There are a number of possible interpretations of that phrase, including initial adjudication of the claim itself (i.e. whether there is a compensable condition); or initial adjudication of the question of subjective, chronic pain as a compensable consequence (which may arise while the worker is still temporarily disabled or when the worker is undergoing assessment for a section 23(1) award).

Although the Board has issued a practice directive (Practice Directive #61 on "Pain and Chronic Pain" publicly available on the Board website at www.WorkSafebc.com) on the new version of the policy, there is no further interpretative guidance on the effective date of the new policy.

The question of which version of the policy to apply in this case arises because the Board's pension decision of January 22, 2003 was issued after the effective date of the new policy.

I find that the phrase "initial adjudication" in the Panel of Administrators resolution means an initial adjudication with respect to entitlement for compensation for subjective, chronic pain. This means that all active claims awaiting an initial adjudication on subjective, chronic pain (whether the worker's condition is still temporary or has become permanent) on and after January 1, 2003 should be considered in light of the new version of the policy. This is the most reasonable approach in light of the stated purposes behind the policy amendment to bring clarity to the consideration of the question of subjective, chronic pain in light of current scientific and medical knowledge.

In reaching this conclusion, I note a similar conclusion reached by the panel in WCAT Decision #2004-00820 (publicly available on the WCAT website at www.wcat.bc.ca). It is also open to the Board to issue further directions to the workers' compensation system on the effective date of this new policy.

Unfortunately, this does not entirely resolve the question arising in this particular appeal. The Board officer first dealt with the worker's entitlement to compensation for subjective, chronic pain in the April 23, 2002 memo. It took a further eight months before the worker was formally awarded his pension award in the decision letter under appeal. This time period was spent gathering further information on the worker's long-term employability.

What should be considered the initial adjudication of the worker's entitlement to compensation for subjective, chronic pain in this case: the April 2002 memo or the January 2003 decision letter?

I find that the initial adjudication of the worker's entitlement to compensation for subjective, chronic pain occurred in January 2003. Although for purposes of registering appeals, WCAT may take jurisdiction over memos or other forms of correspondence on a worker's claim file, I interpret the phrase "initial adjudication" to mean the formal communication of a decision to the worker. Although there were telephone communications between the worker and Board officers subsequent to the April 2002 memo, the subject matter of these communications concerned the worker's long-term employability, rather than his specific entitlement to compensation for subjective, chronic pain. The worker was only informed in January 2003 of that entitlement. The January 2003 decision can be characterized as a decision adverse to the worker's interest, therefore requiring notification of the reasons supporting the decision and the worker's right to appeal such a decision. In reaching this conclusion, I note the provisions of item #99.20 of the RSCM I.

Therefore, since the initial adjudication of the worker's entitlement to compensation for subjective, chronic pain took place after January 1, 2003, the new version of the policy at item #39.01 of the RSCM I applies to this appeal.

The new policy clearly defines chronic pain as "pain that persists six months after the injury and beyond the usual recovery time of a comparable injury." Two types of chronic pain are distinguished: specific chronic pain (pain that exists with clear medical causation or reason) and non-specific chronic pain (pain that exists without such clear medical causation or reason). In evaluating a worker's entitlement to a section 23(1) award for chronic pain, the policy contemplates consideration of numerous types of evidence, including a multidisciplinary assessment, other medical information and the worker's own statement, conduct, and activities. However, central to the question of entitlement to a section 23(1) award for chronic pain is the determination of whether the worker's chronic pain is consistent with the impairment or disproportionate to the impairment. In this way, the new version of the policy appears to adopt at least a portion of the reasoning expressed in Appeal Division Decision #2001-0916 (publicly available on the Board website at www.WorkSafebc.com).

I find that the worker is entitled to an additional award under section 23(1) for specific chronic pain that is disproportionate to his impairment. In reaching this conclusion, I have considered the following:

- The Board officer's conclusion that the worker's subjective complaints were "more significant" than what would be consistent with the objective findings.

- The medical evidence from Dr. Parhar, Dr. Bland, and Dr. Favero consistently documenting pain and fatigue in both elbows, particularly after activity. I note that the worker's treating specialist, Dr. Favero, stated in July 2000 that the worker's left elbow pain would need indefinite accommodation. Although there is minimal objective impairment in the worker's left elbow, he continues to have consistent pain complaints in the left elbow. In combination with his objective right elbow impairment, the left elbow chronic pain has affected the worker's ability to function. I find that this meets the criteria outlined in item #39.01 of the RSCM I regarding disproportionate pain, where the extent of the pain is greater than what would be expected from the impairment.

- The worker's consistent and credible evidence of chronic pain. There is no suggestion in the evidence that the worker's pain complaints are the result of exaggerated pain behaviours or malingering. His conduct, particularly in requesting accommodation at the workplace, is also consistent with his pain complaints.

I allow the worker's appeal on this issue and vary that portion of the July 30, 2003 decision of the Review Division to the following extent. I note that the policy no longer gives discretion regarding the quantum of a section 23(1) award for chronic pain. Therefore, aside from the 0.25 percent award for objective impairment, the worker is entitled to a further 2.5 percent award for subjective, chronic pain.

Projected Loss of Earnings Award

Section 23(3) provides in part that:

> Where the board considers it more equitable, it may award compensation for permanent disability having regard to the difference between the average weekly earnings of the worker before the injury and the average amount which the worker is earning or is able to earn in some suitable occupation after the injury . . . and regard must be had to the worker's fitness to continue in the occupation in which the worker was injured or to adapt to some other suitable employment or business.

As noted above, Board policy in the RSCM I describes this method of assessing permanent partial disabilities as the projected loss of earnings method.

In this case, the Board declined to assess the worker for a loss of earnings award because the worker was fit to perform his full-time duties as a storesman. However, the worker submits that while he can perform his work duties, he does not have the physical endurance to work full-time hours in this position.

In considering this issue, I have referred to item #40.12 of the RSCM I which provides guidelines on assessing what are suitable and available occupations for the claimant in the long term. In particular, item #40.12 provides that:

> In advising on the suitability of the claimant for reasonably available jobs, the Rehabilitation Consultant must have regard to the limitations imposed by the residual compensable disabilities of the claimant and assess the claimant's earnings potential in light of all possible rehabilitation measures that might be of assistance, including the possibility of retraining or other measures that may be appropriate to the particular worker.

Having carefully examined the evidence, I give weight to the opinion of the vocational rehabilitation consultant that the worker's position with the employer was physically suitable. Although the opinion of the rehabilitation consultant mischaracterizes the conclusions of the nurse advisor (who limited her opinion to the question of whether the worker needed assistance from a co-worker), I am still comfortable in relying on it because the rehabilitation consultant actually visited the worksite and analyzed the worker's work duties. Although the medical evidence from the worker's treating physicians is that he should be working a reduced workweek, I find that these opinions are largely based on the worker's self-report and not on a detailed analysis of the worker's work duties. I further note that the worker consistently admits that he has no difficulty performing his work duties, but also states that his endurance to work full-time is affected by his activities of daily living. I also note that the worker was able to complete approximately three months of three 12-hour shifts per week in 2003.

Therefore, I deny the worker's appeal on this issue and confirm that portion of the July 30, 2003 decision of the Review Division.

Conclusion

In summary, I partially allow the worker's appeal and vary the July 30, 2003 decision of the Review Division to the following extent:

- I confirm the portion of the worker's section 23(1) award for right elbow objective impairment at 0.25 percent. I find that the worker is not entitled to an additional percentage of total disability for objective, left elbow impairment.

- However, the worker is entitled to an additional 2.5 percent under section 23(1) for subjective, chronic pain in both elbows. I apply the new version of policy item #39.01 of the RSCM I to this appeal.

- I confirm that the worker is not entitled to an assessment for a section 23(3) award for projected loss of earnings, as he is fit to perform his regular, full-time duties as a storesman.

When asked at the oral hearing, the worker said there were no expenses incurred in mounting this appeal. Thus, I make no order for reimbursement of expenses under section 7 of the *Workers Compensation Act Appeal Regulation*.