World Bank Administrative Tribunal

2024

Decision No. 705

HO,
Applicant

v.

International Bank for Reconstruction and Development,
Respondent

World Bank Administrative Tribunal
Office of the Executive Secretary

HO,
Applicant

v.

International Bank for Reconstruction and Development,
Respondent

1. This judgment is rendered by the Tribunal in plenary session, with the participation of Judges Janice Bellace (President), Seward Cooper (Vice-President), Lynne Charbonneau (Vice-President), Ann Power-Forde, Martha Halfeld Furtado de Mendonça Schmidt, Thomas Laker, and Raul C. Pangalangan.

2. The Application was received on 13 November 2023. The Applicant was represented by Jeffrey A. Bartos and John J. Grunert of Guerrieri, Bartos & Roma, P.C. The Bank was represented by David Sullivan, Deputy General Counsel (Institutional Affairs), Legal Vice Presidency. The Applicant's request for anonymity was granted on 2 May 2024.

3. The Applicant challenges the Bank's "denial of coverage for medical treatment obtained by [the Applicant] from October 5, 2020 to the present, and the Administrative Review Panel decision of March 23, 2023."

FACTUAL BACKGROUND

4. The Applicant is a national of Canada and France and joined the Bank in 2011 as an Extended-Term Consultant. He subsequently served as a Grade Level GF Security Specialist. The Applicant states that he has served the Bank on security assignments in Iraq, Libya, Afghanistan, Sri Lanka, and Haiti, where he is currently stationed.

5. In 2018, the Applicant was assigned to a three-year rotation in Tripoli, Libya.

6. In Libya, the Applicant's accommodation was a villa complex provided by the Bank, and the Applicant states that he "spent almost all his time, working, sleeping, and living in the same villa."

7. According to the Applicant, "[t]hroughout 2018, [he] developed a persistent cough and had trouble breathing, sleeping, and even speaking."

8. In January 2019, the Applicant visited the United Nations (UN) military hospital in Tripoli. The Applicant explains that "[h]is condition deteriorated" and that "[h]is symptoms progressed to severe, constant cough marked by bloody phlegm and inflamed lungs."

9. In March 2019, the Applicant saw a pulmonologist, Dr. E, in Tunisia, who prescribed medication. The Applicant states that his symptoms "partially dissipated" then worsened in February 2020, and that he saw Dr. E again, in March 2020, "who this time associated [the Applicant's] symptoms with interior environmental conditions, likely mold, caused in turn by moisture and humidity."

10. According to the Applicant, the villa in Libya where he had been living and working "had severe mold contamination."

11. In the spring of 2020, the Applicant and other Bank staff were evacuated from Libya due to civil war and the Applicant was assigned to work from Morocco.

12. In March and April 2020, the Applicant had medical consultations with a Dr. S at Clinique Medicale la Patrie in Montreal, Canada. Per a 23 September 2020 medical note, the consultations were "on account of a condition of severe acute bronchitis associated with signs of bronchial spasms while returning from Libya." The medical note further stated that, "[d]ue to his poor pulmonary condition, the patient has a high risk of severe pulmonary infection, considered as Chronic Obstructive Pulmonary Disease (COPD) while waiting for a Pulmonary Function Test (PFT) to be carried out and for a pulmonologist to examine him after he has returned to Quebec." The medical note stated, "[I]t is recommended that the patient leave the place at high risk of

COVID 19 in order to receive medical care as well as to avoid precocious recurrence of bronchitis, also considering that the patient is prone to coughing while speaking and has coloured phlegm."

13. On 25 September 2020, the Applicant sought workers' compensation benefits with the Bank's Claims Administrator. The Applicant claimed a "Work related sickness" of his lungs and stated that the sickness occurred "[s]pring–summer 2019 [and] again Feb[ruary] 2020." The Applicant further explained on the Bank's "Injury or Sickness Reporting Form":

> On two very specific occasions early this year February into March, as well as last year 2019, I contracted severe bronchitis while staying in our World Bank Libya accommodations when I was posted there alone, more precisely my security office where I stayed 20–22 hours per day for last few years[.] I worked, lived [and] slept in my security office[.] The problem stemmed from water infiltration in the concrete walls which lead to a heavy moisture, mildew and mold accumulation and contamination in the units as well as the neighboring unit[.] This problem was finally addressed by the facility management with significant interior documented repairs[.] As a result of this, on two occasions and upon leaving Libya, I had to resort to a lung specialist after seeing the UN doctor and Aspen clinic in Tripoli but to no avail, both clinics could not treat the perpetual coughing and discharge from my lungs, and they actually could not find what was causing this[.] Both bronchitis bouts lasted in excess of 4 to 5 months each time, and I have all the medical records on file[.] The first time around, although it took months to cure, it finally cleared up[.] Then I got this second bout upon returning back to Libya[.] My lung doctor based on his investigation and the fact that I was isolated in Tripoli in my office without […] movement outside my unit, determined it due to extended exposure to moisture and mold while working and sleeping in these conditions in the WB [World Bank] Security Office[.] I was placed on numerous medications and ventilator pumps etc[.] on both times for a number of months[.]

14. On 25 September 2020, the Applicant received an email from the Claims Administrator which stated, "Thank you for submitting the completed World Bank Group Injury or Sickness Report. I will have a claim opened and claim number assigned to you." On 29 September 2020, a Senior Claim Examiner emailed the Applicant and stated that she was assigned to his claim and asked the Applicant to complete documentation and to provide his availability to discuss his claim.

15. The Applicant states that, while awaiting a decision on his claim, on 5 October 2020, he sought treatment in France with a pulmonologist, Dr. F. According to the Applicant, "[h]is urgent medical needs, including near constant severe pain, demanded prompt action." Further, the

Applicant states that, "[a]s of [a]utumn 2020, [his] symptoms appeared linked to his lungs, and in the absence of medical directives from HSD [Health and Safety Directorate] or [the Claims Administrator], he operated under the assumption that a pulmonologist was the specialist needed." The Applicant also states that he "decided upon using a doctor in France, and [Dr. F] in particular, due to its relative proximity to Morocco, an approximate two hour flight."

16. According to the Applicant, "[Dr. F] prescribed a comprehensive treatment plan for [the Applicant] involving at home treatments and weekly office visits," and the Applicant states that he "began using masks, inhalers, pumps, and antibiotics, among other treatments to alleviate his difficulty breathing." The Applicant further explains that he rented an apartment near Dr. F's office from October 2020 until March 2021, while also working remotely for the Bank one day per week.

17. The Applicant states that, in December 2020, he returned to Canada and saw a naturopathic doctor "upon whose recommendation he undertook an at home test for Ochratoxins ('OTA'), the samples of which were sent to a laboratory in the United States." The Applicant provides a 15 July 2021 lab report which he states indicates high levels of toxins in his system. As stated in the lab report:

> Ochratoxin: Ochratoxin A (OTA) is a nephrotoxic, immunotoxic, and carcinogenic mycotoxin. This chemical is produced by molds in the Aspergillus and Penicillium families. Exposure is done primarily through water damaged buildings. Minimal exposure can occur through contaminated foods such as cereals, grape juices, dairy, spices, wine, dried vine fruit, and coffee. Exposure to OTA can also come from inhalation exposure in water-damaged buildings. OTA can lead to kidney disease and adverse neurological effects. Studies have shown that OTA can lead to significant oxidative damage to multiple brain regions and is highly nephrotoxic.

18. On 8 December 2020, the Applicant emailed the Senior Claim Examiner regarding "Status Check [and] Follow up," with respect to the Applicant's claim for workers' compensation filed 25 September 2020. The Senior Claim Examiner responded the same day apologizing for the delay and stating that the Applicant's documents were being translated.

19. On 18 December 2020, a Nurse Case Manager with Akeso Care Management, a company contracted by the Claims Administrator to provide medical management services to Bank staff

members located outside the U.S., emailed the Applicant "to assist with obtaining [the Applicant's] medical records to address compensability of [the Applicant's] claim." Also on 18 December 2020, the Senior Claim Examiner emailed the Applicant and explained the email from the Nurse Case Manager. The Senior Claim Examiner's email further stated that "we do not have enough information to make a determination on the file as to compensability" and "[w]e need more time and I wanted to take the time to try to gather additional information rather than submitting a denial of the claim to you. As well as needing additional information, we may also need an IME or Independent Medical Examination or a peer review of the information to help us make the determination."

20. On 29 December 2020, the Applicant emailed the Nurse Case Manager and stated that he was sending his "full file with signed waiver." The Applicant further stated in his email that "[t]he only thing I have not sent you is all my invoices," and he asked the Nurse Case Manager to inform him whether his file was complete. The Nurse Case Manager responded the same day indicating that she had sent the files to be translated.

21. On 12 January 2021, the Applicant emailed the World Bank Group's Vice President for Human Resources explaining his experience to date with the Claims Administrator. The Applicant stated that, after submitting his claim on 25 September 2020, there was "one month of absolute communication silence from [the Claims Administrator]," and the Applicant's email outlined further delays from the Claims Administrator in November and December 2020. The Applicant stated that it "is unacceptable and shocking that anyone would have to wait for a response and a clear action plan, particularly when you are a sick person and [in] need of clarity and support when it comes to your health, life and your work."

22. On 13 January 2021, the Nurse Case Manager emailed the Applicant and stated that his medical records would be sent for a peer review. The Nurse Case Manager also asked the Applicant to send a copy of his CT scan for purposes of the peer review. On 14 January 2021, the Applicant responded to the Nurse Case Manager's email and stated that he was "hoping to have the results of your review soonest as I need to know what's happening and I need support," and the Applicant inquired about the timeline. With respect to the CT scan, the Applicant explained that he would

try to send materials but stated that "we are on lock down for covid and with my lung condition I don't go out much."

23. On 29 January 2021, the Claims Administrator denied the Applicant's claim, stating that his "illness/injury did not arise as a direct result of [his] employment." The Claims Administrator's denial letter stated that it had obtained a peer review from Dr. R, an internal medicine and pulmonary specialist, who stated that the Applicant's "current [complaints] are a direct result of an ordinary disease of life that occurred naturally and is not a result of the reported workplace exposure."

24. On 16 February 2021, the Applicant submitted a request for reconsideration of his claim with the Claims Administrator and provided photographs of the alleged mold contamination of the villa in Libya and related statements.

25. On 10 March 2021, the Claims Administrator reversed its previous decision and found that the Applicant was eligible for workers' compensation benefits. The Claims Administrator concluded that the Applicant had a covered illness/injury of "[r]espiratory difficulties secondary to mold exposure in the workplace." Thereafter, the Applicant began to receive reimbursement for some of his medical costs from the Claims Administrator.

26. In 2021, the Applicant continued his treatments with Dr. F. On 19 July 2021, the Applicant provided the Claims Administrator with a report from Dr. F, dated 8 July 2021. Dr. F's report stated, "ASTHMA resistant to several treatments with chronic cough, predominantly morning and evening," and "CONCLUSION: beginning asthma due to exposure to mold in the workplace (very humid premises). Normal chest x-ray. Non-smoking and athletic patient. Allergy to dust mites that appeared following this occupational exposure to dust mites."

27. According to the Applicant:

> In September 2021, [Dr. F] informed [the Applicant] that his condition had become unresponsive to his treatments, was now deteriorating, and that the cause of this was systemic mold and toxin contamination. [Dr. F] then recommended and

> prescribed that [the Applicant] receive an Ayurvedic Detoxification Protocol from the Maharishi Ayurveda Health Center in Seelisberg, Switzerland.

28. As stated in an 11 October 2021 medical report from Dr. F:

> ASTHMA resistant to several treatments with chronic diurnal hacking cough, predominantly morning and evening. […]
>
> Dry cough in January 2019 and February, but 2020 (6 was in Libya). Infiltration of the professional premises with molds. Failure of Fexofenadine 180, Solupred, Bricanyl, REVINTY. Recurrence of cough in Morocco (damp place). […]
>
> CONCLUSION: Early asthma caused by unsanitary workplaces (damp rooms). Normal chest X-ray – Non-smoking and sporting patient[.] Allergy to house dust mites which appeared following this occupational exposure to dust mites. […]
>
> 11/10/21: improvement in the cough which, however, is present in the evening and in cold or humid weather.
>
> Programed detoxification (toxins, moisture) for Switzerland.
>
> Presence of toxins in urine. […]
>
> A detoxification treatment (mold) will soon be taken up in Switzerland.

29. The Applicant states that he contacted the clinic in Switzerland and planned for treatment with Dr. B.

30. On 11 October 2021, the Applicant emailed the Senior Claim Examiner and sent a report from Dr. F, which was in French. In the email, the Applicant provided his translations of portions of Dr. F's report and noted that Dr. F required the Applicant "to undergo a specific treatment with [Dr. B] in order to remove […] toxins and molds within my system, this as soon as possible and for a period of 2 weeks."

31. On 14 October 2021, the Claims Administrator denied the Applicant's request for treatment and guarantee of payment for the two-week treatment in Switzerland. The Claims Administrator stated, "The medical documentation fails to establish a causal connection between the recommended treatment and the occupational illness/exposure to mold."

32. According to the Applicant, on 15 October 2021, he had a videoconference with Human Resources (HR) representatives and informed the Bank and the Claims Administrator that "he would be seeking a mold and toxin specialist for treatment." According to the Applicant, HR "agreed to seek out specialists who could evaluate [the Applicant] who would be covered by Workers' Compensation and to facilitate a treatment program for [the Applicant]."

33. On or around 18 October 2021, the Applicant traveled to Switzerland for the treatments with Dr. B, and he states that he found these treatments "most effective." As stated in a 30 November 2021 "Treatment report" from Dr. B:

> I strongly recommended [the Applicant] to proceed through a full mold and toxins ayurvedic detoxification protocol consisting of initial 2 weeks of intense sessions.
>
> […]
>
> Ayurveda Medicine is recognized by the World Health Organization and by the Swiss Health Care System.
>
> **Treatment Objectives**
> - Eliminate toxins and mold from deep tissues
> - Prevent further spreading of mold toxins
> - Clear lungs and respiratory system
> - Return patient to a healthy condition with normal quality of life
>
> **Treatment Plan**
> - Two weeks at the Swiss-Seelisberg MAHC [Maharishi Ayurveda Health Center]
> - In-patient extensive treatment
> - Accommodated in a settled and controlled environment within facility to prevent aggravation of his condition. The requirement is that he be treated in an acute setting of an in-patient clinic stay.
> - Ayurvedic Herbal Medicines with a global approach including various daily Therapies and Treatments to move the toxins out of the organs and tissues consisting of herbalised Steam baths, Inhalation Therapies, Purgation and Enemas for bowels deep cleansing.
> - Training for stress management technique
> - Nutrition and life style counseling to support healing process.

34. The Applicant states that he received no follow-up on his 15 October 2021 meeting with HR, and he states that, in November and December 2021, he "undertook his own search for mold

and toxin specialists in North America," and eventually was treated by Dr. M of Whole World Health Care in Roswell, New Mexico, and Dr. T of Rezilir Health in Hollywood, Florida.

35. On 10 January 2022, the Applicant requested that the Claims Administrator reconsider its denial of coverage for the treatment in Switzerland. In his request, the Applicant stated that "[Dr. F] recommended the urgent initiation of detoxification treatment which requires intensive inpatient hospitalization," and the Applicant explained that he "was informed that failure to pursue this treatment would result in toxic contamination that if unchecked would result in permanent damage to my lungs and potentially other vital organs." The Applicant also provided a 10 January 2022 letter from Dr. F with his request, which stated, "Following my conclusive comments of October 11, 2021, a detoxifying treatment for toxins and mold in his system was necessary due to the fact that these mold-based toxins did spread into his system starting from his lungs." Dr. F's letter further stated:

> Furthermore, in order to preserve the improvement achieved and possibly continue to reduce and curb the toxin levels, I continue to recommend that my patient maintain with my continual supervision, all treatments including specialized medical treatments, including those he recently underwent in Switzerland as the results demonstrated a significant decrease in the level of toxins and improvement of his general condition.

36. On 11 January 2022, an HR Specialist emailed the Applicant. The HR Specialist stated that, "prior to your seeking treatment in Switzerland, we had discussed seeking some additional medical consultations on your case," and the HR Specialist shared "a couple of suggestions of specialists [who] can do evaluations of your case." The HR Specialist asked the Applicant to "take a look at the providers" and inform "if you have any preference among them." The HR Specialist explained that, "[o]nce we hear back from you, we will reach out to you to coordinate travel arrangements."

37. On 14 January 2022, the Applicant responded to the email from the HR Specialist and stated that he had already secured an appointment with a U.S. specialist, Dr. M. He stated in his email:

> In the absence of any response from HR or [the Claims Administrator] since our Oct 15th meeting, and while waiting for [the Claims Administrator] to organise a

> timely follow-up for my treatment and condition, which they never did, I had no choice, and as I did for Switzerland and all other related care, I have already organised myself […] to see a specialist in the US and currently engaged with him.
>
> My physician specialists advised that I cannot delay a follow-up treatment without risking a relapse, and further damage to my health.

38. On 24 January 2022, an HR Employment Policy, Compensation and Systems Representative (HR Representative) emailed the Applicant regarding treatment with a U.S.-based specialist. The HR Representative noted that the physician the Applicant selected, Dr. M, "is a board-certified Pediatrician located in Roswell, NM, who trained under another physician (a Dr. Shoemaker) in an area for which no board certification exists, and who appears to be the only physician that has undertaken this course of study."

39. On 27 January 2022, the Claims Administrator rejected the reconsideration of benefits request from the Applicant with respect to the Ayurvedic Detoxification Protocol in Switzerland. The Claims Administrator's denial letter stated that the Applicant's medical records "were submitted to Utilization Review pursuant to section 32-1501 of the District of Columbia Worker[s'] Compensation Act." The Utilization Review, dated 22 January 2022, was conducted by Dr. I, and the Claims Administrator's denial letter informed the Applicant that the Utilization Review determined that the Ayurvedic Detoxification Protocol was "not medically recommended for treatment of [the Applicant's] condition." The 22 January 2022 Utilization Review included the following:

> 1. Are the medical records and accompanying information sufficient to answer the following questions? **Yes**.
>
> 2. Please determine if the recommended or requested health care service **(Ayurvedic Detoxification Protocol)** is medically necessary for the claimant's condition? **No. See Rationale.**
>
> 3. Please determine if the requested medication, **(Ayurvedic Detoxification Protocol)**, has been approved by the FDA [Food and Drug Administration]? If yes, is it FDA approved for this claimant's condition? **No. See Rationale.**

40. With respect to the question of determining "if the recommended or requested health care service (Ayurvedic Detoxification Protocol) is medically necessary for the claimant's condition," the Utilization Review rationale included the following:

> There is limited evidence available at present to demonstrate the safety and efficacy of the requested intervention for treatment of the claimant's condition. There is not enough evidence to reliably assess the possible role of the requested ayurvedic detoxification in the treatment of the claimant's condition. Further high-quality studies are needed to assess whether individuals respond to [an] Ayurvedic Detoxification Protocol for mold exposure. Due to lack of recommendation from evidence-based medicine guidelines or evidence from high quality studies, the recommended or requested health care service (Ayurvedic Detoxification Protocol) is not seen medically necessary for the claimant's condition.

41. From February 2022 to April 2022, the Applicant was treated by Dr. T in Florida who diagnosed the Applicant with Chronic Inflammatory Response Syndrome (CIRS). As stated in a 14 March 2022 report from Dr. T, "CIRS-WDB [water damaged buildings] is a multi-system, multi-symptom illness that can cause significant clinical issues. Symptoms include neurological, visual, gastrointestinal, musculoskeletal, respiratory, dermatological, hormonal, urinary, and metabolic issues."

42. The Applicant states that he "remained in Florida from the initial appointment in February until April 8, 2022, while he underwent almost daily treatments with [Dr. T], including intravenous (IV) treatment, binders to remove the molds, and an array of other therapies." According to the Applicant, "[d]uring those months, he rented an apartment and car which he paid for out of pocket, and did little else except travel to doctor appointments."

43. On 15 March 2022, the Applicant submitted Dr. T's treatment plan to the Claims Administrator.

44. On 18 March 2022, the Claims Administrator submitted the Applicant's proposed treatment plan to peer review with Dr. R. The peer review report, dated 24 March 2022, included the referral question "Please address whether the proposed treatment plan is reasonable, necessary, and related to the original on the job injury." In response, Dr. R stated:

> The additional clinical information does not support that the claimant had any compensable injury as a result of reported mold exposure. The claimant reported bronchitis occurred while overseas; however, there is no clinical evidence that mildew exposure as reported by the claimant caused the bronchitis. No diagnostic evidence such as eosinophils present in blood or from bronchoalveolar lavage was noted to support a causal relationship between the reported exposure to mildew and the development of bronchitis. Therefore, while the current recommended treatment is reasonable, it is unrelated to the reported workplace even[t].

Dr. R further determined that the "Treatment plan is not optimal."

45. On 29 March 2022, a Team Manager for the Claims Administrator emailed the Applicant and stated, "At this time, based upon the peer review we are not authorizing additional treatment."

46. On 31 March 2022, the Applicant filed an appeal with the Bank's Administrative Review Panel (ARP) challenging the denial of reimbursement for the Ayurvedic Detoxification Protocol in Switzerland.

47. On 1 April 2022, the HR Representative emailed the Applicant requesting invoices and proof of payment for the treatments referenced in the Applicant's appeal.

48. Also in April 2022, as part of the appeal process, the Bank sought a peer-to-peer discussion between Dr. T and Dr. R. In a 20 April 2022 email to the HR Representative, the Applicant expressed concerns about Dr. R. The Applicant stated that Dr. R "initially refused me my claim, and was then overruled," and that Dr. R "has never seen me and is compromised with an agenda."

49. In a 26 April 2022 email, the HR Representative explained to the Applicant that "[t]he peer-to-peer discussion involves a conversation between medical doctors to discuss items such as symptoms, treatment regimen, review of gathered data, etc." In his email, the HR Representative noted the Applicant's concerns about Dr. R and stated that he would inquire as to whether the Claims Administrator could provide a professional other than Dr. R for the peer-to-peer discussion.

50. According to the Bank, "[a]s Independent Medical Exams ('IME') had been suspended at this point, the peer-to-peer discussion was essential for [the Claims Administrator] and [Dr. R] to

evaluate [the] Applicant's condition, specifically regarding whether bronchitis and the subsequent diagnosis of CIRS was caused by the workplace environment." According to the Bank, Dr. T was unresponsive to the Claims Administrator's and Dr. R's efforts to complete the peer-to-peer discussion.

51. On 27 April 2022, the HR Representative informed the Applicant that he would be reimbursed for his treatments in Switzerland and Florida. In this email, the Applicant was also informed that "[f]uture treatments should follow the established process used for prior authorization of medical treatments." The Bank explains that it was "in a gesture of good faith and acknowledging [the] Applicant's financial outlay" that the Bank notified the Applicant that medical expenses for past treatments, including the treatments in Switzerland and the treatments with Dr. T up to 6 April 2022, would be reimbursed. Further, as stated in a 4 May 2022 email from the HR Representative to the Applicant,

> because a treatment plan was not coordinated with [the Claims Administrator] in advance, we cannot reimburse for any travel expenses associated with this treatment nor on any medical or travel expenses from April 6, 2022 onwards without engagement between [the Claims Administrator] and your physician. This is to ensure your health and treatment are managed in a coordinated way that reflects the design of the Workers[']Compensation program.

52. The Bank states that the Applicant was reimbursed in the amount of $57,003.54. According to the Applicant, the reimbursement did not provide an explanation of which of his claims were considered closed, pending, or denied, and "left unresolved the issue of [the Applicant's] pending requests for future treatment with [Dr. B], [Dr. T], and [Dr. M]."

53. In May 2022, the Applicant sought approval from the Claims Administrator for a June 2022 appointment with Dr. T and a treatment session with Dr. B in Switzerland. The Claims Administrator approved the appointment with Dr. T, but the Applicant states that the session with Dr. B was denied and that he did not attend. With respect to the appointment with Dr. T, on 20 June 2022, the Applicant emailed the HR Specialist and stated:

> I'm very sorry here, but you folks are going to have to step in and intervene with this, it is not up to me to be fighting this out with your service provider […].

> I cannot be in a battle between [the Claims Administrator] and my treating doctor, its simply wrong and not up to me the staff to deal with this [….]
>
> This is not how we are going to move forward and quite frankly this is another one of those times where I have to fight for what is rightfully mine.
>
> The doctor has asked in his medical report and recommendations that I come back for a progress assessment in June – this is basic and common for all doctors to do a follow-up.
>
> [The Claims Administrator] to this day has not once supported me, and this is another case of nonsense and more stalling and delaying [….]

54. On 22 June 2022, the HR Specialist emailed the Applicant and stated:

> I reiterate the willingness from both the Disability team and [the Claims Administrator] to help you find a specialist for your needs, that is, a specialist who will be able to establish a medical relationship with [the Claims Administrator] so that you are not caught in the middle, and you also do not have to pay out of pocket. Back in January, three pulmonologists were suggested by [the Claims Administrator] and if you are interested in these providers, I can send you their respective contact information. However, if you would like to ask [Dr. T] for a recommendation of medical practitioners who specialize in pulmonology, and who are willing to work under the WBG's [World Bank Group's workers'] compensation system, [the Claims Administrator] can certainly establish contact with those practitioners.

55. On 22 June 2022, the Applicant responded to the HR Specialist's email and stated:

> [I'm] sticking with my specialists, the ones that have worked for me and with me, and their treatment has proven effective, and I trust them – not the ones handpicked by [the Claims Administrator] and their agenda, you need to investigate these/their recommended Doctors…. Plus what toxicology specialist do they have – none. Again misleading and leading me to see the wrong doctors. Why would I go and see new doctors when my treatment for the first time is working, why would we do this to me? The report from [Dr. T] the expert is clear, toxins need to be eliminated…where does he mention pulmonology? This is not your area of expertise nor responsibility .... And [the Claims Administrator] is playing God from their keyboard when they have never assessed me. My treating expert physicians are the subject matter experts, and have the treating authority at this point, not [the Claims Administrator]….

56. In July 2022, the Applicant began a series of video appointments with Dr. M. Per a 17 August 2022 letter regarding the Applicant, Dr. M stated that he had

> made the diagnoses of chronic inflammatory response syndrome (CIRS), exposure to mold, immune system dysfunction, endocrine system dysfunction, toxic encephalopathy, orthostatic hypotension, chronic headaches, shortness of breath, dizziness, recurrent abdominal issues, polydipsia, polyuria and chronic fatigue.

57. On 14 August 2022, the Applicant sought retroactive payments for previous medical and travel expenses and inquired with HR as to the status of his ARP appeal. He was informed that, in light of the decision to reimburse him in May 2022, consideration of the appeal was deemed not necessary but that the ARP remained an available avenue of redress.

58. On 1 September 2022, Dr. T completed "a series of written inquiries" which had been provided to him by the Claims Administrator in July 2022. According to the Bank, these "written inquiries" were necessary due to "[Dr. T's] lack of collaboration or availability to engage in a peer-to-peer discussion." Dr. T stated in his response to the inquiries:

> For the record, there was no peer-to-peer review conducted with me, his treating physician.
>
> [The Applicant] gives a history of living and working in a heavily water-damaged and moldy structure during the time he developed his symptoms while deployed to Libya.
>
> To a reasonable degree of medical certainty, [the Applicant] has CIRS as established by 3 published and peer reviewed diagnostic methods that were outlined in detail in my initial letter. I confirm that his exposure to toxic mold (during his World Bank assignment in Libya) has resulted in the syndrome of CIRS. [Dr. M] who has been an expert witness in numerous cases supports this diagnosis based on his review of the data.

59. On 30 September 2022, the Applicant submitted a new appeal to the ARP, in which he challenged the Claims Administrator's 27 January 2022 decision regarding his request for reconsideration of benefits denied on 14 October 2021. In his ARP submission, the Applicant claimed that the Claims Administrator's decision was based on the wrong procedure of Utilization Review, that his Ayurvedic treatments were necessary, that the Claims Administrator considered

the wrong illness, that the Claims Administrator's decision imposed U.S. FDA standards, and that the Claims Administrator's decision discriminated between participants. He included a referral letter from Dr. F for the treatment in Switzerland.

60. On 4 November 2022, the Claims Administrator submitted its written response to the Applicant's appeal with the ARP. The Claims Administrator's response included Utilization Reviews by Dr. I, dated 22 January 2022 and 18 October 2022. In its response, the Claims Administrator stated:

> World Bank Group Directive Staff Rule 6.11, Section 3.01 specifies that the Administrator is to administer the worker[s'] compensation program in accordance with the provisions of the D.C. Act, unless there is a conflict with the Rule, in which case the Rule will govern. While Section 6.01 requires payment of "reasonable" medical costs causally related to the injury, it does not provide a mechanism by which to determine whether any given treatment is reasonable or not.
>
> As such, the DC Act pertaining to workers' compensation must be consulted. In that regard, the Act provides:
>
> **32-1507(6)** Any medical care or service furnished or scheduled to be furnished under this chapter shall be subject to utilization review. Utilization review may be accomplished prospectively, concurrently, or retrospectively.

61. Dr. I's 18 October 2022 Utilization Review stated:

> The office visits have been reasonable and medically necessary per ODG [Official Disability Guidelines] criteria.
>
> The CT of the lungs was reasonable and medically necessary per ODG noting this is useful (high resolution) in identifying individuals with severe asthma.
>
> As noted in the 01/22/22 Independent Review previously performed, the Ayurvedic Detoxification Protocol was not reasonable or medically necessary per evidence-based medicine. […]
>
> As related to the contact with and suspected exposure to mold; contact with and (suspected) exposure to other hazardous, chiefly nonmedicinal, chemical; unspecified toxic encephalopathy, and systemic inflammatory response syndrome, nonacute, evidence-based medicine guidelines would support a pulmonologist/allergist to oversee medical treatment for these specialized conditions. […]

> It is not reasonable or medically necessary for the claimant to seek medical treatment from distant providers as adequate medical treatment from a pulmonologist/allergist should be available in the Montreal area for appropriate treatment without the need for air travel. […]
>
> As related to the respiratory issues of the claimant, evaluation by a pulmonologist/allergist is reasonable. […]
>
> The recommended or requested health care services are not medically necessary for the claimant's condition.

62. The Claims Administrator's 4 November 2022 response also included an Expert Report by Dr. C, Board Certified in Internal Medicine and Preventive Medicine with stated expertise in Respiratory Environmental Medicine, dated 29 September 2022. Dr. C's report stated that "the constellation of reported symptoms or complexes [the Applicant] and [Dr. T] attribute to the alleged mold and/or mycotoxin exposures is neither indicative of any single, identifiable organic condition nor any recognized or generally accepted inhaled mold or mycotoxin related illness." Dr. C stated that "[t]here is no evidence that [the Applicant] was exposed to any levels of mold and/or mycotoxins that could cause his alleged injuries or illnesses."

63. Dr. C's report further stated:

> A pulmonologist/allergist should be overseeing the treatment of [the Applicant] in relation to his respiratory issues that are allegedly related to his work environment. I would also recommend an occupational medicine and a university travel medicine specialist evaluation. […]
>
> [Dr. F], [Dr. B], [Dr. T] and [Dr. M's] methodologies are not scientifically valid and are not generally accepted. The conclusion and opinions are, therefore, unreliable and scientifically flawed. […]
>
> It is my opinion that it is not necessary for the claimant to seek medical treatment from distant providers. Moreover, throughout the medical records reviewed [the Applicant's] healthcare providers including [Dr. F], [Dr. T] and [Dr. M] have repeatedly restricted [the Applicant's] travel due to the increased exposure risks including COVID-19. […]
>
> [The Applicant] sought treatment from [Dr. T] and [Dr. M], who both currently treat patients with "mold related illness." Both [Dr. T] and [Dr. M] ascribe to the novel and unproven protocol developed by Richie [*sic*] Shoemaker, MD for treating

> Chronic Inflammatory Response Syndrome (CIRS). The methodologies used are not scientifically valid and are not generally accepted.

64. The Claims Administrator's 4 November 2022 response stated, "Based on [Dr. C's] report and the utilization review findings, the Administrator challenges the reasonableness and medical necessity of the treatment recommended by [Dr. F], [Dr. B], [Dr. T], and [Dr. M]."

65. On 14 December 2022, the Applicant submitted a reply to the Claims Administrator's 4 November 2022 response. The Applicant's reply included supporting letters and reports from Dr. F, Dr. B, Dr. T, and Dr. M. In a 20 June 2022 "Treatment report" submitted with the Applicant's reply, Dr. B stated:

> Being aware that a prolonged mold intoxication could cause irreversible damage to his health, because of his persistent condition and to further support his current lung treatment with [Dr. F] and [Dr. T], **I strongly recommended [the Applicant] to proceed through a full mold and toxins ayurvedic detoxification protocol consisting of 3 weeks of intense sessions. The goal is to further remove and eliminate the toxins in his system and to reduce or stop the symptoms so that [the Applicant] could return to a normal quality of life which has been severely impacted.** (Emphasis in original.)

66. In a 22 September 2022 letter submitted with the Applicant's reply, Dr. F stated that, "as a pulmonologist, respiratory treatments are now reduced and have reached their optimum effectiveness" and "[f]rom now on [the Applicant] must continue to follow his very specific and targeted detoxification treatments for toxins and molds throughout his system." Further, in a 23 November 2022 letter submitted with the Applicant's reply, Dr. T stated that the Applicant was "currently under treatment" and had "improved since his last visit in June 2022," and further that "[i]t is anticipated that effective January 1, 2023, [the Applicant] can resume full-time work."

67. In his 14 December 2022 reply, the Applicant also provided a "Rebuttal of Administrator's Response to Claimant's Request for Administrative Review" from Dr. M. Dr. M's rebuttal referred to the Claims Administrator's response to the Applicant's claim and stated:

> This response leans heavily on the opinions of a qualified independent medical examiner, [Dr. C]. I believe [Dr. C's] findings are not consistent with the medical literature on CIRS (chronic inflammatory response syndrome), are not consistent

> with the scientific and medical literature on mold-based illnesses, not consistent with the principles of evidence-based medicine and wholly inaccurate. If [the Claims Administrator] refuses to accept the CIRS diagnosis, I will offer the other 14 diagnoses I have made for him, all of which are supported by ICD-10 codes and all are supported by the mold-based medical literature. I ask [the Claims Administrator] to reverse their position and recommendations regarding [the Applicant].

68. On 23 March 2023, the ARP issued its decision. The ARP was composed of an HR Specialist, Compensation and Benefits; a Manager, Occupational Health and Safety Unit of HSDDR; and a Senior Operations Officer, a Staff Association Representative.

69. The ARP found that "there is insufficient compelling evidence to overturn the decision of the Claims Administrator" and affirmed the Claims Administrator's denial of the Applicant's requests, finding that "the treatment received and associated travel was not reasonable in the context of the accepted illness/injury." In its decision, the ARP "expressly affirm[ed] that [the Applicant] has a compensable workers' compensation claim" and stated that "this decision does not impact his right to seek coverage for reasonable, necessary and causally related medical treatment."

70. On 13 November 2023, the Applicant filed this Application with the Tribunal. In his Application, the Applicant states that he is contesting the following:

> The World Bank's denial of coverage for medical treatment obtained by [the Applicant] from October 5, 2020 to the present, and the Administrative Review Panel decision of March 23, 2023.

71. With respect to relief, the Applicant states that he

> requests the Tribunal to order reimbursement for [the Applicant's] out-of-pocket medical, travel, lodging, and per diem expenses, totaling: $107,156.76. The Applicant further seeks compensation for moral and/or intangible injuries in an amount the Tribunal deems appropriate.

72. The Applicant further requests

> the Tribunal to order the Bank and/or [the Claims Administrator] to authorize [the Applicant] to receive treatment for his approved Workers' Compensation claim, "Respiratory difficulties secondary to mold exposure in the workplace", from [Dr. B] of the Maharishi Ayurvedic Health Center in Seelisberg, Switzerland, from [Dr. T] of Rezilir Health in Hollywood, Florida and [Dr. M] of Whole World Health Care in Roswell, New Mexico until such time as there is a medical determination that such treatment may safely cease.

73. The Applicant requests legal fees and costs in the amount of $56,275.95.

SUMMARY OF THE CONTENTIONS OF THE PARTIES

The Applicant's Main Contention

74. The Applicant's main claim is that there were delays, denials, and negligence with respect to the handling of his claim for workers' compensation which violated the Principles of Staff Employment, the Staff Rules, and the Workers' Compensation Program Claims and Appeals Procedures. He asserts that the totality of the Bank's mistreatment of him violated these rules by interfering with his "right to reasonable medical care, to be treated by the doctor of his choice, to advance payment or timely reimbursement, and to guidance in navigating the program and to timely responses." The Applicant makes specific contentions with respect to "operative decisions and documents" from the Bank and the Claims Administrator, which he avers led to a flawed ARP decision.

The Applicant's Contention No. 1

The Claims Administrator ignored the deadline to respond to the Applicant's Workers' Compensation claim, initially improperly denied the claim, and neglected his treatment

75. The Applicant asserts that he submitted his claim for workers' compensation on 25 September 2020, and he contends that, pursuant to the Workers' Compensation Program – Claims Procedure, paragraph 4.05, the Claims Administrator had until 25 October 2020 to issue a determination regarding his claim. The Applicant submits that the Claims Administrator did not

issue a determination until 29 January 2021, and thus the Claims Administrator violated the Workers' Compensation Program – Claims Procedure.

76. In the Applicant's view, an interpretation of the 30-day deadline "which places no onus on the Claims Administrator to ensure a claim is deemed 'completed and documented' renders this mandate hollow." He avers that, while he submitted his claim for Workers' Compensation on 25 September 2020, he did not receive notice that more information was needed until 18 December 2020 due to delays attributable to the Claims Administrator. The Applicant submits that the Claims Administrator's delays were unreasonable and "added stress and anxiety to [the Applicant's] predicament from the organization that was supposed to be providing him with care."

77. With respect to the Claims Administrator's 29 January 2021 determination, the Applicant alleges that the Claims Administrator "first wrongly denied his claim without conducting a physical examination of him, without interviewing him and without investigating properly, if at all, the condition of the villa in Libya." The Applicant stresses that the initial denial forced him, "while sick, to prepare an appeal," and, in the Applicant's view, the Claims Administrator's ultimate 10 March 2021 approval of his claim "is an acknowledgment that it earlier erred in relying on [Dr. R's] inaccurate conclusions and in forcing [the Applicant] to arrange an appeal."

78. The Applicant further claims that he "was essentially abandoned by the Bank" while waiting on the claim decision, and he alleges that there was "no oversight of his condition and no interest in his wellbeing." The Applicant alleges that the Bank violated its obligation to act with fairness and to follow a proper process under Principle 2.1 of the Principles of Staff Employment in that the Claims Administrator acted unfairly with respect to its untimely response and initial denial, and the Applicant asserts that the Bank and the Claims Administrator "essentially had no process in place for assisting him or for ensuring open communication while awaiting the initial determination."

79. The Applicant also references the Workers' Compensation Program – Claims Procedure, paragraph 4.02, and asserts that the Claims Administrator did not request sufficient information, and did not properly assess the information it received, until the Applicant presented additional

information on appeal. The Applicant submits that, during the nearly six months when the Claims Administrator failed to approve his claim, "he was left entirely on his own in finding an appropriate doctor and in trusting that his doctor was providing an accurate diagnosis." The Applicant contends that during these months he "developed a strong trusting doctor-patient relationship with [Dr. F], [Dr. F] became familiar with [the Applicant's] condition, and continued treatment with [Dr. F] became the most reasonable and efficient course of action." To the Applicant, "the compilation of abandonment, delays, and mistreatment he endured from the Bank and the [Claims Administrator]" entitles him to relief.

The Bank's Response

The initial decision was within the prescribed time frame, and the Applicant was treated fairly

80. The Bank submits that the Applicant was treated respectfully, was accorded fair treatment, and received timely notice of decisions throughout the administration of his claim. To the Bank, the Claims Administrator and the ARP "acted responsibly and remained available for [the] Applicant throughout the entire process." The Bank submits that the record demonstrates that the ARP followed all applicable rules and provided the Applicant with every opportunity to submit information and documents, and shows that the Applicant was treated fairly by the Claims Administrator in its earlier review of his claim.

81. The Bank asserts that the Claims Administrator's initial denial of the Applicant's claim on 29 January 2021 was in compliance with the Workers' Compensation Program – Claims Procedure, paragraph 4.05. The Bank underscores that, pursuant to the Claims Procedure, "[t]he Claims Administrator will have 30 calendar days from the notification to the claimant of the receipt of **the completed and documented claim** to inform the claimant […] of the decision to approve or deny the claim," and the Bank submits that, as of 13 January 2021, the Claims Administrator was still seeking medical records from the Applicant. (Emphasis added by the Bank.) To the Bank therefore, the decision was within the 30-day period.

82. Further, the Bank submits that the Staff Rule allows the Claims Administrator flexibility to ensure that it can properly assess a claim without unfairly denying it for lack of documentation.

In the Bank's view, "it is evident that there was no deliberate intent to prolong the process," and the Bank avers that "[t]he efforts [the Claims Administrator] took demonstrate its commitment to accommodating [the] Applicant's requests and ensuring a thorough record prior to reaching a conclusive decision." Moreover, the Bank asserts that "the record shows that [the] Applicant himself is partially to blame for the delay." The Bank also submits that the Claims Administrator's 10 March 2021 reversal of its initial denial occurred within the 60-day time frame specified in the Workers' Compensation Program – Claims Procedure, paragraph 5.14, thus "underscoring the expeditious nature of the reconsideration process."

The Applicant's Contention No. 2

The Claims Administrator unfairly rejected the Applicant's request for reconsideration regarding Ayurvedic treatment, relied upon an erroneous Utilization Review, and violated the Workers' Compensation Program Claims Procedure by closing his appeal

83. The Applicant submits that, in October 2021, due to the intensification of his illness, Dr. F determined that urgent Ayurvedic detoxification was necessary; and the Applicant submits that, while Dr. F urged that the "treatment must be carried out as soon as possible," the Claims Administrator "summarily dismissed the claim."

84. The Applicant notes his 10 January 2022 appeal of the Claims Administrator's denial of his request for Ayurvedic treatment and the Claims Administrator's further denial of 27 January 2022, and submits that, with respect to the Utilization Review relied upon by the Claims Administrator, Dr. I never met him and "erroneously applied U.S. FDA standards to a clinic in Switzerland." The Applicant states that Ayurvedic treatment is recognized internationally, and further claims that Dr. I "disregarded the fact that [the Applicant] had been severely ill upon entering the clinic in October 2021 and achieved as much improvement in two weeks there as he had the prior 12 months with [Dr. F]."

85. The Applicant contends that the Utilization Review "presumption that approval by the U.S. FDA is a base standard, is faulty, unfairly applies a U.S.-centric approach, and disregards the international character of the Bank." To the Applicant, "[t]he basic unfairness and lack of proper

process in holding non-U.S. providers to FDA standards violates Bank Staff Principle 2.1 and demonstrates a bias in favor of U.S. standards," and he submits that the Utilization Review finding that the Ayurvedic treatment was not "medically necessary" should be disregarded to the extent it was reached using U.S. FDA standards. To the Applicant, this reliance on U.S. standards "is a radical position on behalf of the Bank" and is not supported by the Staff Rules. The Applicant further alleges that the Claims Administrator has approved other staff members for Ayurvedic treatments and, invoking Principle 2.1 of the Principles of Staff Employment, asserts that such differentiation between staff must be justified.

86. Finally, with respect to his ARP appeal of the Claims Administrator's 27 January 2022 decision, the Applicant states that, "in early May 2022, without a formal response from [the Claims Administrator], the Bank intervened and reimbursed [the Applicant] for the October 2021 treatment"; and he avers that the unilateral closing of his appeal, without notice, violated Principle 2.1 of the Principles of Staff Employment and the Workers' Compensation Program's Claims and Appeal procedures regarding deadlines and entitlement to a response.

The Bank's Response

The Applicant failed to comply with established procedures regarding requests for treatments, and the Bank's use of U.S. law was not unreasonable

87. The Bank contends that the Applicant was advised that some of the treatments he sought were not compensable and that, accordingly, he would not be reimbursed. The Bank submits that the Applicant still underwent these treatments for which he now seeks reimbursement and, further, that the Applicant failed to follow applicable procedures. Moreover, the Bank states that the Claims Administrator has not previously approved Ayurvedic treatment for respiratory difficulties secondary to mold exposure in the workplace.

88. In the Bank's view, "[d]espite numerous oral and written reminders from both the Bank and [the Claims Administrator], underscoring the imperative to adhere to established procedures, [the] Applicant persisted in seeking medical care without prior authorization, and [in] some instances, knowingly pursued treatment that had been denied." The Bank submits that "[t]his was

particularly disconcerting in instances where [the] Applicant embarked on journeys to consult with physicians of his own selection in Switzerland, Florida, and New Mexico." To the Bank, the "Applicant's constant failure to obtain prior approval for medical treatment, as required by Staff Rule 6.11, paragraph 6.02, and despite numerous reminders, resulted in the denial of reimbursement for some of the treatments of [the] Applicant's own selection"; and the Bank emphasizes that the "Applicant cannot continue seeking specific treatments without proper authorization."

89. In response to the Applicant's position that the Claims Administrator's use of U.S. standards is problematic, the Bank avers that Staff Rule 6.11, paragraph 3.01, "directs the application of the law of the District of Columbia to determine whether an illness arises out of and in the course of employment" and thus precludes the application of medical practice standards other than those endorsed by the U.S. FDA. With respect to the use of U.S. law, the Bank states that "using the jurisdiction where most staff are located, and applying the standards used there, […] allows for the use of a consistent methodology throughout the Bank, including in certain locations where worker[s'] compensation may be more limited, or not even exist."

90. Moreover, the Bank notes that, while the Applicant submits that Ayurvedic treatment is covered in Switzerland, this treatment is not covered in other countries such as Canada, which the Bank notes is "one of [the] Applicant's countries of nationality," and that, in fact, a warning has been issued in Canada with respect to "certain Ayurvedic medicinal products." To the Bank, whether or not some jurisdictions may be more favorable, it is not unreasonable or prohibited for the Bank to have selected D.C. law as that applicable to the workers' compensation framework in this case. The Bank submits, "It is not [the] Applicant's prerogative to second guess the rationale of why one jurisdiction was chosen over another, nor is it the Tribunal['s] authority to review [the Bank's] policy."

The Applicant's Contention No. 3

The ARP's decision was conclusory, relied upon Utilization Reviews and an "expert" report that are erroneous, and failed to consider the Applicant's reply and the evidence of recovery from his treating physicians

91. The Applicant contests the Claims Administrator's adoption of a mechanism based on D.C. law to determine the reasonableness of his medical costs as well as the Utilization Reviews and expert report. The Applicant contends that "the determination of reasonability by [the Claims Administrator] and its doctors was based on flawed methodologies, lacked transparency, and failed to comport with the governing authority contained in the Staff Principles, Staff Rules, and Workers' Compensation Program." He further avers that the ARP summarily affirmed the Claims Administrator's denial of his claim "by reflexively and sweepingly deferring to the reports of [the Claims Administrator's] doctors," and he claims that, in this way, the ARP adopted "all the errors therein, while simultaneously disregarding the reports of [the Applicant's] doctors and failing to resolve or acknowledge the discrepancies between the two." In the Applicant's view, the ARP decision cannot be reasonably sustained.

The Claims Administrator's 4 November 2022 Response

92. With reference to the Claims Administrator's 4 November 2022 response to his 30 September 2022 appeal to the ARP, the Applicant notes that the Claims Administrator invoked Section 32-1507 of the D.C. Workers' Compensation Act. The Applicant submits that Staff Rule 6.11 does not specifically incorporate this section and, as such, it does not formally apply. Additionally, the Applicant asserts that, because the Claims Administrator invoked Section 32-1507, "it should be held to that standard."

93. The Applicant submits that, "[w]hile the [ARP] 'may' assign more weight to the Claim[s] Administrator's chosen doctors, any such balancing process must still be reasonable." The Applicant contends that the Claims Administrator's reviews were not IMEs but were instead "merely document reviews." He further contends that he submitted reports from four doctors and underscores that three of them had physically examined him while the fourth met him by

videoconference. The Applicant alleges that the Claims Administrator's doctors did not communicate with him and that, while he attended numerous appointments with his doctors, he had no contact from the Claims Administrator's doctors. The Applicant further submits that all of his doctors were retained for actual treatment before his request for reconsideration or appeal to the ARP while the Claims Administrator retained its doctors solely for the purpose of litigation.

94. Moreover, the Applicant submits that the Claims Administrator relied on D.C. law with respect to the Utilization Review, and, citing case law, the Applicant avers that "D.C. law demonstrates a clear preference for according greater weight to the doctor who has physically examined the claimant and treated him or her the longest." He notes that Dr. F, Dr. B, Dr. T, and Dr. M have examined and treated him over several years and submits that this is in contrast to Dr. I and Dr. C who never met the Applicant.

95. Further, the Applicant submits that he "repeatedly asked for assistance from the Bank in developing an overall plan for his treatment, in locating a mold specialist in North America, for advance approval for his initial and follow up visits to his treating doctors, and for responses to his requests for reconsideration and appeals to the ARP." The Applicant claims that "[i]n many instances weeks or months passed with no definitive response from the Bank or [the Claims Administrator]," and that this required him "to act on his own to secure urgent care for his illness." To the Applicant, under Section 32-1507(d) of the D.C. Act as well as in the interest of logic and fairness, negligence on the part of the Claims Administrator or the need for immediate treatment due to the nature of the illness suggests that the claimant should not be penalized and is in fact "entitled to recover any amount expended for the treatment."

96. The Applicant also takes issue with the report from Dr. C relied upon by the Claims Administrator in that, according to the Applicant, it questions his initial compensable injury of "respiratory difficulties secondary to mold exposure in the workplace," which the Applicant states was not in issue on appeal to the ARP. The Applicant asserts that Dr. C's "entire report is tainted by the failure to begin his analysis from the perspective that [the Applicant's] illness is '[r]espiratory difficulties secondary to mold exposure in the workplace.'"

97. The Applicant states that, with respect to his CIRS diagnosis and treatment, the Claims Administrator relies on Dr. I's Utilization Review, which refers to the Applicant as having "asthma" and which the Applicant submits is "unsupported by any physical examination," and on Dr. C's report, which the Applicant considers "particularly suspect," to deny his claim. He notes that these reports recommend treatment with a pulmonologist or allergist, but, to the Applicant, the recommendations are "flatly contradicted" by Dr. F, "who wrote that by September 2022 he had essentially exhausted his options as a pulmonologist and that [the Applicant] should see a mold specialist."

98. The Applicant submits that Dr. C is unwarranted in questioning the Applicant's credibility and whether the Applicant was exposed to mold in Libya, and the Applicant stresses that the Claims Administrator has already approved his claim for "[r]espiratory difficulties secondary to mold exposure in the workplace." Further, the Applicant avers that Dr. I contradicts Dr. C's conclusion in that she found that office visits to Dr. T and Dr. M "*have been reasonable and medically necessary* per ODG criteria." (Emphasis added by the Applicant.) He further submits that Dr. R also found that the Applicant's treatments for mold infection were reasonable.

The ARP Decision

99. The Applicant contends that the ARP "issued a hasty three page decision which failed to distinguish or examine the myriad issues on appeal before it" and which shows none of the thoroughness or care the Bank claims. The Applicant submits that he "is entitled to know the decision-making process behind the denial of his claims," and, in this respect, he avers that the ARP decision does not meet the requirements of the Workers' Compensation Program – Appeals Procedure, paragraph 4.07. He contends that, "[d]ue to the vagueness of the ARP Decision, the Tribunal should not afford it the deference requested by the Bank." Moreover, the Applicant submits that, in deferring to the Utilization Reviews and "expert" report, the ARP "incorporated all of their errors to its own decision."

100. The Applicant submits that, while the ARP found that the Applicant failed to obtain prior authorization from the Claims Administrator for the treatments in question, prior authorization is

not required under Staff Rule 6.11 and not obtaining prior approval "is not by itself grounds to deny an otherwise valid claim." The Applicant states that, although he did not always have prior authorization, he attended treatments because he "believed it prudent and necessary to follow the advice of his doctors and feared deferring treatment could result in deterioration of his health or be life threatening." He avers that "claims may still only be denied where they are found to be 'unnecessary or unrelated to the covered condition,'" and he submits that requesting and obtaining prior approval is not always possible.

101. The Applicant reiterates that "a claimant cannot be faulted where the Administrator takes an unreasonably long time to respond or fails to respond, especially where urgent appointments are needed." He submits that, while he informed the Bank on 15 October 2021 that he required a mold specialist in North America and the Bank agreed to assist him, it did not respond until January 2022. He submits that this "promise of assistance and failure to follow up" with his worsening condition violated Principle 2.1 of the Principles of Staff Employment.

102. The Applicant further takes issue with the ARP decision and asserts that "the ARP performed no analysis of Dr. F's diagnosis and treatments." To the Applicant, "[t]he reasonableness and necessity of [the Applicant's] subsequent treatments cannot be properly assessed by detaching them from his first 12 months of treatment […] by [Dr. F]." He submits that the Utilization Reviews and expert report recommendation to see a pulmonologist ignore the fact that he saw a pulmonologist for over a year who recommended additional specialists.

103. The Applicant next contends that the ARP "summarily rejected" all of his claims for Ayurvedic treatment. He contends that the ARP did not address the fact that his first such treatment had been approved and paid for by the Bank, and further did not address that Dr. I, who opined that the treatment was not medically reasonable for the Applicant's condition, had not met the Applicant and had performed a document review and improperly applied U.S. FDA standards. He stresses that, while the treatments were endorsed by his four doctors, the ARP "inexplicably defers to just one doctor […] to find the treatment unreasonable." Further, the Applicant stresses that "the reality is that the Ayurvedic treatment was immensely helpful in restoring [the Applicant] to health."

104. With respect to his diagnosis of CIRS, the Applicant asserts that the ARP failed to address that his first two months of treatment with Dr. T had been approved, and that the treatments from Dr. T and Dr. M "had been largely successful" and were endorsed by Dr. F and each other. He emphasizes that Dr. I found the visits "reasonable and necessary" and claims that the ARP ignored this. To the Applicant, "[a]s [the Applicant's] respiratory illness *was related* to mold in the workplace, and the treatments *were found reasonable* for the symptoms, the claims should be approved." (Emphasis in original.)

105. In the Applicant's view, the ARP accords more weight to the Claims Administrator's doctors but does not explain why such deference is deserved. He submits that "deference is not warranted where the claimant's doctor is a specialist in the relevant field, has treated the claimant for months or years, and where such treatment was successful, while none of the foregoing can be said about the Claims Administrator's doctors." The Applicant asserts that "[t]he ARP's inexplicable crediting of [Dr. I] and [Dr. C] was unreasonable and flatly contradicts the caselaw under the D.C. Act […], that greater weight is to be according to the treating physician." The Applicant asserts that the ARP is entitled to accord greater weight to one doctor over another, but he contends that the ARP's methodology for doing such should be reasonable and consistent. He avers that "[t]he ARP provides no rationale whatsoever, and thus its decision cannot be reasonably sustained." Additionally, the Applicant contends that, to the extent that it was tainted by adopting the findings of doctors who did not accept that the Applicant already had an approved claim based on exposure to mold, the ARP decision should not stand.

106. With respect to the 11 January 2022 email from the HR Specialist providing a list of three potential doctors for the Applicant, the Applicant submits that this email "was merely an offer of assistance," and the Applicant avers that "the Bank never put [him] on notice that there could be any detrimental consequences to his not meeting with one of those three specific doctors." The Applicant states that he "*declined* the Bank's offer of a favor, he did not *refuse* to attend a mandatory examination." (Emphasis in original.)

107. To the Applicant, the ARP decision, either directly or by its adoption of the Claims Administrator's underlying processes, violated Principle 2.1, Staff Rule 6.11, and the Workers'

Compensation Claims and Appeals Procedures. The Applicant submits that "it is particularly troubling" that the Bank questions the Applicant's integrity with respect to cooperating and with respect to submitting requests for treatment and reimbursement. The Applicant submits a character reference from a Bank Corporate Security Manager, dated 8 March 2024, in support. The Applicant avers that

> each time [he] sought treatment, even if it involved travel from Morocco to France, France to Switzerland, or Canada to Florida, it was because he earnestly believed his life was in danger from the mold infection, and not in pursuit of superfluous medical treatments or experimental treatments for the sake of experiment, as the Bank suggests.

108. The Applicant asserts that he "never refused to cooperate in any way," and he contends that he "should not be faulted merely for not being able to immediately respond to all emails." He submits that he requested assistance in navigating the Claims Administrator's bureaucracy which involved over twenty individuals.

109. Finally, the Applicant submits that the Bank's accounting of his claims does not demonstrate that he was reimbursed for all of his out-of-pocket expenses. He claims that he has not been reimbursed for treatments with Dr. M commencing in July 2022, for his treatment with Dr. B in April 2023, or for other expenses beyond April 2022. With respect to "related expenses – travel, accommodation, and per diem allowance," the Applicant states that he "seeks reasonable reimbursement based on the events well documented" in his Application, and that he "seeks approval for continued treatment as needed with his doctors."

The Bank's Response

The ARP decision was reasonable and based on the evidence

110. The Bank asserts that the main question before the Tribunal is whether the ARP decision was reasonable, based on the evidence before the ARP. The Bank submits that it was. The Bank avers that the ARP's reliance on one set of facts over another does not render its decision unreasonable, and the Bank highlights that, pursuant to Tribunal precedent, it is not unreasonable for the ARP to assign more weight to the Claims Administrator's doctors. The Bank cites *J,*

Decision No. 349 [2006], para. 35, and submits that the reviews by Dr. I and Dr. C were the kind of "independent reviews" which the Tribunal has found may reasonably be accorded greater weight in instances of doubt or uncertainty. The Bank states that, "[w]hile it is not unusual for the Claims Administrator to seek an IME in workers' compensation claims, the Claims Administrator elected instead for peer review/independent review."

111. The Bank submits that the ARP decision was based not on weighing the opinion of one doctor versus another but instead on the diagnosis and treatment advanced by the doctors. The Bank avers that the "Applicant refused to consult with any of the recommended specialists instead insisting on only consulting physicians of his choice." To the Bank, the

> Applicant's refusal to see any of the doctors recommended by the Claim's Administrator, specialists in their respective fields (and similar specialty to [the] Applicant's original treating physician [Dr. F], namely a pulmonologist), deprived the Claims Administrator, and ultimately the ARP, of potentially valuable analysis which could have assisted the review.

Additionally, the Bank submits that Dr. M is a pediatrician who later received a certificate from Dr. Shoemaker in CIRS while Dr. C "is an internationally recognized expert in Respiratory Environmental Medicine, Plant and Indoor Environmental Quality, Risk Communication and Medical Advisory Services." To the Bank, "[i]t is difficult to accept [the] Applicant's position that [Dr. M] was more qualified than [the Claims Administrator's] doctors when the only relevant 'certification' [Dr. M] has is in an area where no board certification exists."

112. With respect to the ARP's review and decision, the Bank submits that the ARP observed that the Applicant sought treatment with various physicians of his own choosing, and, further, the Bank submits that the ARP "meticulously examined" the documentation from the Claims Administrator. The Bank avers that the ARP consulted an "external medical consultant" and incorporated insights from this independent physician, who the Bank states practices as an occupational physician in the D.C. metro area, as well as insights from the HSD staff member who served on the ARP. The Bank contends that "[a]dditional diagnoses and treatments beyond the initial respiratory presentation were not generally considered medically acceptable among the

present physicians," and the Bank submits that this determination was "consistent with the medical experts engaged by [the Claims Administrator] for independent review."

113. The Bank avers that Peer-to-Peer Review is allowed pursuant to WBG Procedure, Staff Procedure: Information Used to Determine Eligibility for Disability Insurance Programs, Section 3.07. The Bank claims, however, that the Applicant's doctor, Dr. T, was not available for Peer-to-Peer Review "despite several attempts to communicate with him." The Bank submits that, as a result of Dr. T's unavailability, the Claims Administrator transmitted written inquiries to Dr. T, seeking clarification on its primary concern of whether the administered treatments were substantiated by medical evidence. The Bank submits that Dr. T did not provide a diagnosis code for CIRS, as one does not exist, and further that Dr. T did not answer the question of whether the Applicant's current treatment plan was related to the original reported exposure and "simply provided a list of suggested treatment."

114. The Bank further asserts that the ARP consulted with the administrators of the Bank's medical insurance plans regarding the CIRS diagnosis and treatment requests, and the Bank claims that the administrators confirmed that "CIRS is not a recognized disease by any major professional." The Bank submits further that its medical insurance providers exclude Ayurvedic medicine from the policies because it is considered experimental and not medically necessary.

115. Further, the Bank takes issue with the Applicant's claim that the Claims Administrator's doctor, Dr. R, found the Applicant's treatment to be "reasonable." The Bank avers that the reimbursement of an expense requires that it be reasonable and that it be causally linked to the injury, illness, or death as approved by the Claims Administrator. The Bank notes that Dr. R stated, "[W]hile the current recommended treatment is reasonable, **it is unrelated to the reported workplace even[t]**." (Emphasis added by the Bank.)

116. With respect to the Applicant's contentions regarding the D.C. Act, the Bank asserts that the Applicant is "misguided." Specifically, the Bank avers that the issues of causally related costs and of the use of Utilization Reviews are separate issues which cannot be linked together. Further, the Bank submits that the Applicant's claims of errors in the Claims Administrator's submission

to the ARP "are of no consequence" because the ARP decision makes no finding with respect to the applicability of the D.C. Act, and, further, the ARP decision makes no reference to the D.C. Act.

117. The Bank notes that the Applicant has been found to have a compensable illness, but the Bank avers that, pursuant to the Workers' Compensation Program – Claims Procedure, "[t]reatments must be: i) medically necessary, and ii) related to the compensable condition." The Bank submits that the Staff Rules do not provide the applicable standard of determining the reasonableness of medical expenses, and the Bank accepts that the Workers' Compensation Program – Claims Procedure, paragraph 5.02, does not explicitly incorporate the D.C. Act in the determination of the reasonableness standard. To the Bank, while the Workers' Compensation Program – Claims Procedure "does not explicitly state that the reasonableness standard of the D.C. Act is applicable, in absence of any such standard, it was reasonable for [the Claims Administrator] to apply the standard set out in the D.C. Act"; and the Bank cites *Courtney (No. 4)*, Decision No. 202 [1998], para. 14, to support this contention.

118. With reference to the ARP decision, the Bank submits that the requirements of the Workers' Compensation Program – Appeals Procedure, paragraph 4.07, are met in that the decision provides the reasons for the decision and, further, includes the background and procedural history of the matter as well as the Staff Rules relied upon. The Bank submits that the "ARP Decision clearly explains what documents it reviewed in order to make its determination," and the Bank avers that these included documents by the Applicant's treating physicians. The Bank maintains that the ARP decision was reasonable, noting:

> The thoroughness of the ARP's decision, citing to multiple physicians, evaluations and examinations, demonstrates the rigor and care with which it assessed [the] Applicant's claim for workers' compensation on the basis of the medical evidence presented. The ARP diligently reviewed the entirety of [the] Applicant's medical file, considered all medical information submitted to the Claims Administrator, and independently consulted with competent physician advisors and insurance providers, to ensure a comprehensive review of [the] Applicant's claim. Importantly, the ARP did not reject the compensability of [the] Applicant's workers' compensation claim, and explicitly affirmed that [the] Applicant had a compensable injury/illness, and this decision did not impact his right to seek coverage for reasonable, necessary and causally related medical treatment. The

> decision to deny reimbursement for specific treatments requested was grounded in the medical input received, rather than challenging the compensability of the claim itself.

119. Finally, with respect to the Applicant's claims for relief, the Bank submits that "it is incumbent upon [the] Applicant to fully substantiate his claim," and the Bank avers that the "Applicant does not 'show his work' as to how he arrives at his claim for $107,156.76 in unpaid expenses." Specifically, the Bank states that the

> Applicant requests the Tribunal to order [the Bank] to reimburse him for his out-of-pocket medical expenses accrued pursuant to his treatments by [Dr. F] (France), [Dr. B] (Switzerland), [Dr. T] (Florida), and [Dr. M] ([New Mexico]), however he does not provide a detailed account of what service he is seeking reimbursement, or when the service was completed and by whom. […] [The] Applicant further requests the payment of travel expenses, accommodation expenses, and a *per diem* allowance relating to his time in France, Switzerland, and Florida. While [the Claims Administrator] excluded some of the testing and treatment protocols [the] Applicant received in 2022, [the Bank] nonetheless reimbursed [the] Applicant's travel expenses, including hotel, car rental, *per diem*, and air travel to Florida.

120. The Bank asserts that most, if not all, of the claims by the Applicant have been paid either directly by the Claims Administrator "or by the *ex gratia* payment" in April 2022. The Bank submits that "[i]t is not enough for [the] Applicant to seek reimbursement for estimated expenses or approximations without providing some level of detail that [the Bank], as well as the Tribunal, can quantify." Further, the Bank alleges that the Applicant has chosen to submit invoices directly to the Tribunal rather than to the Claims Administrator and, further, contends that "[t]he Tribunal should disregard any claims that were not first submitted to [the Claims Administrator] and that are subsequent to the ARP Decision of March 23, 2023." Finally, the Bank contends that the Applicant's request that the Tribunal approve his continued treatment with his doctors as needed "is beyond the purview of the Tribunal and therefore should be denied."

THE TRIBUNAL'S ANALYSIS AND CONCLUSIONS

121. Pursuant to Staff Rule 6.11, paragraph 3.01, in place at the relevant time:

> The Claims Administrator will determine whether an injury, illness or death arises out of and in the course of employment and otherwise administer the workers' compensation program in accordance with the provisions of the D.C. Act specified in this Rule, except that where the provisions of this Rule differ from the provisions of the D.C. Act specified, the provisions of this Rule will govern. Provisions of the D.C. Act not specified in this Rule will not apply. Except for paragraph (d) in Section 32-1505 and paragraph (a) in Section 32-1506, where provisions of the D.C. Act specified in this Rule refer to the Mayor, this will be taken to mean the Claims Administrator.

122. Pursuant to Staff Rule 6.11, paragraph 4.01, in place at the relevant time:

> If a Staff Member's injury, illness or death is believed by a claimant to arise out of and in the course of employment, a claim for applicable workers' compensation benefits may be filed with the Claims Administrator by the Staff Member, a surviving spouse or Domestic Partner, a Child, or an appointed guardian. A claim must be filed with the Claims Administrator within the timeline provided in the Procedure, "Workers' Compensation Program – Claims Procedure."

123. Pursuant to the Staff Rules, the Applicant sought and was ultimately approved for workers' compensation benefits on 10 March 2021. The Claims Administrator concluded that the Applicant had a covered illness/injury of "[r]espiratory difficulties secondary to mold exposure in the workplace."

124. Pursuant to Staff Rule 6.11, paragraph 6.01, in place at the relevant time:

> When a claim has been determined to be compensable, the Claims Administrator will approve the appropriate course of medical treatment. The Bank Group will pay all reasonable medical, hospital, and medical rehabilitation costs causally related to the injury, illness, or death as approved by the Claims Administrator.

125. Further, pursuant to Staff Rule 6.11, paragraph 6.02, in place at the relevant time:

> A Staff Member must seek the authorization of the Claims Administrator prior to an anticipated change in the course of treatment by the treating physician to ensure such treatment is eligible for continued payment. A Staff Member must seek the prior approval of the Claims Administrator for any change of treating physician, either at his/her own initiative or by referral from the original treating physician. Failure to seek such prior authorizations may result in the denial of a subsequent claim if the Claims Administrator determines that the treatment is unnecessary or unrelated to the covered condition.

126. The Tribunal recalls that, on 11 October 2021, the Applicant sought approval from the Claims Administrator for treatment in Switzerland – Ayurvedic Detoxification Protocol – with Dr. B. His request was denied by the Claims Administrator on 14 October 2021 on the grounds that "[t]he medical documentation fails to establish a causal connection between the recommended treatment and the occupational illness/exposure to mold."

127. Pursuant to the Workers' Compensation Program – Claims Procedure, paragraph 5.12, in place at the relevant time:

> A claimant who wishes to contest the denial of a claim for workers' compensation benefits or a decision taken in connection with the administration of a compensable claim must request reconsideration of the decision by the Claims Administrator within 90 days of receiving notice of the decision.

128. In accordance with the above Staff Rule, on 10 January 2022, the Applicant requested that the Claims Administrator reconsider its denial of coverage for the treatment in Switzerland.

129. On 27 January 2022, the Claims Administrator rejected the reconsideration request from the Applicant with respect to the Ayurvedic Detoxification Protocol. It explained that, pursuant to section 32-1501 of the D.C. Workers' Compensation Act, the Applicant's medical records were submitted to Utilization Review which determined that the Ayurvedic Detoxification Protocol "is not medically recommended for treatment of [the Applicant's] condition."

130. Pursuant to the Workers' Compensation Program – Claims Procedure, paragraph 5.15, in place at the relevant time:

> If upon reconsideration, the Claims Administrator upholds the denial of the claim[,] the claimant may appeal to the Administrative Review Panel at the Bank Group.

131. On 31 March 2022, the Applicant filed an appeal with the ARP challenging the denial of reimbursement for the Ayurvedic Detoxification Protocol in Switzerland.

132. The record indicates that, in May 2022, even though the Applicant had not obtained prior approval, the Bank reimbursed the Applicant "*ex gratia*" and "on an exceptional basis" for the

Ayurvedic Detoxification Protocol treatment in Switzerland, as well as for the Applicant's treatments with Dr. T in Florida up to 6 April 2022. The Bank states that "[t]his reimbursement decision was made despite the deviation from the established pre-approval and reimbursement procedures, the non-contestation of payments for [Dr. T] in the [ARP] Appeal, and legitimate concerns raised by [the Claims Administrator] regarding [Dr. T's] bills." The Bank states that, as a result of this reimbursement, it deemed the Applicant's ARP appeal claim moot.

133. On 30 September 2022, the Applicant submitted a new appeal to the ARP, in which he challenged the Claims Administrator's 27 January 2022 decision regarding his request for reconsideration of benefits denied on 14 October 2021.

134. On 23 March 2023, the ARP issued its decision. The ARP "affirm[ed] the Claims Administrator's denial of [the Applicant's] requests as the treatment received and associated travel was not reasonable in the context of the accepted illness/injury." Cognizant that the reasonableness of the ARP decision is at issue, the Tribunal reproduces the relevant paragraphs in full here. The ARP decision stated:

> From 2020 to present, the [Applicant], who lives in Montreal, Canada, has sought the advice of various physicians and has traveled internationally to France, Switzerland, and locations in the United States to pursue medical evaluations, testing, and treatment for his condition, which he relates to the mold exposure. This present appeal concerns the Claims Administrator's denial of [the Applicant's] request for payment/reimbursement of medical expenses and associated travel costs. Specifically, [the Applicant] is seeking: 1) immediate approval of treatments prescribed by his specialist physicians and received by [the Applicant]; 2) approval of the treatments plan outlined by his treating physicians (Doctors [F, B, T, and M]); 3) that the Claims Administrator cease insisting on a pulmonologist as his treating physician; and 4) payment for all medical bills incurred including evaluations, exams and testing and associated travel and accommodations expenses. […]
>
> This Panel reviewed all documents submitted by [the Applicant] and the Claims Administrator regarding his medical condition. The Panel convened on four (4) separate occasions – January 12, 2023, January 19, 2023, January 26, 2023 and February 7, 2023 – to consider the parties' submissions and reach this decision. […]
>
> There is no indication in the record reviewed by this Panel that [the Applicant] received the Claims Administrator's prior authorization for the treatment at issue.

> The Panel reviewed the documentation provided by [the Applicant] and the Claims Administrator. [The Applicant] provided documentation related to his condition, and, has treated with several physicians. He has identified [Dr. F], a physician in France, as his treating pulmonologist. He has also come under the care of [Dr. T] (from Rexilir [*sic*] Health in Florida), [Dr. B] (from Maharishi Ayurveda Health Centre in Switzerland), and [Dr. M] (from Whole World Care PC in New Mexico). As per the documentation provided, his initial diagnosis was of mild asthma, gastroesophageal reflux disease, and possible allergies by pulmonologist [Dr. F]. Internist [Dr. T] subsequently diagnosed him with chronic inflammatory response syndrome (CIRS).
>
> The Claims Administrator has identified fundamental concerns as to the reasonableness of the testing, evaluations, diagnoses and treatment received and recommended, and the associated costs with international travel, in the context of the accepted illness/injury and follow-on methodology utilized by [the Applicant's] treating physicians. On January 22, 2022, the Claims Administrator obtained a utilization review (UR) addressing [the Applicant's] request for Ayurvedic medicine in Switzerland. The UR physician opined that Ayurvedic medicine lacks quality peer review studies on treatment of mold exposure to improve the accepted condition. In light of these considerations, the UR physician opined that due to lack of recommendation from evidence-based medicine guidelines or evidence from high quality studies, the recommended or requested health care service (Ayurvedic Detoxification Protocol) is not seen as medically reasonable for [the Applicant's] condition. Further, the Claims Administrator arranged an independent record review of [the Applicant's] medical records by occupational/environmental physician, [Dr. C]. The Panel notes that [Dr. C] did not examine [the Applicant]. In the report dated September 29, 2022, [Dr. C] identified that "CIRS is not an accepted diagnosis according to the National Center of Health Statistics (NCHS)," and that many of the tests conducted in order to reach this diagnosis have not "been approved by the FDA and are generally not accepted by the scientific community for diagnosis and/or treatment of mold, mycotoxin…"
>
> This Panel has considered [the Applicant's] claim carefully with input from an external medical consultant and sought advice on what would be covered from the WBG health insurance plans for staff seeking medical treatment for the diagnosed conditions including on travel supported for such treatment. Based on the totality of the record, this Panel finds that there is insufficient compelling evidence to overturn the decision of the Claims Administrator.

135. Pursuant to Staff Rule 6.11, paragraph 13.02, in place at the relevant time:

> If a claimant, after receiving the final decision of the Administrative Review Panel, […] wishes to pursue his/her complaint further, the claimant may then file an appeal with the World Bank Administrative Tribunal in accordance with the provisions of Staff Rule 9.05, "The World Bank Administrative Tribunal."

136. Accordingly, the Applicant has appealed the ARP's decision to the Tribunal.

137. As the Tribunal stated in *Chhabra (No. 2)*, Decision No.193 [1998], para. 7:

> The task of this Tribunal is limited to reviewing the decision of the [Administrative] Review Panel, by reference to the evidence before that body, with a view to determining whether the conclusion reached by the [Administrative] Review Panel could be reasonably sustained on the basis of that evidence and also whether the [Administrative] Review Panel has acted in accordance with the relevant legal rules and procedural requirements.

See also GJ (No.2), Decision No. 692 [2023], para. 97; *ER (No.3) (Merits)*, Decision No. 656 [2021], para. 62; *FM (Merits)*, Decision No. 643 [2020], para. 133.

138. The Tribunal will determine whether the ARP's denial of the Applicant's claim for benefits could be reasonably sustained in light of the evidence before it and, further, whether the ARP acted in accordance with the relevant legal rules and procedural requirements.

WHETHER THE ARP'S DECISION TO DENY THE APPLICANT'S CLAIM FOR BENEFITS IS REASONABLY SUSTAINABLE

139. The Tribunal recalls that, pursuant to Staff Rule 6.11, paragraph 6.01, once a claim is deemed compensable, it is the Claims Administrator that "will approve the appropriate course of medical treatment." The Tribunal observes that, pursuant to this rule, the Bank pays "all reasonable medical, hospital, and medical rehabilitation costs causally related to the injury, illness, or death as approved by the Claims Administrator."

140. Pursuant to the Workers' Compensation Program – Claims Procedure, paragraph 5.01, in place at the relevant time:

> The Staff Member has the right to select an attending physician, as well as other medical services providers to carry out the appropriate medical treatment, subject to the approval of the Claims Administrator.

141. Pursuant to the Workers' Compensation Program – Claims Procedure, paragraph 5.02, in place at the relevant time:

> When an appropriate course of medical treatment has been approved by the Claims Administrator, the Bank Group will cover all reasonable medical, hospital, laboratory, and therapy expenses associated with the approved treatment. To that end, the claimant must complete and submit a Workers' Compensation Medical Claim Form, which may be obtained from the Claims Administrator or from the Bank Group via the link provided.

142. And pursuant to Workers' Compensation Program – Claims Procedure, paragraph 5.06, in place at the relevant time:

> The Claims Administrator will review all claims for medical expenses and will have the authority to reject any expenses that do not comply with the approved treatment plan or are not deemed to be necessary and related to the compensable condition. The Claims Administrator may also authorize reimbursement on a provisional basis subject to further review. Claimants may appeal rejection of a medical expense claim in accordance with the Procedure, "Workers' Compensation Program – Appeals Procedure."

143. The Tribunal recalls that the Applicant's claim was stated as follows in the ARP decision:

> This present appeal concerns the Claims Administrator's denial of [the Applicant's] request for payment/reimbursement of medical expenses and associated travel costs. Specifically, [the Applicant] is seeking: 1) immediate approval of treatments prescribed by his specialist physicians and received by [the Applicant]; 2) approval of the treatments plan outlined by his treating physicians (Doctors [F, B, T, and M]); 3) that the Claims Administrator cease insisting on a pulmonologist as his treating physician; and 4) payment for all medical bills incurred including evaluations, exams and testing and associated travel and accommodations expenses.

144. The Tribunal first observes that the ARP noted in its decision that "[t]here is no indication in the record reviewed by this Panel that [the Applicant] received the Claims Administrator's prior authorization for the treatment at issue."

145. The Tribunal recalls that, pursuant to Staff Rule 6.11, paragraph 6.02, staff members "must seek" the Claims Administrator's prior approval "for any change of treating physician, either at his/her own initiative or by referral from the original treating physician." As stipulated in Staff

Rule 6.11, paragraph 6.02, "[f]ailure to seek such prior authorizations may result in the denial of a subsequent claim if the Claims Administrator determines that the treatment is unnecessary or unrelated to the covered condition."

146. The Tribunal notes that the Applicant did not obtain prior authorization for the treatments in question. The language of Staff Rule 6.11, paragraph 6.02, indicates that a claim "may" be denied if prior authorization has not been sought "if the Claims Administrator determines that the treatment is unnecessary or unrelated to the covered condition." The Tribunal considers that prior authorization procedures are important to the fair and efficient management of a system that supports the collective needs of many staff members. The Bank may elect to pay a claim for which prior authorization was not sought, but this does not make seeking prior authorization optional.

147. The Tribunal next observes that the ARP stated that it "reviewed all documents submitted by [the Applicant] and the Claims Administrator." In addition to noting the Applicant's physicians – Dr. F, Dr. T, Dr. B, and Dr. M – the ARP noted the Utilization Review of 22 January 2022 by Dr. I, which the Claims Administrator had obtained in relation to the Applicant's request for Ayurvedic treatment and which found that the proposed treatment was not medically reasonable for the Applicant's condition. Further, the ARP referenced the 29 September 2022 "independent record review" of the Applicant's medical records by Dr. C, which had been sought by the Claims Administrator and submitted with its 4 November 2022 response to the Applicant's ARP appeal. Moreover, the ARP decision stated that it received "input from an external medical consultant" in considering the Applicant's claim.

148. The Tribunal considers that it is the Applicant's main position that the ARP decision cannot be reasonably sustained because it "sweepingly defer[s]" to the reports of the Claims Administrator's doctors while disregarding the reports of the Applicant's own doctors. The Applicant asserts that the ARP fails to reconcile the discrepancies between the two sets of doctors, and fails to explain its rationale for according more weight to the Claims Administrator's doctors than to his own treating physicians.

149. Pursuant to Workers' Compensation Program – Claims Procedure, paragraph 5.08, in place at the relevant time:

> The Claims Administrator may require the claimant to undergo an Independent Medical Examination (IME) at any time deemed necessary during the treatment period.

150. The Tribunal recalls that in *J* [2006], para. 35, the Tribunal stated:

> The opinion of personal physicians may be valuable, but in case of doubt or uncertainty those of independent medical examiners may reasonably be assigned more weight in view of the fact that under Staff Rule 6.11, paras. 3.02 and 3.03, it is the Claims Administrator's function, in deciding whether a claim is compensable or continues to be compensable, to select a medical examiner to help make its assessment.

See also FS (Preliminary Objection), Decision No. 640 [2020], para. 62.

151. The Tribunal notes that the Bank submits that the reviews by Dr. I and Dr. C were "independent reviews" in the nature envisioned by the Tribunal in *J* [2006], para. 35, which may reasonably be assigned more weight in instances of doubt or uncertainty; and the Bank explains that, at the relevant time, there was a moratorium on Independent Medical Examinations.

152. The Tribunal recalls that in *BI (No.2)*, Decision No. 445 [2010], para. 30, it explained that

> the Claims Administrator's role is not merely to undertake a passive review of the evidence adduced by a claimant. The Claims Administrator bears the responsibility of making the necessary "investigations," through such affirmative means as engagement of independent medical examiners, to assist it in arriving at a determination of the compensability of a claim.

153. The Tribunal considers that, in light of the moratorium on Independent Medical Examinations, the Claims Administrator acted appropriately in obtaining reviews by Dr. I and Dr. C in the context of clarifying, understanding, and assessing the Applicant's claim for medical expenses and in responding to his related appeals of these claims.

154. Further, with respect to the Utilization Review by Dr. I, the Tribunal recalls that in *Courtney (No. 4)* [1998], para. 14, the Tribunal determined that it would apply provisions of D.C. law which "the parties have treated […] as applicable" and "because those provisions embody principles that are manifestly reasonable." The Tribunal has also previously declined to incorporate certain aspects of D.C. workers' compensation law into the Tribunal's jurisprudence. *See ER (No. 3) (Merits)* [2021], para. 66; *Hasselback*, Decision No. 364 [2007], para. 50. On the facts of the instant case, and recalling that "[t]he Claims Administrator bears the responsibility of making the necessary 'investigations,' through […] affirmative means" (*BI (No.2)* [2010], para. 30), the Tribunal finds that the Claims Administrator's adoption of the concept of Utilization Review from D.C. law was reasonable; and the Tribunal observes that the ARP decision, though citing the Utilization Review findings, does not make any specific reference to the D.C. Act or its applicability.

155. The Tribunal considers that it is clear from the ARP decision that the Panel accorded more weight to the perspectives of Dr. I and Dr. C than to the Applicant's various doctors in reaching its decision. In line with the standard articulated in *J* [2006], para. 35, the Tribunal will determine whether the ARP did so "reasonably." *See also GJ (No. 2)* [2023], para. 107.

156. The Tribunal observes that, although the ARP decision states that it reviewed the medical documentation provided by the Applicant, it does not expound upon or engage with the perspectives of the Applicant's physicians other than stating that the Applicant's "initial diagnosis was of mild asthma, gastroesophageal reflux disease, and possible allergies by pulmonologist [Dr. F]. Internist [Dr. T] subsequently diagnosed him with chronic inflammatory response syndrome (CIRS)."

157. The Tribunal considers that the lack of discussion in the ARP decision related to its analysis of the opinions of the Applicant's physicians as against those of the Claims Administrator could create the impression that the opinions of the Applicant's physicians were not properly considered in the ARP's review as the Applicant suggests. However, the Tribunal is not persuaded that this is the case. The Tribunal observes that the ARP's use of the opinion of Dr. I is tailored to determining the medical reasonableness of the requested Ayurvedic treatment which was recommended by Dr.

F and carried out by Dr. B. The Tribunal also observes that the ARP acknowledges the Applicant's diagnosis of CIRS by Dr. T, and that the independent record review from Dr. C provides an opinion as to the CIRS diagnosis which the ARP references in its decision.

158. More specifically, the Tribunal observes that the ARP decision states that Dr. I "opined that Ayurvedic medicine lacks quality peer review studies on treatment of mold exposure to improve the accepted condition," and further states that Dr. I "opined that due to lack of recommendation from evidence-based medicine guidelines or evidence from high quality studies, the recommended or requested health care service (Ayurvedic Detoxification Protocol) is not seen as medically reasonable for [the Applicant's] condition." Further, the ARP decision states that "[Dr. C] identified that 'CIRS is not an accepted diagnosis according to the National Center of Health Statistics (NCHS)'" and that diagnostic tests related to CIRS have not been FDA-approved and "are generally not accepted by the scientific community for diagnosis and/or treatment of mold, mycotoxin."

159. The Tribunal is of the view that the opinions of Dr. I that Ayurvedic medicine "lacks quality peer review studies on treatment of mold exposure to improve the accepted condition" and of Dr. C that "CIRS is not an accepted diagnosis according to the National Center of Health Statistics" reflect fact and evidence-based assessments related to consideration of the Applicant's claims. In this respect, the Tribunal observes that the ARP "sought advice on what would be covered from the WBG health insurance plans for staff seeking medical treatment for the diagnosed conditions including on travel supported for such treatment," and takes note of the Bank's position that the administrators confirmed that "CIRS is not a recognized disease by any major professional" and that its medical insurance providers exclude Ayurvedic medicine from the policies because it is considered experimental and not medically necessary. Further, the Tribunal notes that the Bank states that Ayurvedic treatment has not been previously approved by the Claims Administrator for the treatment of "respiratory difficulties secondary to mold exposure in the workplace," the Applicant's compensable illness/injury.

160. The Tribunal observes that the record shows the urgency with which the Applicant pursued treatment of his health conditions, and the Tribunal acknowledges the Applicant's conviction that

the treatments at issue have been effective. The Tribunal notes that a staff member may unilaterally determine what treatment he or she wishes to pursue and from whom. However, the Bank's rules and processes nevertheless apply in determining whether the associated expenses will be paid by the Bank. The applicable standard pursuant to Staff Rule 6.11, paragraph 6.01, is that the Bank "will pay all reasonable medical, hospital, and medical rehabilitation costs causally related to the injury, illness, or death as approved by the Claims Administrator." Further, pursuant to Workers' Compensation Program – Claims Procedure, paragraph 5.06, "[t]he Claims Administrator will review all claims for medical expenses and will have the authority to reject any expenses that do not comply with the approved treatment plan or are not deemed to be necessary and related to the compensable condition."

161. In this respect, the Tribunal finds it notable that on 11 January 2022, just one day after the Applicant requested that the Claims Administrator reconsider its denial of coverage for the treatment in Switzerland, the HR Specialist emailed the Applicant and shared "a couple of suggestions of specialists [that] can do evaluations of your case." The HR Specialist asked the Applicant to indicate if he had a preference among the specialists and further stated that, "[o]nce we hear back from you, we will reach out to you to coordinate travel arrangements." The Applicant responded on 14 January 2022 and stated, "I had no choice, and as I did for Switzerland and all other related care, I have already organised myself […] to see a specialist in the US and currently engaged with him."

162. The Tribunal considers that the Applicant's decision not to consult with any of the doctors provided by the Claims Administrator, and his response to the HR Specialist's email, is indicative of the Applicant's expectation that any and all of his preferred doctors' recommended treatments and associated expenses be automatically approved by the Claims Administrator pursuant to his compensable workers' compensation illness/injury. The Tribunal notes that the Applicant was explicitly reminded when notified of the *ex gratia* payments for certain treatments in Switzerland and Florida that future treatments should follow the established process, yet he continued not to do so. Neither the Bank's choice to make an *ex gratia* payment nor the Claims Administrator's approval of certain expenses legitimizes an expectation on the Applicant's part that compliance with the required process was optional. The Tribunal considers that the Applicant's approach is

incompatible with the procedures laid out in the Staff Rules on the Bank's workers' compensation program as noted above, and it is of the view that such an approach would serve to undermine the administration of the program.

163. In the Tribunal's view, no administrator can reasonably administer claims and manage a workers' compensation program if staff members themselves decide that whatever treatment they seek must be approved. The Tribunal acknowledges that staff members may choose to pursue their own treatment but reiterates that they are not entitled to reimbursement for every such treatment and associated costs. Rather, reimbursement is governed by the Staff Rules and by the policy, as articulated in Staff Rule 6.11, paragraph 6.01, that the Bank is only required to pay "all reasonable medical, hospital, and medical rehabilitation costs causally related to the injury, illness, or death as approved by the Claims Administrator." The corresponding duty on the part of the Bank's Claims Administrator is to make its decisions on a reasonable basis.

164. In sum, the Tribunal is of the view that the ARP's decision reflects that it assigned more weight to the opinions of the Claims Administrator's doctors which found, per a fact-based evaluation of peer review studies and diagnostic codes, that the Applicant's doctors presented an unrecognized diagnosis and recommended unapproved treatment not medically reasonable for the Applicant's condition. The Tribunal finds that the ARP reasonably assigned more weight to the opinions of Dr. I and Dr. C in reaching the decision to "affirm the Claims Administrator's denial of [the Applicant's] requests as the treatment received and associated travel was not reasonable in the context of the accepted illness/injury."

165. Moreover, the Tribunal notes that the ARP states it considered the entirety of the medical evidence and met on four occasions to consider the parties' submissions, and recalls that the ARP considered the Applicant's claim "with input from an external medical consultant" and in consultation with the Bank's health insurance plans.

166. In view of the foregoing discussion, the Tribunal concludes that the ARP's decision to deny the Applicant's claims is reasonably sustained on the basis of the evidence.

WHETHER THERE WERE PROCEDURAL VIOLATIONS IN THE ADMINISTRATION OF THE APPLICANT'S CLAIMS

167. Principle 2.1 of the Principles of Staff Employment provides that the Bank "shall at all times act with fairness and impartiality and shall follow a proper process in [its] relations with staff members." Principle 9.1 further provides that "[s]taff members have the right to fair treatment in matters relating to their employment."

168. Pursuant to the Workers' Compensation Program – Claims Procedure, paragraph 4.05, in place at the relevant time:

> When the Claims Administrator is in receipt of the completed and documented claim, along with any additional information and documentation that the Claims Administrator may request during the course of the review, the Claims Administrator shall promptly notify the claimant that his or her claim is deemed completed. Once the Claims Adjuster and the Case Manager have completed their independent reviews of the claim, they will agree on a determination to approve or deny the claim. The Claims Administrator will have 30 calendar days from the notification to the claimant of the receipt of the completed and documented claim to inform the claimant, the Bank Group's Insurance Unit, and Health Services Department of the decision to approve or deny the claim.

169. The Tribunal notes that the Applicant asserts that the Claims Administrator's 29 January 2021 initial denial of his claim for workers' compensation filed on 25 September 2020 exceeded the 30-day deadline stipulated in the Workers' Compensation Program – Claims Procedure, paragraph 4.05. The Bank contends that the 30-day clock begins when the Claims Administrator notifies the Applicant that it is in "receipt of the completed and documented claim," and the Bank asserts that, as of 13 January 2021, the Claims Administrator was still seeking medical records from the Applicant.

170. The Tribunal notes that, on 13 and 14 January 2021, the Applicant and the Claims Administrator engaged in email correspondence in which the Claims Administrator sought a CT scan from the Applicant. Accordingly, the Tribunal observes that, as of 13 January 2021, the Claims Administrator was still requesting, reasonably, further information and documentation. The Tribunal finds that, as the initial denial decision was issued on 29 January 2021, the 30-day

time frame of the Workers' Compensation Program – Claims Procedure, paragraph 4.05, was not violated.

171. The Tribunal next notes that the Applicant contends that, with respect to his 31 March 2022 appeal to the ARP, the Bank unilaterally closed this appeal without notice and in violation of Principle 2.1 of the Principles of Staff Employment as well as the Workers' Compensation Program, Claims Procedure and Appeals Procedure.

172. Pursuant to the Workers' Compensation Program – Appeals Procedure, paragraph 4.05, in place at the relevant time:

> Upon receipt of the appeal request, the Administrative Review Panel will provide a copy of the appeals request to the Claims Administrator who will prepare a written response within 60 days of receipt. The claimant will be provided a copy of the Claims Administrators written response and he/she will have 30 days to provide comments to the Administrative Review Panel on the response given by the Claims Administrator.

173. Further, pursuant to the Workers' Compensation Program – Appeals Procedure, paragraph 4.07, in place at the relevant time:

> Within 90 days of receiving all requested documentation, the Panel will transmit a memorandum to the claimant and the Workers' Compensation Administrator detailing its decision and the reasons for the decision on the Appeal. In the absence of receipt of requested documentation within a reasonable period of time as determined by the Panel, the Panel may proceed to issue its decision.

174. The Tribunal observes that, on 27 April 2022, the Applicant was notified that his expenses for past treatments would be approved *ex gratia* and that future treatments should follow the established process for prior authorization. The Bank explains that, pursuant to the *ex gratia* payment, the Applicant was reimbursed in the amount of $57,003.54. On 14 August 2022, the Applicant was informed that, in light of the *ex gratia* payment, consideration of the appeal was deemed not necessary and that the ARP remained an available avenue for redress. In these circumstances, the Tribunal does not find a violation of the applicable rule.

175. Finally, the Tribunal notes the Applicant's contention that the ARP decision fails to meet the requirements of the Workers' Compensation Program – Appeals Procedure, paragraph 4.07, in that the ARP failed to detail its decision and the reasons for its decision. The Tribunal considers that the ARP explained both its decision and the reasons for its decision, as already evaluated by the Tribunal in its assessment of the ARP decision.

DECISION

The Application is dismissed.

/S/Janice Bellace
Janice Bellace
President

/S/ Zakir Hafez
Zakir Hafez
Executive Secretary

At Washington, D.C., 3 May 2024