DECISION OF THE WORKERS' COMPENSATION APPEAL TRIBUNAL

Introduction

[1] On December 3, 2015 a disability awards case manager at the Workers' Compensation Board (Board), which operates as WorkSafeBC, in implementation of a September 28, 2015 Review Division decision (*Review Reference #R0191149*) decided that the worker was assessed at 0% for permanent disability related to the psychological condition of adjustment disorder with mixed anxiety and depressed mood[1].

[2] A review officer in a May 25, 2016 Review Division decision (*Review Reference #R0201687*) noted that on August 20, 2014 the Board had accepted the worker's claim for a somatic symptom disorder and an adjustment disorder with mixed anxiety and depressed mood as permanent conditions. The review officer confirmed the December 3, 2015 Board decision.

[3] The worker appealed the above decision to the Workers' Compensation Appeal Tribunal (WCAT) and asked that the appeal proceed by oral hearing which occurred on February 9, 2017 at Richmond, B.C.

[4] The employer, although originally indicating an intent to participate, confirmed just prior to the oral hearing that it was waiving its right to participation.

Issue(s)

[5] The issue is whether the worker is entitled to a permanent disability award for psychological impairment.

Jurisdiction

[6] This is a rehearing by WCAT. WCAT reviews the record from previous proceedings and can hear new evidence. WCAT has inquiry power and the discretion to seek further evidence, although it is not obliged to do so. WCAT exercises an independent adjudicative function and has full substitutional authority. WCAT may reweigh the evidence and substitute its decision for the appealed decision or order. Under the provisions of section 253 of the *Workers Compensation Act* (Act), WCAT may confirm, vary, or cancel the appealed decision or order.

[7] Sections 239(1) and 241(1)) of the Act provide that a worker may appeal a decision of a review officer made under section 96.2 to WCAT.

[1] The decision did not specifically reference an accepted somatic symptom disorder.

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[8] Section 250 provides WCAT may consider all questions of law and fact arising in an appeal, but is not bound by legal precedent. WCAT must make its decisions on the justice and merits of the case.

[9] I am bound to apply the published policies of the Board, subject to the provisions of section 251 of the Act.

[10] The standard of proof required in this appeal is proof on a balance of probabilities but with a qualification. Section 250(4) of the Act provides that in an appeal respecting the compensation of a worker, where the evidence supporting different findings on an issue is evenly weighted, WCAT must resolve the issue in a manner that favours the worker.

[11] Section 254 of the Act provides WCAT has exclusive jurisdiction to inquire into, hear, and determine all those matters and questions of fact, law, and discretion arising, or required to be determined, in an appeal before it. The WCAT considers the record and also has jurisdiction to consider new evidence and to substitute its own decision for the decision under appeal.

Background and Evidence

[12] The Review Division decision described some of the background and evidence relevant to the issue in question. I have considered this summary, the claim file evidence, and the submissions provided to WCAT and those on the claim file. I will not set out the evidence on the claim except as necessary to decide the issue and will refer in a summary way to the evidence as it relates to my findings in this case.

[13] The worker's claim was accepted for a left knee injury that occurred in 1997. The claim was later accepted for permanent aggravation of pre-existing mild osteoarthritis, anterior cruciate ligament surgery, and permanent left knee chronic pain. The worker underwent numerous left knee surgeries including a total knee replacement in 2012.

[14] The worker initially was granted a permanent disability award in relation to his left knee in 2000. There were subsequent increases to the permanent disability award during the intervening years to the present.

[15] The Review Division summarized that in August 2013, the Board determined the worker was entitled to a permanent partial disability award of 18.95% of total disability on a loss of function basis for reduced range of motion, anterior cruciate ligament and medial collateral ligament laxity, and disproportionate left knee chronic pain. The award did include a 2.5% chronic pain award.

[16] On August 20, 2014 the worker was advised that his claim was accepted for permanent somatic symptom disorder and adjustment disorder with mixed anxiety and depressed mood, with an effective date of December 11, 2013.

[17] A February 24, 2014, psychological assessment report from Dr. Joy, registered psychologist, provided a diagnosis of somatic symptom disorder (former pain disorder) and adjustment

disorder with mixed anxiety and depressed mood. Those were the conditions accepted by the Board. However, Dr. Joy also spoke of a long history of psychological impact and suffering since 1997 and probable periods of anxiety and depression, pretty much throughout the entire period, since the work incident. Dr. Joy saw the worker as having moderate symptoms and moderate impairment in social and occupational functioning. He also saw the worker as partially disabled from work, although currently attending work on a regular basis. It was noted the worker generally used all his sick days on an as-needed basis. The worker was also viewed as moderately disabled with getting around and moderately disabled with work activities. Dr. Joy stated there were no obvious psychological restrictions at the time of reporting.

[18] In response to the specific question as to his psychologist opinion as to the appropriate category applicable to the worker's condition, according to the Board permanent functional impairment (PFI) ratings for psychological disabilities, Dr. Joy responded:

> There are two DSM-5[2] conditions to consider, namely, Somatic Symptom Disorder, with predominant pain, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. Both conditions are of moderate severity and chronic. These conditions interact and are likely at approximately the same severity. Assuming that these conditions are at a plateau in recovery, in my opinion, the impairment rating falls somewhere in the moderate range. Under the table, Psychological Disability (Volume II, A4-13, August 1, 2006), I note that the moderate range runs between 30 and 70 percent. The descriptor reads, "Impairment levels are compatible with some but not all useful functioning." In the present case, for the depression, pain, and anxiety, I would be thinking in terms of a rating between 30 and 40 percent. Referring to the document entitled, "Psychological Disability Awards Committee Section 23(1) Guidelines[3]," the behavioural description for the present work capability is likely found in the PFI range between 30 and 45 percent. There are moderate residual symptoms. [The worker] is marginally capable of competitive work. He is at moderate increased risk of decompensation and under normal stress. There is likely inadequate adaptation to impairment. Note is made of a reported 100 tablets of Tylenol #3 weekly plus 15 tablets of oxycodone to manage pain symptoms in order to function at work and elsewhere. There is variable Ativan use to help with anxiety and sleep.
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> [all quotes reproduced as written, except for changes noted]

[19] On February 12, 2015 and November 30, 2015 the Psychological Disability Awards Committee (PDAC) met to review the level of functional psychological impairment on the claim. The first portion of both LTD (Long Term Disability) memos appear to be identical template discussions defining, in part, the use of terms mild, moderate, marked-extreme in the Guidelines and other factors to be taken into account when evaluating impairment.

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[2] The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition

[3] The Psychological Disability Awards Committee Section 23(1) Guidelines are hereinafter referred to as the Guidelines

[20] The February 12, 2015 memo noted that in comparing the accepted psychological conditions to the diagnosed conditions, the PDAC finds them to be equivalent for the purposes of determining the worker's psychological PFI. It was noted there was no pre-existing psychological impairment to be taken into account.

[21] In reviewing limitations, the PDAC stated that:

> The psychological limitation(s) accepted on claim are:
>
> - None.
>
> The psychological limitation(s) identified in the psychological assessment are:
>
> - Moderate difficulty in doing the most important work well
> - Moderate difficulty with getting his work done as quickly as needed
> - Moderate difficulty with his day-to-day work activities.
>
> In comparing the accepted limitations to those identified in the psychological assessment, the committee finds that the limitations suggested by Dr. Joy appear to describe pain related impairments and minor indicators of psychological impairment not likely to affect current or future earning capacity. However, in taking account these limitations, the committee was also aware that a significant proportion of each limitation arises from physical, rather than psychological issues.

[22] The PDAC recommended a psychological PFI award in the mild range of 0% to reflect the impact of the compensable conditions on the worker's psychological functioning.

[23] On September 28, 2015 the Review Division was unclear whether the February 12, 2015 PDAC memo considered whether the worker was entitled to a psychological permanent disability award for the adjustment disorder with mixed anxiety and depressed mood. As well it noted that Practice Directive #C3-1 "Chronic Pain" was amended May 15, 2015, to reflect that where a somatic symptom disorder with predominant pain is accepted as a permanent condition, the Board may also accept permanent chronic pain and refer the conditions to the Disability Awards Department. The worker may be entitled to compensation for both chronic pain and the Pain disorder where both conditions are present.

[24] As part of the November 30, 2015 PDAC LTD memo, it was stated the PDAC continued to be of the opinion that somatic symptom disorder with predominant pain should not be rated independently, because its effects were already subsumed under a combination of three other awards as appropriate. These awards were the worker's physical PFI award, psychological PFI award, and pain award.

[25] The PDAC stated, in part: "…the PDAC considered whether the worker was entitled to a psychological permanent disability award for the adjustment disorder with mixed anxiety and depressed mood, the PDAC is of the opinion that they did and that this resulted in a recommendation of a psychological impairment award of 0.0%."

[26] The PDAC was of the opinion that many of the worker's symptoms arise wholly from pain, and many of the remaining symptoms arise partially from pain and partially from a normal and expectable response to significant persistent pain. It was stated the worker's severe pain had already resulted in an award for chronic pain.

[27] The PDAC acknowledged that some of the symptoms arise solely from the adjustment disorder and some of the other symptoms arose partially from the adjustment disorder. However, it was stated a psychological PFI award is specifically concerned with the level of impairment, not the level of psychological symptoms. It was noted psychological impairment refers only to areas where the individual will have difficulty interacting with the world as a result of their symptoms, such as sleep dysfunction, sexual dysfunction, social dysfunction, or work dysfunction. For this reason, the overall level of severity of psychological symptomatology is not a good guide to the overall level of psychological impairment arising from that symptomatology. It was stated Dr. Joy described pain-related impairments and minor indicators of psychological impairment not likely to affect current or future earning capacity. The committee was also aware that a significant proportion of each limitation arises from physical, rather than psychological issues.

[28] Subsequent to the PDAC review, the worker's representative attempted to get an updated report from Dr. Joy but was informed that Dr. Joy was no longer providing psychological assessments in Board matters. Therefore, a January 31, 2017 report was provided from Dr. Nader, a registered psychologist.

[29] Dr. Nader noted that the worker probably under-represented his level of distress. Dr. Nader noted the worker continued to meet diagnostic criteria for somatic symptom disorder and adjustment disorder. It was indicated the findings from the current assessment were consistent with the conclusions of Dr. Joy in February 2014. It was, however, noted that the worker was experiencing an episode of depression after he stopped working in the fall of 2016. The worker believed he would likely not be able to return to his job contributing to a sense of loss and uncertainty about his vocational future.

[30] Dr. Nader commented specifically on the PDAC report when he stated:

> I am not entirely clear what the PDAC meant when they referred to Somatic Symptom Disorder as a "pathological thought process" that does not result in psychological impairment. This is not consistent with the DSM-5 definition of Somatic Symptom Disorder. The DSM-5 notes that Somatic Symptom Disorder may or may not be associated with another medical condition and that the diagnosis of Somatic Symptom Disorder and a concurrent medical illness are not mutually exclusive. The DSM-5 specifies that Somatic Symptom disorder does, in fact, result in psychological impairment, providing the example of an individual who became seriously disabled by symptoms of Somatic Symptom Disorder after an uncomplicated myocardial infarction, even if the myocardial infarction itself did not result in any disability. The PDAC appears to only focus on cognitive aspects of Somatic Symptom Disorder, but fails to recognize that the criteria for Somatic Symptom Disorder incorporates affective and behavioural components as well, not simply viewing it as a maladaptive cognitive process. Therefore, it is my opinion that the PDAC is only focusing on one aspect of Somatic Symptom

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> Disorder (maladaptive thought patterns), without considering the affective and behavioural components of the disorder that contribute to impairment. Additionally, the PDAC does not appear to consider how maladaptive thought patterns, in and of themselves, can contribute to psychological impairments, as documented in the DSM-5.

[31] Although Dr. Nader recognized that the worker's limitations were a combination of physical and psychological factors, he also provided consideration of limitations associated solely with psychological impairments. It was stated:

> Associated with his Somatic Symptom Disorder and Adjustment Disorder, [the worker] experiences a fairly high level of anxiety on an ongoing basis. His anxiety is focused primarily on concerns and worries about his physical functioning and the impact that his physical functioning will have on his future and ability to work. His anxiety would interfere with cognitive functions such as concentration, focus and short-term memory, resulting in [the worker] having difficulty in work environments requiring sustained focus, multitasking or completing tasks with strict deadlines. While his chronic pan complaints are likely also contributing to some of his cognitive difficulties, there is no way to tease apart how much of his cognitive difficulties are a result of his chronic pain and how much are a result of his psychological conditions. The reality is, his cognitive impairments are likely due to both factors, each playing a significant role in his cognitive inefficiencies. His cognitive difficulties also lead to him losing focus in conversations, which would limit him in work settings requiring frequent interaction with other people (e.g., sales, customer service). [The worker] would likely struggle in work environments requiring him to make quick decisions, given his levels of self-doubt and indecisiveness, resulting from his anxiety and low mood symptoms. He has withdrawn socially over the years, largely due to his difficulties with focus and the fact that he does not want people to see him as a "downer", contributing to decreased confidence in his ability to interact effectively with others. As a result of [the worker's] Somatic Symptom Disorder, he has heightened fear of reinjury and would likely be extremely anxious in work situations that he perceive[s] might exacerbate his pain. Therefore, he may be highly anxious and would avoid attempting to work in work environments that he would perceive as too physically demanding for his left knee, even if he were actually physically capable of working in those environments. Finally, [the worker's] heightened anxiety reduces his capacity for managing or tolerating stress and, therefore, he would have difficulty functioning in stressful or demanding work environments.

[32] It was Dr. Nader's opinion that the worker's PFI related to his somatic symptom disorder and adjustment disorder would be between 30% to 35% based on the Guidelines. It was noted that in coming to the opinion, Dr. Nader took into account the severity of residual symptoms, if the worker was capable of competitive work, level of adaptation to impairment, level of accommodation the worker would require, and his role of decompensation under normal stress. It was noted although the worker was capable of competitive work, from a psychological standpoint, he has demonstrated inadequate adaptation to the impairment associated with his

psychological conditions to date. The worker's heightened fear of reinjury, somatic focus, deterioration, and mood were a function of pain and avoidance activities that he felt may worsen his pain condition all indicating that the conditions were still significantly interfering for him. It was also the opinion of Dr. Nader that the worker was at a moderate risk of decompensation under normal stress.

Oral Hearing

[33] The worker was a very personable, well-spoken individual who identified himself as 56 years of age, having had eight surgeries on his left knee, the last being about two years ago. He has also has a fused back from a car accident[4] and advised bulging discs had been a major factor in him not returning to work.

[34] His knee gets sore and this worsens with bad or cold weather. His knee replacement surgery took place around 2012. He avoids certain types of activities because of his knee. He is cautious with things such as climbing stairs. He avoids hiking, as he tried it with a friend but had too much pain. He also has become a little antisocial as he has a hard time dealing with people and stays away from a lot of people. He has some problems with concentration and forgetting things. He is taking no medication for psychological conditions. He is not attending counselling since it is no longer funded. He continues to take Tylenol.

[35] He mentioned he was not as forthright with Dr. Nader as he should have been, as he did not want to discuss some areas such as his thoughts of hurting himself.

[36] He identified he worked over the years as he needed medical benefits for both his wife, who has a neurological disorder, as well for his son. It was very important.

[37] Back problems are now a greater issue than his knee.

Submissions

[38] The worker's representative at the hearing submitted that the worker's psychological condition should result in a functional impairment award of 30%.

[39] It was acknowledged, as it was by Dr. Nader and Dr. Joy, that there is significant overlap between the physical and psychological aspect of the worker's limitations and impairment. However, it was submitted that the approach of PDAC to entirely discount all the psychological aspects was incorrect.

[40] The PDAC memos are in the nature of adjudicative advice rather than expert evidence and should be given minimal weight. The insistence on refusing to rate a somatic symptom disorder and state that this disorder was subsumed under other awards clearly ignores medical evidence as well as disregarding policy and practice directives.

[4] The worker appears to have had car accidents in 2011 and 2012.

[41] Practice Directive #C3-1 provides that compensation may be provided for both chronic pain and a pain disorder when both are present. Dr. Nader confirms that somatic symptom disorder does result in psychological impairment and can include behavioural components in addition to cognitive changes in that maladaptive thought patterns can result in psychological impairment.

[42] It is submitted that the two accepted psychological conditions are interrelated as both are a response to the pain and anxiety surrounding the knee injury. It is not necessary to attempt to parcel out the limitations and impairment between the two conditions. Rather, the global impact of both psychological conditions can be considered together to obtain an impairment rating. This was the approach taken by the tribunal in *WCAT-2015-01808* (paragraphs 93 and 94).

[43] Dr. Nader's opinion distinguishes between limitations stemming from pain and those stemming from a psychological condition, although he recognizes both factors play a role in the worker's disability.

[44] The PDAC does not distinguish between which symptoms relate to pain and which relate to psychological conditions. It is submitted that Dr. Nader's opinion should be preferred. Dr. Nader rates the worker's psychological impairment in the 30% to 35% range and this is when only considering the psychological impairment. Dr. Nader noted that from a psychological standpoint, the worker was capable of competitive work but that significant symptoms remain in terms of anxiety, fear of reinjury, mood, and avoidance of activities and that the worker has not adapted to these impairments. It was also noted the worker is at risk of further decompensation.

[45] It is submitted, although Dr. Nader recommends the 30% to 35% rating and that the totality of symptoms would place the worker in the higher end of the range, that a 30% rating is appropriate in order to take into account the fact that some difficulty is caused by chronic pain, which can only ever result in a 2.5% award for impairment.

[46] After the hearing, on February 15, 2017, the worker's representative noted although he had relied on the RSCM II at the hearing, after review he submits that the provisions of *Volume I* should apply for the purpose of rating the worker's permanent psychological impairment. However, it was submitted there are no substantial differences between the two versions of policy that would impact how that impairment is rated.

Discussion Reasons and Findings

[47] Policy #1.03 in both the *Rehabilitation Services and Claims Manual, Volume I* (RSCM l) and *Rehabilitation Services and Claims Manual, Volume II* (RSCM II) provides for transitional rules assisting in determining what volume of the policy applies. It notes, in part, that where the first indication of permanent disability occurs before June 30, 2002, the permanent disability award will be adjudicated under the former provisions. Where the first indication of permanent disability is on or after June 30, 2002, the award will be adjudicated under the current provisions. The determination of when permanent disability first occurs will be based on available medical evidence.

[48] The worker had permanent disability assessed prior to 2002 and, on plain reading of the provision, RSCM I would apply. In addition, although the effective date of the permanent psychological disability was not assessed until after 2002, according to Dr. Joy and Dr. Nader the first indications of such disability would have been prior to 2002.

[49] For the purposes of the issue before this panel, I agree with the representative's submissions that it makes little difference which volume applies. The reason for that is that policy #39.10 of RSCM I provides that for all section 23(1) assessments and reassessments undertaken with reference to the Permanent Disability Evaluation Schedule (PDES) on or after August 1, 2003, reference is made to the PDES in Appendix 4 of *Volume II* and the appropriate policies in Chapter 6 of *Volume II* on the application of the PDES. As well, the same provision is found in the preamble to Appendix 4 in RSCM I.

[50] For the issue before this panel the practical effect is that Chapter 6 and Appendix 4 of the RSCM II apply.

[51] Policy #39.10 also provides, in part, that the PDES is a set of guide-rules, not a set of fixed rules. The disability awards officer or adjudicator in Disability Awards is still free to apply other variables in arriving at a final pension.

[52] Appendix 4 item XX in the PDES relating to psychological disability states:

> Due to overlapping symptoms across diagnoses and their potential interactions, psychological disability awards are not made per diagnosis. All accepted psychological diagnoses are combined and rated as a whole.

[53] I therefore conclude that the worker's Somatic and Anxiety conditions should be combined for the purposes of rating impairment. This is also consistent with the opinions of Dr. Joy, Dr. Nader, and the PDAC observations relating to an overlap

[54] Under section XX of Appendix 4 applicable percentages relate to a number of "disturbances." I am satisfied that XX(C) primarily applies. The relevant portion of that table states:

> C. Emotional (Mental) and Behavioural Disturbances
>
> The impairment levels below relate to activities of daily living, social functioning, concentration, and adaptation
>
> | | |
> |---|---|
> | Mild - impairment levels are compatible with most useful functioning | 0 – 25 |
> | Moderate - impairment levels are compatible with some, but not all useful functioning | 30 – 70 |

[55] The provision also notes that disability ratings greater than 0% are made in 5% increments.

[56] The PDAC has adopted the Guidelines, which assign various ratings to specific indicators of psychological disability. The Guidelines are not binding policy, but can provide a useful

framework for assessing psychological permanent partial disability ratings. The Guidelines elaborate on, but do not replace the PDES descriptions of psychological disability. The relevant portions of the guidelines include:

Criteria	PFI Range
• does not meet minimal criteria for consideration of award • may be minor indicators of impairment but not likely to affect current or future earning capacity • Chronic Pain/Pain Disorder Diagnosis with some depressive/anxiety symptoms not out of keeping with same (apply Chronic Pain Policy)	0%
MILD IMPAIRMENT LEVELS ARE COMPATIBLE WITH MOST USEFUL FUNCTIONING	
• minor residual symptoms • no, or little significant increased risk of decompensation • accommodation or different job would likely attenuate psychological impairments	5%
• minor residual symptoms • some increased risk of decompensation under stressful situations • accommodation or different job would not likely completely attenuate psychological impairments • only sporadic continuing treatment likely	10-15%
• mild residual symptoms • moderate increased risk of decompensation under stressful situations • accommodation or different job would not significantly attenuate psychological impairments • continuing treatment and support likely	20-25%
MODERATE IMPAIRMENT LEVELS ARE COMPATIBLE WITH SOME, BUT NOT ALL USEFUL FUNCTIONING	
• moderate residual symptoms • capable of competitive work • inadequate adaptation to impairment with or without accommodation • moderate increased risk of decompensation under normal stress	30-35%

[57] Dr. Joy and Dr. Nader have both come to similar conclusions when assessing the degree of the worker's PFI related to somatic symptom disorder[5] and adjustment disorder with mixed anxiety and depressed mood. This was indicated to be in the moderate range of 30% to 40% by Dr. Joy and 30% to 35% by Dr. Nader, based on the Guidelines.

[58] This is in sharp contrast to the PDAC estimation of 0%. The PDAC appears to be concluding that since the worker received 2.5% for chronic pain and the worker's psychological conditions overlap with that award, the worker should not be awarded an additional amount in relation to the psychological conditions. However, the PDAC also specifically acknowledges that some of the symptoms arise solely from the adjustment disorder and some of the other symptoms arise partially from the adjustment disorder. The question is do those give rise to an impairment rating?

[59] I do note that somatic symptom disorder is a condition recognized under the DSM-5 and reflects signification changes in classification since the PDAC last updated its Guidelines in 2004 and when they used the fourth edition *Guides to the Evaluation of Permanent Impairment* (the Guides) as part of the basis of their formulation of how impairment would be rated. The Guides have evolved and are now up to a sixth edition. I do note that the current Appendix 4 does reference "The PDES was developed by WorkSafeBC based on consideration of expert medical opinion, current medical/scientific literature and schedules from other jurisdictions and organizations, including but not limited to various editions of the American Medical Association *Guides to the Evaluation of Permanent Impairment* (the "AMA Guides")."

[60] I do not find the PDAC analysis that resulted in a 0% award for the psychological conditions persuasive for the reasons outlined below.

[61] Policy item #97.40 (Disability Awards) states that the normal practice when a worker is referred to the Board's Disability Awards Department is for a PFI evaluation to be conducted. The policy states that the resulting report will usually be the primary input that the Board uses, and that this report takes the form of expert evidence which, in the absence of other expert evidence that is contradictory, should not be disregarded. In this case the initial report that was relied upon by Disability Awards in relation to the psychological conditions was the report of Dr. Joy. That report gave rise to the acceptance of the psychological conditions by the Board. The Board did not forward the worker for any other PFI evaluation, in relation to the psychological conditions, to another external provider.

[62] Dr. Joy, as part of his report, noted, although the worker was working at that time he was likely working at a maximum capacity. The worker was indicated to have little reserves if his work challenges increase or there was deterioration in his physical condition. It was noted Dr. Joy would not be at all surprised if indeed the worker had to go off work again in the not-too distant future. This prediction was accurate, as the worker has gone off work. Dr. Joy also noted that the worker's ongoing physical and psychological conditions would undoubtedly affect his ability to pursue gainful employment.

[5] Somatic symptom disorder has also been called somatic symptom disorder with predominate pain in this claim.

[63] Dr. Joy then specifically addressed the appropriate category in which to place the worker for PFI for psychological disability. Dr. Joy noted that two psychological conditions of somatic symptom disorder with predominant pain and adjustment disorder with mixed anxiety and depressed mood were at a moderate severity level and chronic. It was the opinion of Dr. Joy that the worker's impairment rating fell somewhere in the moderate range. Using the gradients provided in Appendix 4, Dr. Joy noted that the moderate range runs between 30% and 70%. Dr. Joy noted the rating includes the descriptor "Impairment levels are compatible with some but not all useful functioning." In the present case it was noted the depression, pain, and anxiety would lead him to a rating of between 30% and 40%. Specifically referring to the Guidelines, the behavioural description for the present work capability was likely found in the PFI range between 30% and 45%. There were moderate residual symptoms. Dr. Joy was of the opinion that the worker was marginally capable of competitive employment. Dr. Joy was of the opinion the worker was at moderate increased risk of decompensation under normal stress. It was also noted that the worker likely had inadequate adaptation to impairment. It was also noted that the worker used his medication to help with anxiety and sleep.

[64] The PDAC on February 12, 2015 did note that although no specific psychological limitations were accepted on the claim, the psychological limitations identified in the psychological assessment of Dr. Joy were:

- Moderate difficulty in doing the most important work well
- Moderate difficulty was getting his work done as quickly as needed
- Moderate difficulty with his day-to-day work activities

[65] The PDAC, in its memo, under the heading "Permanent Functional Impairment Rating," appears to be using template paragraphs and then states: "Therefore, PDAC recommends a psychological permanent functional impairment award in the Mild range of 0% to reflect the impact of the compensable conditions on the worker's psychological functioning." There is therefore not detailed analysis specific to this worker as to why PDAC reached the conclusion that it did.

[66] After the Review Division returned the issue of psychological disability to the PDAC, there was some further elaboration in the November 30, 2015 LTD memo by the PDAC. The PDAC stated that although Dr. Joy had suggested limitations, the PDAC was of the opinion that they describe pain-related impairments and minor indicators of psychological impairment not likely to affect current or future earnings capacity. The PDAC was of the opinion that a significant portion of each limitation arises from physical, rather than psychological, issues.

[67] The PDAC reiterated that somatic symptom disorder with predominant pain should not be rated independently because its effects were already subsumed under a combination of three other awards. These awards are the worker's physical PFI award, a psychological PFI award, and a pain award. Factually, it, however, should be noted that the pain award was 2.5% and there was no psychological PFI award, as the PDAC recommended a 0% award.

[68] The PDAC was of the opinion that many of the worker's symptoms arise wholly from pain and many of the remaining symptoms arise partially from pain and partially from a normal and expectable response to the significant persistent pain. The PDAC treated the worker's disturbed

sleep, reduced energy, tiredness, fatigue, changes in appetite, and loss of interest in sex as attributable to an expected response to severe pain. It was noted the worker has received an award for chronic pain.

[69] The PDAC noted that "…those difficulties in overall psychological functioning that arise wholly from pain, which is a physical and not a psychological condition, are excluded from consideration." The PDAC went on to explain that "… only those limitations that arise wholly or partly from a psychological condition are considered." PDAC was of the view that such conditions would not affect current or future earnings capacity.

[70] Dr. Nader specifically comments on the PDAC analysis and points to how somatic symptom disorder may give rise to impairment and relies on specific references in the DSM-5. He was of the opinion that PDAC was focusing on one aspect of somatic symptom disorder which was maladaptive thought patterns without considering the affective and behavioural components of disorder that contribute to impairment. He also noted that PDAC does not appear to consider how maladaptive thought patterns, in and of themselves, can contribute to psychological impairments, as documented in the DSM-5.

[71] Dr. Nader then specifically focused on limitations that the worker experienced as a result of his psychological conditions as opposed to physical injuries. Dr. Nader noted that associated with somatic symptom disorder and adjustment disorder, the worker experiences a fairly high level of anxiety on an ongoing basis. The anxiety would interfere with cognitive function including areas such as concentration, focus, and short-term memory. This would result in the worker having difficulty in work environments requiring sustained focus, multitasking, or completing tasks with strict deadlines.

[72] Dr. Nader recognized that there is some inter-play with chronic pain. It was noted cognitive difficulties lead to the worker losing focus in conversations, which would limit him in work settings requiring frequent interaction with other people. The worker would likely struggle in work environments requiring him to make quick decisions given levels of self-doubt, and indecisiveness, which are resulting from his anxiety, and low mood symptoms. The worker has also withdrawn socially over the years due to his difficulties with focus and the fact he does not want people to see him as a "downer," contributing to decreased confidence and ability to interact effectively with others.

[73] Dr. Nader also noted the worker also has heightened fear of reinjury and would likely be extremely anxious in work situations that he perceives might exacerbate his pain. The worker therefore would avoid attempting to work at work environments that he would perceive too physically demanding even though he would be actually physically capable of working in those environments. The worker's heightened anxiety reduces his capacity for managing or tolerating stress, therefore, he would have difficulty functioning in stressful or demanding work environments.

[74] Dr. Nader then specifically referred to the PDAC Guidelines and noted that the worker should be rated in the 30% to 35% range. In coming to this opinion, Dr. Nader noted he took into account the severity of residual symptoms, the worker's capability for competitive work, the level of adaptation to impairment, the level of accommodation the worker would require, and the

worker's risk of decompensation under normal stress. He agreed with Dr. Joy's analysis that the worker's somatic symptom disorder and adjustment disorder are in the moderate range. It was Dr. Nader's opinion that the worker was capable of competitive work from a psychological standpoint but has demonstrated inadequate adaptation to impairment associated with the psychological conditions. He was of the opinion that the worker was' at a moderate risk of decompensation under normal stress. This is evidenced by the fact the worker appears to have experienced significant worsening of his adjustment disorder symptoms over the years to the point that he would have met the diagnosis criteria for Major Depressive Disorder. As the worker has likely experienced multiple depressive episodes in the past, he is at heightened risk of deterioration in the psychological condition the future even independent of psychosocial stressors. The worker's levels of anxiety and low mood place him at moderate risk of psychological deterioration in a normal stress situation.

[75] I conclude the PDAC has overemphasized the fact that the worker received an award for chronic pain of 2.5%, although it is correct that there is overlap between the worker's physical and psychological conditions.

[76] Practice Directive #C3-1, which was amended effective May 15, 2015, although not binding on the panel, clearly provides that where a somatic disorder with predominate pain is accepted as a permanent condition, the Board may not only accept permanent chronic pain but refer both conditions to the Disability Awards Department. It notes the worker may be entitled to compensation for both chronic pain and the pain disorder when both are present.

[77] I also am satisfied that PDAC effectively disregarded the likely effect on this worker's earnings capacity and I rely on the opinions of Dr. Joy and Dr. Nader in that regard. The analyses by Dr. Joy and Dr. Nader were congruent, thorough, and specifically addressed the PDAC Guidelines and also took into account the multiple variables that should be considered when assigning a PFI rating.

[78] Based on all the evidence, I conclude that the worker's psychological impairment falls within the moderate range as identified in Appendix 4 which is an impairment level that is compatible with some, but not all, useful functioning. That would place the worker in a range of 30% to 70% for a rating for impairment.

[79] Using the descriptors in the Guidelines, as commented on by Dr. Joy and Dr. Nader, I conclude that the worker best fits in the category of:

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

[80] This leads to a range of 30% to 35% in the PDAC Guidelines. The representative acknowledges that there is some overlap between the award and the fact that the worker did have a chronic pain award of 2.5%. In my view, that is correct. There is always judgement required in placing

an individual in the appropriate range for a PFI rating. In this case I find that placing the worker at the lower rating of 30% PFI for his psychological conditions also effectively recognizes the overlap with the recognized award of 2.5% that was granted for chronic pain.

[81] No other issues were raised in the appeal, such as the effective date, and being mindful of item #3.3.1 of the MRPP which states that WCAT will generally restrict its decision to the issues raised by the appellant in the notice of appeal and the appellant's submissions to WCAT, I find no compelling reason to address additional issues.

[82] I need not comment on the WCAT decision cited by the representative, as what was argued was effectively the proposition stated in policy that both psychological conditions would be rated together for the purpose of determining the PFI award.

Conclusion

[83] The appeal is granted.

[84] The May 25, 2016 Review Division decision (*Review Reference #R0201687*) is varied to provide a 30% PFI award for the permanent psychological conditions of somatic symptom disorder and adjustment disorder with mixed anxiety and depressed mood.

Expenses

[85] The worker also seeks reimbursement of Dr. Nader's psychological report February 1, 2017 invoice of $2,716.25 plus tax, for a total of $2,852.06.

[86] Coincidentally, that is the exact amount that this panel also dealt with for another report by Dr. Nader in a December 19, 2016 *WCAT Decision A1601899***.**

[87] I repeat what I outlined in that decision although making a decision based on the specifics of this case.

[88] Subsection 7(1)(b) of the *Workers Compensation Act Appeal Regulation* states that WCAT may order the Board to reimburse a party to an appeal for expenses associated with obtaining or producing evidence submitted to WCAT. Item #16.1.3 of the MRPP notes that WCAT will generally order reimbursement of expenses incurred in producing evidence if the evidence was useful or helpful to the consideration of the appeal or it was reasonable for the party to have sought such evidence in connection with the appeal.

[89] MRPP item #16.1.3.1 states that WCAT will usually order reimbursement of expert opinions at the rates or fee schedule established by the Board for similar expenses. The maximum fee schedule rate for a psychological assessment is $2,310.00. This provides for 12 hours of assessment and report production time, and a timely report fee (provision of a report within ten days).

[90] MRPP item #16.1.3.1 goes on to state that WCAT has the discretion to award reimbursement in an amount greater than the fee schedule, in limited circumstances.

[91] The report in this appeal was useful and reasonably obtained. However, I do not consider the circumstances of this case to warrant a departure from the fee schedule rate. The psychologist performed all his required testing and reporting within the 12 hours allocated for such a report.

[92] I note that tax is separate from the fee schedule and is a cost required by other governmental legislation and is legitimately added to the amount to be reimbursed.

[93] The Board shall reimburse an amount of $2,310.00 plus tax for the report of Dr. Nader.

[94] I see no circumstances in this case that would warrant an increase in the amount to be paid.

Paul Pierzchalski
Vice Chair

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