WCAT

DECISION OF THE WORKERS' COMPENSATION APPEAL TRIBUNAL

WCAT Decision Number: A1701323
WCAT Decision Date: January 5, 2018

Introduction

[1] By letter dated September 26, 2016, the Workers' Compensation Board (Board), denied the worker's claim for depression arising as a compensable consequence of her accepted injury.

[2] The worker disagreed with the decision and requested a review. On March 21, 2017 the Review Division (*Review Reference #R0214935*) confirmed the Board's decision.

[3] The worker disagreed with the Review Division's decision and has now appealed that decision to the Workers' Compensation Appeal Tribunal (WCAT).

Issue(s)

[4] Should the worker's Adjustment Disorder with mixed anxiety and depressed mood be accepted as a compensable consequence of her 2011 right knee injury?

Jurisdiction

[5] The appeal was filed with WCAT under section 239(1) of the *Workers Compensation Act* (Act), which provides for appeals of final decisions by review officers regarding compensation matters, subject to the exceptions set out in section 239(2) of the Act.

[6] Section 254 of the Act gives WCAT exclusive jurisdiction to inquire into, hear, and determine all those matters and questions of fact, law, and discretion arising or required to be determined in an appeal before it.

[7] This is an appeal by way of rehearing, in which WCAT considers the record and also has jurisdiction to consider new evidence and to substitute its own decision for the decision under appeal. WCAT has inquiry power, including the discretion to seek further evidence, but is not obliged to do so. WCAT exercises an independent adjudicative function and has full substitutional authority. WCAT may confirm, vary, or cancel the appealed decision or order.

[8] The standard of proof is the balance of probabilities, subject to section 250(4) of the Act. Section 250(4) of the Act states that, if the appeal tribunal is hearing an appeal respecting the compensation of a worker and if the evidence supporting different findings on an issue is evenly weighted in that case, the appeal tribunal must resolve that issue in the manner that favours the worker.

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[9] I am bound to apply the published policies of the board of directors of the Board, subject to the provisions of section 251 of the Act. The policy relevant to this appeal is set out in the Board's *Rehabilitation Services and Claims Manual*, *Volume II* in effect at the time of the Board decision.

[10] I note that the Board decision underpinning this appeal adjudicated "depression and anxiety." However, in this appeal the worker seeks acceptance of Adjustment Disorder with mixed anxiety and depressed mood. As set out in *WCAT-2004-04309*, while the titles of the conditions differ, the range of symptoms addressed by the diagnoses are of a similar nature. The medical evidence, which includes the diagnosis of Adjustment Disorder with mixed anxiety and depressed mood, has been provided to the employer's representative and the employer has made submissions regarding this diagnosis. I am satisfied that I have jurisdiction to make a decision with respect to the diagnosis raised in this appeal.

Method of Appeal

[11] In her notice of appeal the worker requested that the appeal proceed by review of information on the claim file and written submissions. I have considered the criteria set out in the rule at item #7.5 of the WCAT *Manual of Rules of Practice and Procedure.* I am satisfied that this appeal may be considered fully and fairly on the basis of the evidence on the file. There are no credibility concerns or significant factual issues in dispute.

[12] The worker is represented by legal counsel.

[13] The employer is participating represented by a consultant.

Background and Evidence

[14] The Review Division decision describes the history relevant to the issue in question. I have considered that background, the claim file evidence and submissions. I will refer to the background and evidence as it relates to my findings in this case.

[15] On July 6, 2011 while working as a long shore worker, the worker struck her right knee on a metal grate at work. The Board initially accepted the worker's claim for a right knee contusion. While the Board subsequently determined that this condition resolved, the Board accepted a permanent neuropathic injury to the right lateral geniculate nerve. The Board also accepted permanent chronic right knee pain.

[16] On August 20, 2014, the worker attended a permanent functional impairment evaluation. Following this evaluation, the Board granted the worker a loss of function award in the amount of 5.0% of total disability. This award consisted of 2.0% for loss of range of motion of the right knee, 2.5% for chronic pain, and 0.5% for allodynia associated with her nerve injury.

[17] On December 14, 2014 the WCAT determined that the worker was not entitled to an award for loss of range of motion or an award for allodynia, but granted her an award for stance/gait impairment in the amount of 10.0% of total disability. The vice chair confirmed the worker's chronic pain award, for an overall impairment of 12.5% of total disability.

[18] The worker was offered vocational rehabilitation assistance but declined assistance on the basis that she was not ready to engage in return-to-work planning.

[19] On June 27, 2016, the worker advised a vocational rehabilitation consultant that she had been diagnosed with depression, had just started anti-depressants, and was seeing a counselor.

[20] Chart notes from Dr. Riskalla, the worker's attending physician, indicated that in late April 2016, the worker obtained medical treatment for a condition unrelated to her injury, and expressed symptoms of anxiety and stress. Dr. Riskalla assessed the worker's mental health on May 30, 2016. Dr. Riskalla advised the worker to reduce her intake of coffee and walk daily for 30 minutes. Dr. Riskalla also recommended changes to her diet. In mid-June 2016, Dr. Riskalla observed that her depression was improving.

[21] In correspondence dated June 29, 2016, the worker's representative requested a decision on the worker's depression and anxiety. The Board subsequently issued the decision which underpins this appeal. The Board denied depression and anxiety as compensable consequences of the worker's right knee injury on the basis that in April 2016 no root cause was identified in Dr. Riskalla's notes regarding the worker's depression and anxiety and there was no reason to believe that the worker's condition had not resolved or that it was significantly connected to the original 2011 injury.

[22] At review the worker's representative provided various medical reports that were obtained from Dr. Riskalla, as well as a one-page letter dated January 4, 2017, from Dr. Hancock, a registered psychologist. Dr. Hancock stated that between June 20, 2016 and January 4, 2017, he saw the worker on eight occasions. He stated that the worker exhibited signs of a Major Depressive Disorder with Anxiety. According to Dr. Hancock, the worker's right knee injury and the hip injury that resulted from her knee injury delayed her recovery. Dr. Hancock attributed the worker's depression to her frustration and discouragement over the lengthy healing process.

Submissions

Worker's Submissions – New Evidence

[23] The worker, through her legal representative, submitted a psychological assessment dated July 20, 2017 performed by Dr. Nader, registered psychologist, along with the referral letter to Dr. Nader and Dr. Nader's invoice. Dr. Nader details his qualifications and acknowledges his duty to assist the tribunal and not advocate for any party.

[24] Dr. Nader provided an overview of the worker's condition and psychological history. He opined that the worker currently meets the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) diagnostic criteria for an Adjustment Disorder with mixed anxiety and depressed mood. Although the worker has a number of symptoms of Generalized Anxiety Disorder and Major Depressive Disorder, Dr. Nader opined that the worker does not meet the diagnostic criteria for those conditions.

[25] Dr. Nader opined that the worker began experiencing mood and anxiety symptoms in 2012 after her orthopaedic surgeon advised her that there was nothing he could to do to help with her knee injury and he recommended a chronic pain program. It was at this point that the worker realized that her knee injury was not likely to resolve soon and she realized the severity and potential long-term impact the injury was going to have on her life.

[26] Dr. Nader stated that the worker's anxiety and depression symptoms have fluctuated since 2012 but they have never fully resolved. It is Dr. Nader's opinion that the worker's compensable right knee injury played a significant role in the development and onset of her Adjustment Disorder with mixed anxiety and depressed mood. Dr. Nader noted that the worker has a number of additional stressors contributing to her condition such as ongoing pain in her right hip, right lower back and right groin and a level of frustration and aggravation in dealing with her claim. Dr. Nader opines that it is possible that the worker experienced Major Depressive episodes between December 2015 and March 2016 associated with stress related to her claim and a WCAT hearing, and in November/December 2016 to March 2017, likely associated with fatigue/exhaustion caused by a throat cyst/infection and the negative impact this had on her rehabilitation and return-to-work plans. Dr. Nader notes that the worker has responded well to treatment with Wellbutrin (which she has been taking since May 2016) and she does not currently meet the diagnosis criteria for Major Depressive Episode. Dr. Nader also notes that since May 2017 the worker has been anxious about the possibility of throat cancer which was only recently discounted. These additional stressors have likely contributed to her anxiety and mood symptoms.

[27] Dr. Nader opined that the worker's Adjustment Disorder with mixed anxiety and depressed mood has not yet reached maximal clinical recovery. He anticipates that the worker could experience further improvement within the next 12 months and this is likely dependent on the outcome of her September 2017 surgery. If the surgery is successful by allowing her to fully resume her physical rehabilitation, Dr. Nader anticipates her mood and anxiety symptoms would decrease.

Employer's Response

[28] The employer submitted that that Dr. Nader's report holds no merit because he states that "there are no other medical records to show that [the worker] to have suffered ongoing psychological distress other than which I have become aware." The employer submitted that this indicates that Dr. Nader had not been provided with the worker's prior medical records which refer to a psychological condition. The employer also submitted that the cost of the report ought not to be reimbursed.

[29] The employer submitted that is simply no evidence that the worker developed symptoms temporal to her right knee injury in 2011. In fact the first suggestion of psychological symptoms occurred over a year later in August 2012. The employer submits that the file shows that in late April 2016 the worker obtained medical treatment unrelated to her injury and expressed symptoms of anxiety and duress unrelated to her workplace injury. On May 30, 2016 Dr. Riskalla advised her to reduce her intake of coffee, walk daily for 30 minutes and change her diet. In mid-June Dr. Riskalla observed that her depression was improving. The employer also refers to medical evidence from Dr. Hancock which attributed the worker's frustration and discouragement over the lengthy healing process.

[30] In August 2013 the worker saw Dr. Riskalla for jaw problems and sleep disruption. Symptoms of depression and anxiety were not mentioned. In February 2014 Dr. Riskalla observed that the worker was cheery. In July 2015 Dr. Riskalla recorded that the worker was making progress and she was happy because she was no longer on medication and this was the best she had felt in three years. It wasn't until April 2016 when the worker was receiving treatment unrelated to her right knee that Dr. Riskalla noted that the worker started to cry and that she felt anxious

and stressed. It is important to note that the worker was involved in a motor vehicle accident a year prior to seeing Dr. Wang in December 2016. Dr. Riskalla observed that she had been doing fine until October when she had to take care of her husband who required surgery, this caused the worker to have to discontinue her exercise routine making things worse for her.

[31] The employer submitted that it is unreasonable to associate the worker's psychological symptoms to her July 2011 work injury. The employer submitted that the worker had pre-existing psychological issues and that the motor vehicle accident and taking care of her husband were the real issues that caused her psychological distress. The employer stated that little weight ought to be afforded to the brief report from Dr. Hancock because his report did not address the evidence on file or the medical reports referencing the worker's mood and other issues impacting her psychological functioning such as pre-existing health problems, dental problems, a 2015 motor vehicle accident, her non-compensable right hip and back symptoms and the health problems of her spouse.

Worker's Rebuttal

[32] The worker stated that the employer is arguing against expert evidence. The worker submitted that the employer's statement that the assessor had not been provided with the worker's prior medical records referring to her psychological condition is incorrect. The worker's prior representative had supplied Dr. Nader with the entire medical section of the claim file as well as updated physician records on June 19, 2017.

[33] The worker submitted that all clinical records were taken into account by Dr. Nader and the contents of these records do not detract from the reliability of the formal psychological assessment. Causation of a psychological condition is one that requires expert analysis. Chart notes are one of several pieces of information an assessor takes into account; however, they are not assessments of psychological functioning and causation nor are they intended to be used by others for such purposes, particularly laypersons.

[34] The worker submitted that the employer asserted, without any basis, that the cause of the worker's condition is a series of non-compensable factors. These include a non-existent pre-existing condition, an abscess in the worker's tooth that was remedied in a routine manner, a motor vehicle accident in 2015 which did not occur but was a typing error in Dr. Wang's medical records which he later corrected, and by having to take care of her husband after his surgery and two-week recovery. The worker submits that these assertions are not based on evidence and are contrary to the evidence.

[35] The worker continues to rely on her original submissions and the expert opinions of Drs. Nader and Hancock.

Reasons and Findings

Should the worker's Adjustment Disorder with mixed anxiety and depressed mood be accepted as a compensable consequence of her 2011 right knee injury?

[36] I find that the worker's Adjustment Disorder with mixed anxiety and depressed mood should be accepted as a compensable consequence of her right knee injury for the following reasons.

[37] Section 5(1) of the Act provides for compensation where a personal injury or death arises out of and in the course of the employment.

[38] Policy item C3-22.00, *Compensable Consequences*, provides guidance for determining a worker's entitlement to compensation for a further injury, increased disablement, disease, or death that is a consequence of a compensable injury. This policy confirms that in order for an additional condition to be accepted as compensable, there must be evidence that the work injury or treatment for the work injury had causative significance in producing the further injury, increased disablement, disease, or death.

[39] Policy item C3-22.30, *Compensable Consequences – Psychological Impairment*, specifies that psychological impairment may be accepted as compensable where the evidence indicates that it developed as a consequence of an employment-related injury or occupational disease. This policy states that it cannot be assumed that a psychological impairment exists simply because the worker has unexplained subjective complaints or is having difficulty in psychologically or emotionally adjusting to physical limitations that resulted from a compensable injury. There must be evidence that the worker has a psychological impairment.

[40] Although not binding, practice directives offer guidance. Practice Directive #C3-6, *Compensable Consequences – Psychological Conditions*, explains that psychological conditions are complex and often involve multiple contributing factors. This directive states that in order for a psychological condition to be compensable, the work injury must have been a significant contributing factor. The directive specifies that the Board should consider whether or not the compensable injury is one that may reasonably be expected to cause a psychological condition.

[41] This directive also states that where multiple factors have contributed to a psychological condition, including factors unrelated to the work injury, the Board officer weighs the available evidence to determine the significance of the factors related to the work injury and those not related to the work injury. In some cases, the impact of factors unrelated to the work injury may be so great that the work injury cannot be considered to be of sufficient significance to meet the causation threshold. The directive confirms that there has to be reliable evidence to establish a significant causal relationship between the work injury and the psychological condition. The directive also states that a temporal relationship is a factor supporting causation but is not sufficient on its own to meet the causative significance test.

[42] Dr. Nader's Appendix A details the records he reviewed which include the entire medical records from the Board's claim file, medical records from the worker's treating physician and from Dr. Hancock, psychologist. I am satisfied that Dr. Nader had access to all of the materials necessary from which to provide his opinion.

[43] The medical evidence on file indicates that the first suggestion of any psychological symptoms occurred a year after the worker's injury in August 2012 when she reported a specific episode of anxiety. This concurs with Dr. Nader's opinion that the worker's psychological disorder began in the summer of 2012. He opines that the worker's anxiety and depression symptoms have fluctuated since then although they have not fully resolved. I am satisfied that these fluctuations account for the reports of times when the worker was found to be "cheery" and "making progress."

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[44] I note that in late April 2016 Dr. Riskalla noted that the worker started to cry and felt anxious and stressed. In follow-up, on May 30, 2016, the worker was noted to be anxious and depressed. When the worker saw Dr. Riskalla in mid-June 2016, she was doing better and Dr. Riskalla indicated that her depression was improving. By June 27, 2016, the worker was observed to feel much better, and was more energetic and active and while she still experienced some sense of "emptiness" on occasion, it was less than before.

[45] On July 11, 2016, Dr. Riskalla reported that the worker was feeling less exhausted but still had some anxiety. The worker continued to report some psychological distress, and on August 8, 2016, Dr. Riskalla advised the worker to lose weight to help regain her energy.

[46] I acknowledge that some of the worker's consultations with Dr. Riskalla were not related to her compensable injury; however, I am satisfied that symptoms of a psychological condition were apparent and noted.

[47] The employer raised a number of other stressors which the employer submits accounts for the worker's condition. However, Dr. Hancock attributed the worker's psychological distress to the effects of her right knee and right hip injury (a claim which the Board has since denied). Dr. Nader now opines that the worker's right knee injury played a significant role in the development and onset of the worker's Adjustment Disorder with mixed anxiety and depressed mood. Dr. Nader agrees that there are a number of additional stressors that have contributed to her disorder; however, he opines that the worker's disorder began in the summer of 2012 as a result of her right knee injury and that she has not recovered from the disorder and she is not likely to improve within the next 12 months.

[48] With respect to the temporal discrepancy between the worker's accepted injury and her 2012 psychological diagnosis, Dr. Nader opined that the worker's symptoms began after her orthopedic surgeon advised her that there was nothing more he could do; at this point, the worker realized the severity and potential long-term impact the injury was going to have on her life.

[49] Overall, I am satisfied with Dr. Nader's opinion and I accept and place significant weight on this opinion. He engaged in a personal clinical assessment of the worker on July 19, 2017, he provided a detailed account of the clinical records he reviewed and of the psychometric tests he administered. I acknowledge that Dr. Nader has indicated that there are a number of additional stressors which have contributed to the worker's psychological disorder and I note that sole causation is not required under the Act. I am satisfied with his opinion that there is causative significance between the work injury and the worker's Adjustment Disorder with mixed anxiety and depressed mood beginning in August 2012. I leave it to the Board to determine the worker's entitlement in this regard.

[50] The worker's appeal is allowed.

Conclusion

[51] As a result of this appeal, I vary the *Review Division decision #R0214935* dated March 21, 2017 by accepting the worker's Adjustment Disorder with mixed anxiety and depressed mood as a compensable consequence of her accepted right knee injury.

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Reimbursement for Psychologist's Medical Report/Opinion

[52] The worker requested reimbursement of the expense associated with Dr. Nader's psychological assessment and report in the sum of $3,130.31.

[53] Item #16.1.3 of the WCAT's *Manual of Rules of Practice and Procedure* provides that WCAT will generally order reimbursement of the expense of obtaining written evidence regardless of the result in the appeal, if the evidence was useful in the consideration of the appeal, or it was reasonable for the party to have sought the evidence.

[54] Under the Board's Psychologists' Fee Schedule the fee, effective April 1, 2017 for a psychological assessment and report is $190.00 per hour to a maximum of 13 hours. Dr. Nader indicates that he spent 11.25 hours in this matter. I am satisfied that it was reasonable for the worker to undergo the assessment and obtain Dr. Nader's report/opinion and it was significant in determining the appeal. However, I see no reason to deviate from the schedule. I therefore order reimbursement of the report under code 19768, that is 11.25 hours x $190.00 per hour.

Debe Simpson
Vice Chair

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