WCAT Decision Number: WCAT-2004-00123-RB
WCAT Decision Date: **January 13, 2004**
Panel: Julie A. Brassington, Vice Chair

Introduction

In a decision letter dated August 19, 2002, a Workers' Compensation Board (Board) case manager advised the worker that his claim was not accepted for "Complex Regional Pain Syndrome" or any other pain condition. The worker was also advised that the Board medical advisor was of the opinion that he had reached a state of maximum medical improvement and would not be left with a permanent functional impairment; therefore a referral to Disability Awards was not warranted. Further the case manager stated that the Board would not provide the worker with preventative vocational rehabilitation. The worker appeals these decisions.

Issue(s)

Is the worker entitled to a referral to Disability Awards for an assessment?

Is the worker entitled to vocational rehabilitation services on a preventative basis?

Is there medical evidence that indicates the worker has "Complex Regional Pain Syndrome" or any other pain condition? If yes, is it related to or a sequela to his compensable epicondylitis?

Jurisdiction

This appeal was filed with the Workers' Compensation Review Board (Review Board). On March 3, 2003 the Workers' Compensation Appeal Tribunal (WCAT) replaced the Appeal Division and Review Board. As a Review Board panel had not considered this appeal before that date, it has been adjudicated as a WCAT appeal. (See the *Workers Compensation Amendment Act (No.2), 2002*, section 38.)

Evidence

I have reviewed the evidence in the claim file, the evidence presented at the oral hearing held in Richmond, British Columbia on December 12, 2003, the *Workers Compensation Act* (Act) and applicable Board policy as set out in the *Rehabilitation Services and Claims Manual, Volume 1* (RSCM). Interested parties have full disclosure of the claim file available to them, and the medical and claim history will not be repeated in detail here except as relevant to the current appeal.

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The worker was employed by the employer as a car detailer. In 2001, the worker was 52 years old; he began working for the employer approximately 20 years ago. On August 20 and 21, 2001, the worker began to have pain in his right elbow. He submitted an application for compensation to the Board, and his claim was accepted for lateral epicondylitis of the right upper extremity.

The October 23, 2001 activity-related soft tissue disorder psychological assessment stated that testing revealed that the worker was mildly depressed, had a tendency to be anxious and felt very disabled by his pain. It was recommended that the worker attend an extended program because of his significant emotional distress due to pain. It was felt he would be able to participate in group psycho-educational sessions focused on managing pain and concomitant stress. In this program he would also have access to individual counselling sessions.

On October 24, 2001 the orthopaedic consultant from the pain program contacted the Board and advised them that the worker was too acute to allow full participation in the program. Due to the high level of symptoms and failure of any modality to give the worker significant relief, it was recommended that he be reviewed in a week's time. He was reassessed and returned to the program. However, he again became too acute and was discharged in early November. At that time the orthopaedic consultant suggested that as the worker appeared to be very significantly distressed, it would be of value for him to have some individual counselling.

Dr. Regan, orthopaedic surgeon examined the worker at the Board Visiting Specialists Clinic on April 6, 2002. He stated the worker had a diffuse complex regional pain syndrome and recommended the worker enter into a pain clinic. The worker was then referred to the Board's medical rehabilitation program to confirm the diagnosis.

The worker was assessed at the medical rehabilitation program on May 13, 2002. The physician at the medical rehabilitation program found no objective evidence of complex regional pain syndrome. He noted the worker complained of subjective complaints with heightened pain. He stated that at this stage, the diagnosis remained a diffuse enthesitis with significant pain response and possible underlying depression.

The worker was again referred to the pain program. The orthopaedic consultant at the pain program examined the worker on May 14, 2002. It was his impression that the worker had possible complex regional pain syndrome type 1 - right forearm, following overuse injury of enthesopathy about the elbow. The discharge summary report dated May 23, 2002 stated that the worker would benefit from intensive psychological counselling in the context of a re-activation program. It also noted that regardless of the source of the worker's pain, it had come to rule his life and he needed both some perspective on it and the ability to rise above the debilitating effects of the pain.

After failed physiotherapy treatment and a stellate ganglion block, the worker was again referred to the pain program. At that time, it was noted that the worker continued to present with a level of depression and barely suppressed anger. The medical impression was that of chronic pain, right elbow, forearm and hand following overuse injury. On September 3, 2003 the worker entered the program.

The intermediate report from the pain program indicated that the worker had been participating in all aspects of the psychology component of the pain program. The worker then entered into an occupational rehabilitation program in September of 2002. It was noted that the worker was pain limited, had inconsistent functional performance, questionable motivation to give full effort and decreased activity tolerance.

On the discharge summary report of October 16, 2002 it was noted that although the worker participated in the daily psycho-educational sessions which were focused on managing pain, concomitant stress and negative mood states, there did not appear to have been any changes in the worker's mood, perceived disability or sense of control over pain. The team felt that for whatever reason the worker did not put full effort forth during the program.

In the claim log entry of December 3, 2002 the case manager noted that in view of the MRI findings and the change in the accepted diagnosis on the claim, to include a probable tear of the right elbow radial collateral ligament, the worker was being referred for a pension assessment and vocational rehabilitation.

In a decision letter dated December 2, 2002 the worker was advised that his claim had been received in the Disability Awards Department and would be assigned to a disability awards officer within 24 months.

In a decision letter dated December 17, 2002 the worker was advised that his claim had been accepted for a probable tear of his right elbow radial collateral ligament. He was further advised that he was deemed at undue risk as per the RSCM item #86.30 (preventative rehabilitation) of permanent disability, due to vulnerability or of increased permanent disability should he return to his pre-injury work. As such the worker was referred to Vocational Rehabilitation Services.

In January of 2003 the worker met with the vocation rehabilitation consultant to review the vocational process. At that time the rehabilitation consultant submitted a budget for ten weeks of planning.

The worker's representative submitted a medical legal report from the worker's physician dated December 3, 2003. In that report the physician stated that the diagnosis of epicondylitis has been confirmed by numerous specialists and rehabilitation treatment/clinics. He reported that the worker described his pain as

throbbing and continuous. Aggravation with movement, gripping or palpation made the pain severe and debilitating. He noted that intervention in the past had only resulted in severe aggravation of the condition and made the worker completely debilitated.

The worker's physician reported that due to the constant pain and lack of improvement the worker had also been suffering from secondary Major Depression. He stated that the depression was not present prior to the injury and had deteriorated with ongoing suffering and conflict with the Board.

In terms of medication the worker was on Oxycontin 15 milligrams twice daily and Percocet for breakthrough pain. He was also being treated with Effexor-XR 75 milligrams daily and Wellbutrin 150 milligrams twice a day for his depression. The physician stated the worker has a diagnosis of a severe case of lateral epicondylitis with some involvement of the medial aspect.

The physician agreed that the worker did not exhibit characteristics of a Complex Regional Pain Syndrome. He noted the lack of progress in pain resolution and stated that functionally the worker has suffered a permanent functional impairment. He stated the worker cannot return to his pre-injury line of work. He will require vocational rehabilitation for retraining into a non-physical line of work.

Findings and Reasons

The issue of whether the worker was entitled to a referral to Disability Awards for an assessment has been dealt with in a subsequent decision (December 2, 2002) by the Board. I find that I am without jurisdiction to consider the issue of whether the worker was entitled to a referral to Disability Awards. While it is true that the Board subsequently reconsidered the matter and ultimately extended a referral to Disability Awards, no appeal regarding that subsequent decision is in place, and I am without jurisdiction to consider the matter. I find that by virtue of the subsequent decision the issue of a referral to Disability Awards in the August 19, 2002 decision letter is moot and not in the jurisdiction of this panel to consider.

On the issue of whether the worker is entitled to vocational rehabilitation services on a preventative basis, it as well has been dealt with in a subsequent decision by the Board (December 17, 2002). No appeal regarding that subsequent decision is in place, and I am without jurisdiction to consider the matter. I find that by virtue of the subsequent decision, the issue of a referral to Vocational Rehabilitation Services on a preventative basis in the August 19, 2002 decision letter is moot and not in the jurisdiction of this panel to consider.

In addressing the issue of Complex Regional Pain Syndrome, or any other pain condition, I note that the Board accepts that psychological conditions are compensable under certain conditions; and Board policy concerning psychological conditions is set

out in the RSCM, at chapter 3, which concerns personal injuries. Policy #13.20 indicates that traumatically induced psychological impairment could be accepted even if unaccompanied by any physical impairment. Psychological conditions may also be accepted as compensable if they are a sequela to an accepted personal injury or occupational disease.

Policy item #22.33 concerns psychological problems and chronic pain. Psychological problems arising from a physical or psychological injury are acceptable as compensable consequences of the injury. However, there must be evidence that the worker is psychologically disabled. It cannot be assumed that such a disability exists simply because the worker has unexplained subjective complaints or is having difficulty in psychologically or emotionally adjusting to any physical limitations resulting from the injury.

This policy also stipulates that chronic pain problems are also acceptable if the evidence indicates that they result from the work injury. If the evidence indicates that the condition is disabling but may be amenable to treatment, the Board will regard the condition as a temporary disability and pay temporary wage loss benefits in the normal way. The Board may arrange for the worker to be treated by a chronic pain clinic.

With respect to his claim for complex regional pain syndrome, chronic pain or chronic pain syndrome, the worker said he has pain all of the time in his right arm, in various forms. His main pain is constant, and would stay at the same level all of the time if he remained still, but he stated that staying still is not always possible.

There is ample evidence early in the worker's claim, contained in the medical reports, that the worker was experiencing chronic pain as a result of his compensable injury. There are numerous medical reports from the worker's attending physician alerting the Board to the worker's ongoing and debilitating chronic pain symptoms.

There are also conflicting medical opinions on the file, with Dr. Regan, orthopaedic surgeon stating the worker had a diffuse complex regional pain syndrome, while the physician in the medical rehabilitation program found no objective evidence of complex regional pain syndrome. This was followed by the physician in the pain program stating that it was his impression that the worker had possible complex regional pain syndrome - type 1 - right forearm. The worker's physician in his letter of December 3, 2003, stated that the worker did not exhibit characteristics of a Complex Regional Pain Syndrome.

In terms of the conflicting medical opinions on file, I have given the most weight to the opinion of the worker's own physician who had followed the worker and examined him regularly over the years. The physician in the pain program did not give a definite diagnosis, rather stated it was his impression that the worker had a possible Complex Regional Pain Syndrome. I do not consider this a definite diagnosis. The worker's physician was the last medical professional to examine the worker and stated the worker

did not exhibit the characteristics of a Complex Regional Pain Syndrome. Accordingly, I find that the Board did not err in stating that they did not accept Complex Regional Pain Syndrome as a compensable consequence of the worker's injury.

Having said that, I do accept that the worker has chronic pain problems and find that the evidence indicates that this resulted from the work injury. I find the evidence indicates that the condition is disabling and has not been amenable to treatment. The Board arranged for the worker to be treated by a chronic pain clinic yet the worker continues to have chronic debilitating pain.

I would be remiss if I did not address the issue of depression which the worker, his representative and physician ascribe to be a result of his compensable injury. I note that no decision has been made in regards to whether the worker's depression is compensable and would recommend that the worker discuss this matter with the Board.

Conclusion

I find that by virtue of the subsequent decision the issue of a referral to Disability Awards in the August 19, 2002 decision letter is moot and not in the jurisdiction of this panel to consider.

I find that by virtue of the subsequent decision, the issue of a referral to Vocational Rehabilitation Services on a preventative basis in the August 19, 2002 decision letter is moot and not in the jurisdiction of this panel to consider.

I allow the worker's appeal as it relates to chronic pain. I find that the worker has chronic pain problems that resulted from the work injury and that they are compensable. I return the claim file to the Board to determine what, if any benefits flow from this decision.

The worker is entitled to such costs of this appeal as he can establish, including reimbursement for the cost of Dr. Hamza's December 3, 2003 opinion.

Julie A. Brassington
Vice Chair

JAB/hba