Noteworthy Decision Summary

Decision: WCAT-2003-03993-RB **Panel**: Janice Leroy **Decision Date:** December 4, 2003

Pain Disorder Associated with Both Psychological Factors and a General Medical Condition – Chronic pain syndrome – Psychological impairment versus chronic pain – Policy items #22.33, #38.10 and #39.01 of the Rehabilitation Services and Claims Manual

Pain Disorder Associated with Both Psychological Factors and a General Medical Condition should be assessed as a psychological condition under policy item #38.10 of the *Rehabilitation Services and Claims Manual* (RSCM) as it is a condition under the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) and is not excluded as being a mental disorder.

The worker, a seafood processor, injured her knee, head, neck and back. The former Appeal Division found the worker had developed both a myofascial pain syndrome, which had an organic basis, and a chronic pain syndrome, which had a psychological basis, and directed the Workers' Compensation Board (Board) to arrange for a psychological assessment. An independent psychologist concluded the worker met the criteria under the DSM-IV for a diagnosis of Pain Disorder Associated with Both Psychological Factors and a General Medical Condition.

The Board accepted chronic pain syndrome and myofascial pain as permanent conditions under the claim but concluded that, although the chronic pain syndrome was a psychological diagnosis, it was not rateable as such and was dealt with as a subjective consideration. The Board assessed the worker under item #39.01 of the RSCM and awarded the worker a permanent disability award (PDA) based on a permanent functional impairment of three percent. The worker argued the Board should have referred her claim to the Board's Psychological Disability Awards Committee to assess the level of her psychological disability and appealed to the former Review Board. On March 3, 2003, the Review Board was replaced by the Workers' Compensation Appeal Tribunal.

The panel noted that item #38.10 provides that the assessment of permanent psychological impairments must be done by either a Board Psychologist or a Board authorised external provider. At the relevant time item #39.01 provided that in cases where a claimant had subjective complaints of pain and discomfort with little or no objective evidence of actual physical impairment, the Board could still grant a PDA where the evidence established that the subjective complaints amounted to a disability.

Effective December 31, 2001 the RSCM had been amended to include psychological impairments in the *Permanent Disability Evaluation Schedule*. Both before and after the amendments, item #22.33 provided that both chronic pain and psychological problems arising from an injury were acceptable as compensable consequences of the injury. The amended version provided that psychological impairment was assessed under item #38.10. It also stated that chronic pain is not assessed as a psychological impairment.

The panel did not accept that the amendment to item #22.33 was intended to exclude a psychological disorder duly diagnosed in accordance with the criteria set out in DSM-IV from assessment as a psychological impairment. The panel provided five reasons:

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- Chronic pain and Pain Disorder Associated with Both Psychological Factors and a General Medical Condition are not interchangeable diagnoses.

- The addition to item #22.33 of the paragraph dealing with chronic pain was intended merely to clarify that chronic pain was not to be assessed as a psychological impairment.

- If the Panel of Administrators had intended to exclude DSM-IV Pain Disorders from the impairment rating process applicable to all other DSM-IV diagnoses, one would have expected them to state the exclusion explicitly, as was done in the case of Reynaud's Phenomenon (item #39.44).

- If DSM-IV conditions were assessed in the same manner as chronic pain problems, the psychological aspect of such conditions would be ignored. Only the effect of the diagnosed disorder on physical function would be considered.

- Although any treating physician can diagnose a chronic pain syndrome/condition/problem, item #38.10 provides that only a psychologist can make a diagnosis under DSM-IV. There would be no point in referring a claimant with chronic pain for a psychological assessment using the diagnostic criteria in the DSM-IV if such diagnosis, once made, was to have no impact on the manner in which the condition was to be rated.

The worker's appeal was allowed. The Board should have assessed the worker's diagnosed Pain Disorder Associated with Both Psychological Factors and a General Medical Condition under item #38.10.

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WCAT Decision Date: **December 04, 2003**
Panel: Janice A. Leroy, Vice Chair

Introduction

The worker is now 43 years old. On April 11, 1994 she was working as a seafood processor. On that day she slipped and fell while carrying a five-gallon bucket of water, causing bruising about her right knee and ongoing head and neck pain. Three months before that she had slipped off a ladder at work, bruising her lateral thighs, right lower leg and left forearm, chipping her teeth and causing tenderness over the left lower rhomboid area and left paralumbar muscles.

The Workers' Compensation Board (Board) paid one day of wage loss on the first injury and concluded benefits on the April 1994 injury on March 30, 1995.

In a decision dated February 14, 2000 a panel of the former Appeal Division found that the worker's symptoms subsequent to March 30, 1995 were causally related to the work injuries. They found the worker had developed both a myofascial pain syndrome, which had an organic basis, and a chronic pain syndrome, which had a psychological basis, as a result of her compensable injuries. The panel directed the Board to arrange for a psychological assessment to determine whether any treatment was recommended, and whether the worker had been disabled from work at any time since March 30, 1995 by a temporary condition.

In a letter dated August 28, 2000 [B Appeal] a case manager enclosed a print out showing the wage loss payments that had been paid on the claim, retroactive to April 10, 1995.

In a decision letter dated September 7, 2000 [C Appeal] a case manager noted that the psychological assessment had indicated a pain program would be beneficial for the worker, and the worker had attended such a program. The case manager advised that the worker's condition was considered plateaued as of the completion of the pain program on September 10, 2000, the claim was being referred to the Disability Awards Department and to the Vocational Rehabilitation Department, and that the worker would be assisted with a twelve-week job search allowance from September 11, 2000 to December 3, 2000.

In a decision letter dated September 13, 2000 [D Appeal] a Board vocational rehabilitation consultant (VRC) confirmed that the Vocational Rehabilitation Department would be administering the twelve-week job search program and would pay any out of pocket expenses in relation to the job search.

In a decision letter dated October 23, 2000 [E Appeal] the VRC noted that the worker had not submitted job search sheets as required and said that it appeared the worker did not intend to actively seek work and saw herself as unemployable on account of her compensable conditions. He advised that the job search allowance was being discontinued effective October 22, 2000, and would be reinstated if the worker chose to participate in job search.

In a decision letter dated March 18, 2002 [F Appeal] a claims adjudicator in the Disability Awards Department (CADA) advised that the worker had been awarded a permanent functional impairment (PFI) pension based on a disability rating of three percent of total from September 11, 2000.

The worker appealed the above decisions. She appeared at the oral hearing with her representative and gave sworn testimony. The employer appeared with a representative and opposed the appeals.

At the hearing the worker's representative withdrew the appeal of the August 28, 2000 decision letter. She initially withdrew the appeal of the September 13, 2000 appeal but later advised that she wished to argue the sufficiency of vocational rehabilitation services, as set out in that letter, as an alternative argument.

On the day before the hearing the worker filed a medical-legal letter dated October 3, 2003 from the worker's family physician, Dr. Matous. This is marked exhibit #1.

Post-hearing, at the panel's request, the employer's representative filed submissions dated November 10, 2003 concerning whether the worker's diagnosed permanent psychological condition ought to have been rated as a psychological impairment in accordance with the procedure set out in item #38.10 of *the Rehabilitation Services and Claims Manual, Volume 1* (RSCM), to which the worker's representative responded in a submission dated November 12, 2003.

Issue(s)

The issues are:

1 Was the worker's pension appropriately assessed?

2 Is the worker entitled to more or different vocational rehabilitation services?

Jurisdiction

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

Relevant Information

Following issue of the Appeal Division decision the Board psychologist referred the worker to Dr. Lum, an independent psychologist, for a psychological assessment. He assessed the worker on May 19, 2000. In his assessment report Dr. Lum said the worker met the criteria for a diagnosis of Pain Disorder Associated With Both Psychological Factors and a General Medical Condition. He said the Pain Disorder was largely rated to the injury events and there were no apparent pre-existing or extra-claims psychological issues that might have contributed to the emergence or maintenance of the disorder. He said that it was premature to consider the condition as plateaued and recommended a multi-disciplinary chronic pain program. He said further that there was no evidence of any other identifiable issues or concerns that might complicate or delay recovery.

The worker attended a pain rehabilitation program from June 19, 2000 to July 21, 2000. She was an active and enthusiastic participant in all aspects of the program. Her mood was low at admission but improved over the course of the program, in part because the doctor had put her on an antidepressant medication. Her mood continued to be a source of concern at discharge and the team recommended further psychological support to assist the worker in her transition form injury status to employment. The worker indicated a desire to return to the workforce. The team cautioned that after a six-year absence from the work force the worker would require significant support and vocational rehabilitation assistance to guide her in the process, and recommended that she be referred to a VRC as soon as possible in order to maintain her current level of motivation and desire to return to a productive lifestyle.

Over the course of the program the worker made improvements in general posture and body awareness, generalised flexibility and physical conditioning, and in actual functional capability. She participated in a functional capacity evaluation (FCE) on July 20, 2000. She was co-operative and attempted all tasks requested of her, but demonstrated overt pain behaviours with many subjective reports of increased symptoms and pain during strength activities and those that required frequent shoulder or neck movements. She did not reach physiological maximum effort during the evaluation as she was limited due to pain. She demonstrated abilities in the sedentary strength category. The evaluator viewed her as capable of working at the sedentary to

light level with restrictions on repetitive lifting, above shoulder work, repetitive neck movements and cold environments.

At a team meeting held on August 17, 2000 the Board medical advisor said that the worker's myofascial pain syndrome had plateaued some time ago. The Board psychologist said that the worker continued to have symptoms suggestive of a pain disorder and that these symptoms were likely permanent. He said that the worker was at risk of developing a psychological PFI if her psychological functioning were to lapse, and supported the view that she receive ongoing supportive counselling in her attempt to return to the workforce.

The case manager concluded that the worker's myofascial pain syndrome and chronic pain disorder had plateaued. He made arrangements for a referral for ongoing counselling, requested the medical advisor's opinion concerning whether temporomandibular joint (TMJ) problems were acceptable under the claim, and arranged to meet with the worker, in the company of the VRC.

The case manager and VRC met with the worker on August 16, 2000 and explained that her compensable conditions had plateaued and wage loss would shortly be concluded. The VRC explained that in light of the eight-week wage rate on the claim, $791 per month in 2002 dollars, the Vocational Rehabilitation Department could offer only limited assistance to help her re-enter the work force.

Based on the medical advisor's opinion that the TMJ problems were likely related to the stress of chronic pain the case manager accepted TMJ under the claim. He referred the claim to the Disability Awards Department on September 5, 2000.

The Board then issued the C Appeal and D Appeal decision letters dated September 7, 2000 and September 13, 2000 respectively. The first letter confirmed that the Board viewed the worker's compensable conditions as plateaued, and advised that wage loss would end effective September 10, 2000, the claim would be referred to the Disability Awards Department, and the worker would be provided with a 12-week job search allowance from September 11, 2000 to December 3, 2000. In the second letter the VRC reiterated that the worker was being provided with a job search allowance for a period of 12 weeks, and advised the worker that she had to complete and return job search forms on a bi-weekly basis.

The worker did not engage in an active job search as required. The VRC spoke with the worker on October 23, 2000. She advised that she did not feel she could seek employment and that she was totally restricted from working. She said her muscles stiffened up in winter and this would preclude her from working. The VRC then issued the E appeal Decision letter dated October 23, 2000 advising that the job search allowance had been suspended effective October 22, 2000, and would be reinstated if the worker actively sought work.

In her report to the Board dated November 8, 2000 the counselling psychologist to whom the worker had been referred for support with her transition to employment said:

> From a psychological perspective, [the worker's] potential for work return might be facilitated by a collaborative, planned approach to vocational counselling /job search. Her search for employment takes place in the broader context of having been out of the workforce for six years; limited education; residing in a small, rural community with limited employment opportunities; chronic pain; and functional limitations. [The worker] reports that she is overwhelmed at the thought of seeking employment alone, in these circumstances.

The counselling psychologist reiterated these thoughts in her January 15, 2001 report, saying the worker remained overwhelmed at the thought of seeking employment without assistance.

In a memo dated March 4, 2002 the CADA set out that a chronic pain syndrome and myofascial pain had been accepted as permanent, and considered the degree to which the worker was disabled by those conditions. He noted that the Board psychologist had said that although the chronic pain syndrome was a psychological diagnosis, it was not rateable as such and was dealt with as a subjective consideration.

He assessed a disability rating of two percent of total to recognise the worker's chronic pain syndrome, saying that rating was consistent with the extent and nature of the original injuries. He awarded a further one percent of total to recognise myofascial pain syndrome, for an overall functional impairment award of three percent of total.

The CADA noted that the FCE had indicated the worker was capable of work at a sedentary to light level, and observed that in view of the very low wage rate on the claim, $791 per month (in 2002 dollars), the worker could match her pre-injury earnings by working only part time at a minimum wage job. On that basis he concluded that no loss of earnings was likely. He then issued the F Appeal pension decision letter of March 18, 2002 awarding a PFI pension of three percent from September 11, 2000, to be applied against 100 percent of the pension wage rate of $791 per month.

At the hearing the worker spoke of her pain. She said she is in pain 95 percent of the time and that her pain escalates with activity. She has sciatic type pain down her left leg. At one point the sciatic pain was controlled by cortisone shots, but she had the last of the permitted shots just before attending the pain program. If she hyperextends her muscles, for instance to scratch her back, she gets spasm in the affected muscles. She cannot sit for long on account of the sciatic pain. She cannot stand for long before onset of mid to left-side low back pain. She can walk two to three blocks on a good day. She can carry a maximum of five pounds in each hand; with heavier weights her shoulders get sore. She can reach out in front but if she does too much of that she

gets palpable knots in her arm muscles. She cannot reach up with the left arm. Her left hand and fingers go numb and drain. She can bend at the knees but not at the low back, especially since her cortisone shots ended. She has trouble sleeping on account of pain. If she is exposed to cold her body tenses and she feels extreme pressure in her chest. Her teeth rattle uncontrollably. She cannot talk or smile too much, or her jaw aches. She has regular and extended headaches.

The worker said she can do dishes; she can help with laundry; and she can accompany her husband for half of the grocery shopping but cannot walk long enough to complete the shopping.

The worker takes Ativan when she feels anxiety coming on, and Tylenol #3s, one or two per day.

The worker recently completed an 11-week course called Bootstraps. This program is intended to help disabled people get back to work. It includes instruction on use of a computer to create and modify a resume, and helps participants identify suitable work. During the course the worker took about four Tylenol #3s per day to cope with the physical requirements of the classroom setting. She determined that she might be able to do part time work in a laundry, and applied for such a job, but was not successful. She also thought she might be able to work as an aesthetician, but remains uncertain as to whether she could tolerate the sitting and constant arm extension.

Apart from that one application to the laundry the worker has not applied for work since her injury.

The worker testified that over the course of the pain program in the summer of 2000 her function was at its highest, largely because she had just had a cortisone shot. She said she became more and more exhausted as the five-week program wore on, but since she had advocated for so long to get into the program, she was determined to see it though. When she got home she tried to continue with the exercises, but found that she could not both do exercises and do the usual and necessary household chores such as making the bed, sweeping the floor and so on. She went to Dr. Matous, who told her not to try doing both, just to do what she could. The worker said she never tried looking for a job. First of all she did not have the stamina to actually go out and knock on doors, and second, she could not think of anything that, realistically speaking, she could do. And as time went on and the weather turned cold, she lost more and more function.

The worker testified that Dr. Matous has been her attending physician for the past eight years. She has a grade eight education. All of her previous jobs were entry level physical positions. She reads the local paper every day. That is how she learned about the Bootstraps program.

In his medical-legal letter dated October 3, 2003, exhibit #1, Dr. Matous said that, in a hypothetical sense, the worker might to able to work part time in a sedentary or light capacity, but that practically speaking it would be very difficult to find employment that would not exacerbate her medical problem. He said any such job would have to:

- be part time;
- permit significant flexibility in scheduling, since the worker is not always able to perform duties with the same ease from day to day;
- be sedentary but allow her to get up and move around from time to time
- not require that her left arm be in contact with a surface such as a desk for any extended period;
- require only extremely light work of her upper body; and,
- not require her to move around frequently or continuously.

Dr. Matous said that, based on his experience with the worker, if she tried to perform duties that did not meet the above restrictions, her symptoms would become significantly worse within a very short period, and she would be unable to continue. Accordingly, he said, in practical terms it is very unlikely that the worker would be employable in any conventionally available setting.

Dr. Matous said the worker's limitations were the same in September of 2000 as they are now, so she would not have been physically able to engage in significant amounts of driving and walking to look for a job. He also said that three percent is not an accurate reflection of the level of disability that the worker experiences, and that if the Board continues to view the worker as capable of working, she will first need to participate in a work conditioning program, so as to demonstrate her current functional capability and restrictions.

The worker, through her representative, argued that the CADA ought to have referred the worker's claim to the Psychological Disability Committee to assess the level of her psychological disability, and that in any event the current disability rating is woefully low. She said the worker is competitively unemployable, and ought to be awarded a loss of earnings pension. She argued in the alternative that the vocational rehabilitation services that were provided to the worker were insufficient to permit her to return to the work force in a suitable position.

The employer, through its representative, argued that the most reliable evidence of the worker's capacity for employment was set out in the discharge report from the pain program. He pointed out that five professionals, each of whom was experienced in assessing chronic pain situations, and all of whom had had an opportunity to observe and work with the worker over a five-week period, had concluded that, with appropriate vocational rehabilitation support, the worker would be able to work in a sedentary to light capacity. He agreed with the worker's representative that the worker's permanent

psychological condition ought to be rated by the Psychological Disability Committee (PDC) in accordance with the procedure set out in item #38.10 of the RSCM.

Reasons and Findings

Impairment Rating

Section 23(1) of the *Workers Compensation Act* (Act) provides that where permanent partial disability results from a compensable injury, the impairment of earning capacity for pension purposes must be estimated from the nature and degree of the injury, or in other words, from the degree of functional impairment.

Section 23(2) of the Act authorises the Board to compile a rating schedule of percentages of impairment of earning capacity for specified impairments to use as a guide in determining the compensation payable in permanent disability cases. The Board has adopted the Permanent Disability Evaluation Schedule (Schedule) found in Appendix 4 to the *Rehabilitation Services and Claims Manual, Volume 1* (RSCM) as the rating schedule. The Schedule includes ratings for psychological disabilities.

Item #38.10 of the RSCM provides that the determination of whether there is a permanent psychological impairment, and the severity of it, is to be made by either a Board Psychologist or a Board authorised external provider. Once that determination has been made the claim is to be referred to the PDC to assess the percentage of disability resulting for the permanent psychological impairment. And although the CADA is to make a recommendation concerning whether a loss of earnings is likely, it is ultimately up to the PDC to reach a conclusion on that issue.

In the present case the CADA arranged for an authorised provider, Dr. Lum, to determine whether the worker suffered from a diagnosable psychological impairment and whether it was permanent. However the Board psychologist advised the CADA that pain disorders were not on the DSM-IV classification, and that as he understood it, pension awards for such disorders were at the discretion of the Disability Awards Department. The CADA did not refer the claim to the PDC, but instead assessed the disability pursuant to item #39.01 of the RSCM.

At the relevant time item #39.01 (RSCM) provided that in cases where a claimant had subjective complaints of pain and discomfort with little or no objective evidence of actual physical impairment, the Board could still grant a PFI award where the facts established that the subjective complaints amounted to a disability.

Effective December 31, 2001 the RSCM had been amended to include psychological impairments in the Schedule. Both before and after the amendments, item #22.33 of the RSCM was headed*: Psychological Problems/Chronic Pain Problems*, and provided,

in the first paragraph, that psychological problems arising from an injury were acceptable as compensable consequences of the injury. Pre-amendment the policy went on to deal with who was to determine the existence of such a problem, and provided for referral to the Board's Chief Psychologist for evaluation, to rate the disability with reference to the American Medical Association Guide to the Evaluation of Permanent Impairment. The policy then went on to provide that chronic pain problems that result from work injuries are also compensable, and set out differing approaches to its management, depending on whether it was temporary or permanent.

The amendments left the heading and first paragraph unchanged. The balance of the provisions dealing with psychological problems were replaced with the following provision:

> When a psychological impairment becomes permanent, it will be necessary to determine whether there is entitlement to a permanent disability pension. The decision-making procedure for assessing entitlement to a permanent disability award for psychological impairment is found in #38.10.

This was followed by the paragraph dealing with chronic pain, into which the Panel of Administrators inserted the bolded sentence:

> Chronic pain problems are also acceptable if the evidence indicates that they result from the work injury. **Chronic pain is not assessed as a psychological impairment**. If the evidence indicates that the condition is disabling but may be amenable to treatment, it will regarded as a temporary disability and …
>
> (emphasis added)

It was this last addition, I suspect, that led the Board psychologist and the CADA to believe that a diagnosis of Pain Disorder Associated With Both Psychological Factors and a General Medical Condition was not to be assessed as a psychological impairment. However, for the reasons set out below, I do not accept that the addition of a provision stating that chronic pain is not assessed as a psychological impairment was intended to exclude a psychological disorder duly diagnosed in accordance with the criteria set out in DSM-IV from assessment as a psychological impairment.

First, chronic pain and Pain Disorder Associated With Both Psychological Factors and a General Medical Condition, are not interchangeable diagnoses. The DSM-IV sets out somatoform disorders, including two pain disorders: Pain Disorder Associated with Psychological Factors and Pain Disorder Associated with both Psychological Factors

and a General Medical Condition. There are five diagnostic criteria:

- Pain is the focus of the clinical presentation and is of sufficient severity to warrant clinical attention
- The pain causes clinically significant distress or impairment in social, occupational, or other areas of functioning
- Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain
- The symptoms or deficits are not intentionally produced or feigned
- The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

A third subtype, Pain Disorder Associated with a General Medical Condition, is expressly not considered to be a mental disorder.

In *Appeal Division Decision #2003-0576* the panel undertook an analysis of the various terms used to describe or diagnose pain and pain conditions. The panel reviewed the various editions of the American Medical Association Guides to the Evaluation of Permanent Impairments (AMA Guides) and surveyed decisions of the former Appeal Division dealing with chronic pain and chronic pain syndrome.

The panel observed that the third edition of the AMA Guide (1990) drew a distinction between chronic pain and chronic pain syndrome. Chronic pain represented the nidus of the chronic pain syndrome. If it was not diagnosed and adequately treated it could result in deteriorating coping mechanisms and pacing skills, which in turn could result in progressive limitations and functional incapacity, which contributed to evolution of a chronic pain syndrome. That is, chronic pain could exist in the absence of chronic pain syndrome, but chronic pain syndrome always presumed the presence of chronic pain. The third edition of the AMA Guide specifically stated that chronic pain syndrome could not be considered a mental disorder. The Guide included six criteria for a diagnosis of chronic pain syndrome, the presence of two or more being diagnostic:

Duration
Dramatisation
Drugs
Despair
Disuse
Dysfunction

The panel noted that the fourth edition of the AMA Guide (1993) adopted a new terminology, saying pain of long duration was properly referred to as “persistent pain” with the term chronic pain being reserved for the devastating and recalcitrant type with major psycho-social consequences. Chronic pain and chronic pain syndrome were viewed as synonymous. That is, persistent pain could exist in the absence of chronic

pain, but chronic pain always presumed the presence of persistent pain. The Guide included eight criteria for a diagnosis of chronic pain syndrome, the presence of four or more being diagnostic:

Duration
Dramatisation
Diagnostic dilemma
Drugs
Dependence
Depression
Disuse
Dysfunction.

The fifth edition of the AMA Guide signalled a return to the approach taken in the third edition. It explained that there had been behavioural/psychological advances in understanding the nature of pain. Chronic pain had come to be seen as not intrinsic to a disease or injury but rather as reflecting environmental contingencies. However this had had the unfortunate effect of increasing scepticism about the validity of pain complaints from those suffering persistent pain. Chronic pain syndrome was now viewed as largely a behavioural syndrome that affected a minority of those with chronic pain – best understood as a form of abnormal illness behaviour that consisted mainly of excessive adoption of the sick role. The term "chronic pain syndrome" was useful in that it directed therapy towards the reversal of regression and away from an exclusive focus on elimination of nociception. Only in a minority of cases would chronic pain lead to chronic pain syndrome. Chronic pain was defined in its glossary as pain that extended beyond the expected period of healing or was related to a progressive disease. It usually commenced with an injury or disease but could be perpetuated by factors that were both pathogenically and physically remote from the original cause. it was seen as likely that environmental and physiological factors interacted with the tissue damage, contributing to the persistence of pain and illness behaviour.

The panel reviewed *Appeal Division Decisions #1993-0277, #2001-1501 and #1995-0899*, which dealt with pain issues and considered the various terms used in the diagnosis and treatment of pain. Based on this review of the AMA Guides and the cases, the panel concluded, among other things, that:

1 Chronic pain syndrome always includes chronic pain, while chronic pain suffers do not always proceed to chronic pain syndrome;

2 Chronic pain syndrome, unlike the pain disorders listed in the DSM-IV, is a medical diagnosis, not a psychological or psychiatric diagnosis;

3 Chronic pain syndrome is not a mental disorder.

Based on my reading of the panel's review I think it is reasonable to add that although the AMA Guide diagnostic criteria for diagnosis of chronic pain and chronic pain syndrome are similar to the DSM-IV criteria for diagnosis of a Pain Disorder, there is one key difference. To warrant a Pain Disorder diagnosis under DAM-IV, psychological factors must be judged as having an important role in the onset, severity or maintenance of the pain. On the other hand, chronic pain and chronic pain syndrome can be diagnosed without psychological factors having played or playing any role in the pain. It is fair to say that chronic pain and chronic pain syndrome can exist in the absence of a DSM-IV Pain Disorder, but a DSM-IV Pain Disorder always presumes the presence of chronic pain. Chronic pain and chronic pain syndrome may or may not be different from each other and from persistent pain, but a DSM-IV Pain Disorder is distinct from each of them.

Second, when item #22.33, as amended, is read as a whole, it emerges that the addition to the paragraph dealing with chronic pain was included merely to clarify that the fact that chronic pain problems are included in the same policy with psychological problems, and the new procedure for assessing impairment in cases of psychological problems is followed directly by a provision stating that chronic pain problems are also acceptable, was not intended to suggest that chronic pain was also to be assessed as a psychological impairment.

Third, if the Panel of Administrators had intended to exclude Pain Disorders meeting the criteria for diagnosis under DSM-IV from the impairment rating process applicable to all other DSM-IV diagnoses, one would have expected them to state the exclusion explicitly, as was done, for instance, in the case of Reynaud's Phenomenon. Item #39.00 provided that in applying the physical impairment method to assess permanent disability, the Board did not normally have regard to the individual worker's actual loss of earnings, but item #39.44 provided that in the case of Reynaud's an award would be granted only if the worker had not returned to the pre-injury or equal paying occupation. That is, the general rule was qualified by the word "normally" and the exclusion was explicitly stated. Here there is no qualification to the direction that psychological impairments are to be assessed in the manner set out in #38.10, and there is no specific exclusion for Pain Disorders Associated With Both Psychological Factors and a General Medical Condition from the procedure set out in #38.10.

Fourth, if the disability associated with a psychological condition diagnosed in accordance with the criteria set out in DSM-IV was to be assessed in the same manner as chronic pain problems, the psychological underlay inherent in the DSM-IV diagnosis, which might well impact the claimant's ability to obtain and sustain employment, would be ignored. Only the effect of the diagnosed disorder on physical function would be considered.

Finally, although any treating physician can diagnose a chronic pain syndrome/condition/problem, item #38.10 provides that only a psychologist can make a

diagnosis under DSM-IV. What would be the point in referring a claimant with chronic pain for a psychological assessment using the diagnostic criteria in DSM-IV if such diagnosis, once made, was to have no impact on the manner in which the condition was to be rated?

Accordingly, I find that the permanent disability associated with the worker's diagnosed Pain Disorder Associated With Both Psychological Factors and a General Medical Condition ought to have been assessed in the manner set out in item #38.10 of the RSCM.

The parties did not raise any issues concerning the one-percent rating the CADA assigned to the permanent myofascial pain syndrome, and for completeness I find that that rating is appropriate.

Loss of Earnings

Section 23(3) of the Act provides that where the Board considers it more equitable it may award a pension based on the likely loss of earnings the claimant will experience, rather than on the functional impairment method. Policy dictates that the Board must compute the pension using both methods, and in each case use the method that results in the higher pension amount.

Item #40.10 of the RSCM explains that to determine whether a long term loss of earnings is likely the Board must consider the limitations imposed by the compensable disability and the fitness of the claimant for different types of work and their availability, and based on that evidence arrive at a conclusion about suitable occupations that the claimant could be expected to undertake over the long terms. The Board must then select, from the jobs that are suitable and reasonably available, those that maximise the claimant's long-term potential, and from there determine whether a loss of earnings is expected over the long term.

In this case the CADA concluded that no loss of earnings was likely. Again, he did not explain his reasoning but merely said he had based his conclusion on a consideration of the nature of the worker's impairment, her work capacity, her age and the wage rate, and noted the worker would only need to work part time at minimum wage to reach her pre-injury level of earnings.

The worker and her doctor say, essentially, that the worker cannot do anything that involves muscle movement, and ought to simply accept her pain limitations and stop each activity as soon as it causes pain. The worker fears exacerbation of pain and considers herself completely disabled and dependent. Her doctor has observed the worker over the course of her disability, and based on the worker's self-reports of disability, agrees with her that she can do very little.

The worker's opinion of her ability to function and that of her doctor differ markedly from that of the kinesiologist from the pain program. The kinesiologist evaluated the worker's functional capacity on July 20, 2000, at the conclusion of the pain program. She concluded, based on her observations and testing, that the worker was able to:

- perform lifting and carrying at a sedentary level accordingly to the CCDO/NOC;
- sit for extended periods without observable difficulty;
- stand for periods of up to 20 minutes before needing to change positions, and with frequent short rest periods and the opportunity to change positions, could stand for up to one hour;
- walk for approximately 45 minutes on even terrain; and
- climb four flights of eight stairs without difficulty.

The kinesiologist said the worker was limited in her ability to sustain work at or above shoulder height and to lift or carry frequently or continuously throughout the day. She said the worker was capable of work at the sedentary to light level that does not involve repetitive neck movements, repetitive lifting, or working at or above shoulder height.

The kinesiologist had worked with the worker throughout the five-week pain program. She had observed the worker being pushed beyond the physical boundaries she had set for herself, undergoing exacerbations of pain, and recovering from them. She was able to observe, over an extended period, which motions and activities caused ongoing exacerbations, and which did not. And she had observed the worker as she worked through the functional testing on July 20, 2000.

It is only natural that the worker and her doctor want to minimise the pain she has to endure. The kinesiologist on the other hand, while not seeking to hurt patients, seeks to maximise repeatable function. The kinesiologist is an expert in functional capacity and by virtue of her experience in the pain program, is likely skilled in assessing pain-related functional issues. So, at the end of the day, I have to conclude that the best evidence of the worker's functional capacity, at least as it was in September of 2000, is the objective and expert opinion offer by the kinesiologist. The worker says that that level of function is no longer achievable because she cannot have another cortisone shot to reduce her sciatic pain. That many well be. But I have difficulty accepting that the cortisone made such a difference that without it the worker was rendered completely disabled, as she now presents.

So, at the end of the pain program the worker was able to work in a sedentary to light capacity, with restrictions on repetitive neck movements, repetitive lifting, and work above shoulder height. The vocational consultant from the pain program reported the worker was wanting to work but on account of the six-year absence from the work force, would require significant support to assist her in her pursuit of employment. She recommended the worker be referred to a Board VRC as soon as possible in order to maintain her current level of motivation and her desire to return to work. The Board's

response was to refer the worker to a psychologist for counselling and tell the worker she had 12 weeks to find a job

The counsellor tried to inspire the Board to provide the worker with some assistance in locating employment. She reported that the worker needed a collaborative, planned approach to vocational counselling/job search, noting the worker's job search took place in the broader context of having a limited education, having been out of the workforce for six years, living in a small community and living with chronic pain.

The VRC simply noted that the worker was not filing job search sheets as required and terminated benefits.

Item #85.10 of the RSCM provides that the Board's vocational rehabilitation mandate is to assist claimants to overcome the effects of their compensable injuries on their earning capacity. Thus the goal of vocational rehabilitation services is to see each claimant returned to the work force in suitable employment that will generate at least the level of earnings he or she was making prior to the injury – that is, that will match or exceed the long-term wage rate on the claim, so as to avoid any loss of long-term earnings on account of the compensable injury. A loss of earnings is likely if any PFI pension award is less than 75 percent of the difference between the maximised long-term earnings and the long-term wage rate on the claim.

Item #85.30 of the RSCM sets out seven "guiding principles" of quality rehabilitation, among them that maximum success in vocational rehabilitation requires that different approaches be used in response to the unique needs of each individual, and the process requires the collaborative involvement and commitment of all concerned participants.

However, in providing vocational rehabilitation services the Board must ensure a wise use of resources, allocating only so much money to each program as is reasonably necessary to accomplish the mandate. So if, for example, a claimant was a minimum-wage earner before the injury, the Board should provide only so much service as is necessary to permit the claimant to obtain a position that will generate those earnings.

Item #40.12 of the RSCM provides that an available job is one that is reasonably available to the claimant in the long run, generally within a reasonable commuting distance of the claimant's home. A suitable job is one that the claimant has or could have the skills to perform, is fit to undertake, and that would not involve adverse health consequences either immediately or in the long run compared with other jobs.

Item #88.32 of the RSCM deals with job search allowances. It provides no guidance concerning how much assistance is appropriate. However, given that the objective of vocational rehabilitation is to get workers back to work in physically suitable positions at

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their pre-injury wage rate, what is appropriate must be a function of how much time is objectively, reasonably necessary for the particular worker to find such employment, in all of the circumstances, including the economic climate and opportunities.

This worker presented a very challenging case for the VRC. She had not worked in six years and was then 40 years old. She had only a grade eight education and had only worked in physical jobs. She lived in a small, rural community with limited employment opportunities, and faced chronic and functional limitations. She suffered from a psychological disorder that likely impacted her ability, from a psychological versus physical standpoint, to obtain and sustain employment.

The problem, from the VRC's point of view, was that the worker's wage rate was quite low. And it would not normally be necessary to provide extensive services to assist a claimant to replace earnings of less than minimum wage. The VRC approached the vocational rehabilitation effort as though there was a specified spending limit corresponding to each wage rate level. However a low wage rate is only one factor to be considered in determining what vocational rehabilitation assistance will be needed to offset a potential loss of earnings. The claimant's disability and personal circumstances must also be taken into account.

In the present case the vocational plan was wholly inadequate. Vocational benefits were concluded with no effort having been made to actually assist the worker to secure employment.

The VRC did not do an employability assessment. The CADA said simply that the worker could match the pre-injury average earnings with any part time minimum wage job, and on that basis concluded there would be no loss of earnings.

Both forgot that before this particular worker could earn any wages she had first to get a job. And in light of her changed circumstances, getting a job was not something she was going to be able to do on her own. The pain program vocational counsellor said as much, as did the counsellor. But she got no assistance, and so the return to work effort failed and the window of opportunity that the pain program vocational consultant identified was lost.

It is indeed true that the worker needs only to work part time at minimum wage to earn sufficient income to match her pre-injury earnings. And, based on the functional assessment that the kinesiologist completed, the worker is functionally capable of a broader range of employment than she and her doctor think possible. So I am not prepared, at this stage, to say the worker is likely to suffer a loss of earnings.

The worker ought, as Dr. Matous recommended, to be registered in an appropriate rehabilitation program, for gradual reactivation and strengthening. At its conclusion a

functional capacity evaluation should be administered by an evaluator experienced in assessing function in the presence of pain issues.

The next step must be to obtain an option from, Dr. Lum or another psychologist, concerning the effect that the worker's diagnosed permanent psychological disorder is likely to have, from a psychological standpoint, on her ability to obtain and sustain employment.

Based on the psychological opinion and the information from the functional evaluation, the Board will have to make an election - whether to develop a vocational plan that stands a good chance of returning the worker to the workforce, or to assess a loss of earnings pension. Any vocational plan that is likely to succeed will have to address the various barriers: age, inexperience, limited education, lack of transferable skills, pain issues, limited job opportunities, and any psychological barriers identified in the psychological opinion, that currently keep the worker from gainful employment.

Commencement Date and Wage Rate

The CADA made the pension payable from the day following the conclusion of wage loss benefits on the claim, and based the wage rate on the worker's earnings over the one-year period prior to her injury. For completeness I find that both the commencement date and the wage rate accord with applicable Board policy as set out in items #41.10 and #67.20 respectively of the RSCM.

Conclusion

The appeals are allowed. I find:

- the impairment rating must be assessed in accordance with the procedure set out in item #38.10 of the RSCM;

- the vocational rehabilitation services provided to the worker were inadequate; and,

- the CADA's determination that the worker would not likely suffer a loss of earnings was incorrect, in that it was based on a flawed vocational assessment and incorrect PFI rating.

The Board officers' decisions are varied. The claim is referred back to the Board to:

- arrange to have the percentage of disability resulting form the worker's diagnosed psychological disorder assessed in accordance with the procedure set out in item #38.10 of the RSCM;

- obtain an opinion, from an appropriate psychologist, concerning the effect that the worker's diagnosed Pain Disorder Associated With Both Psychological Factors and a General Medical Condition is likely to have on her ability to obtain and sustain employment;

- if appropriate arrange for the worker to attend a rehabilitation program, and at its conclusion arrange for a functional capacity evaluation to be administered by an evaluator experienced in assessing function in the presence of pain issues;

- develop, if possible, a vocational plan that is likely to result in the worker obtaining employment that will avoid a loss of earnings; and,

- reassess whether the worker is likely to suffer a loss of earnings over the long term.

Expenses

No expenses were requested or otherwise evident. None are ordered.

Janice A. Leroy
Vice Chair

JAL/lco