Noteworthy Decision Summary

Decision: WCAT-2005-01417 **Panel**: Terri White **Decision Date:** March 21, 2005

Enhancement of Permanent Disability Award – Enhancement Factor - Injury to One Body Part - Policy Item #39.13 of the Rehabilitation Services and Claims Manual, Volume II (RSCM II) - Devaluation of Permanent Disability Award – Loss of Multiple Ranges of Motion - Policy Item #39.12 of the RSCM II - Chronic Pain – Whether pain arising from a known surgical complication resulting from injury can be chronic pain - Policy item #39.02 of the RSCM II

- It is inappropriate to apply an enhancement factor to a permanent disability award unless there is an injury to more than one functional part of the body. The elbow and forearm constitute one functional part of the body.

- Devaluation is not normally applied to each aspect of loss of range of motion of a particular joint. The loss of range of movement of the elbow and forearm constitutes one injury and not an injury to two separate parts of the upper extremity such that devaluation should be applied to either or any of them.

- Where a surgical complication is not an expected consequence of the injury, pain resulting from the complication can be considered disproportionate and a chronic pain award given.

The worker was an operating room aide at a hospital. While moving a stretcher the worker suffered a left arm bicep tendon rupture. The rupture was surgically repaired but the worker suffered from post-surgical lateral cutaneous nerve entrapment, a known complication of the surgery to reattach the biceps tendon. The worker was found to have a permanent functional impairment in his left elbow resulting from the tendon rupture as well as a permanent functional impairment in his left forearm as a result of the entrapment, and the Board gave the worker a permanent disability award that encompassed both impairments. Pursuant to policy item #39.13 of the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II), the Workers' Compensation Board (Board) devalued the award by 0.19% as both injuries affected the same limb and the scheduled award for each injury presumes an otherwise healthy limb. No enhancement factor was applied under policy item #39.12 for any additive effects of multiple injuries, and no award was given for chronic pain under policy item #39.02 of the RSCM II.

The worker argued that the award should have been enhanced as it failed to compensate him for the additive impairing effects of both the left arm (bicep tendon) and left forearm (nerve) conditions; that the award was improperly devalued; and that an award for chronic pain should have been made. The Review Division found that the award had been properly devalued, that no enhancement factor was appropriate, and that the Board never made an initial decision on chronic pain and it was open to the worker to ask for such a decision.

In respect of the enhancement factor issue, the WCAT panel found that it was inappropriate to apply an enhancement factor as this factor applies only to cases where there is an injury to more than one functional part of the body. The elbow and forearm constitute one functional part

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of the body. The fact that there are several "components" to the worker's injury does not bring enhancement into play.

In respect of the devaluation, the WCAT panel found that the Board should not have devalued the worker's award. When calculating the disability award, the Board had separated the impairment relating to elbow flexion/extension from the impairment relating to supination and pronation of the forearm. The WCAT panel considered both of those sets of movements to relate to the loss of range of motion resulting from the elbow injury only. The loss of range of movement of the elbow and forearm constituted one injury and not an injury to two separate parts of the upper extremity such that devaluation should be applied to either or any of them.

In respect of the chronic pain issue, the WCAT panel found that the worker should be given a chronic pain award. In denying the worker a chronic pain award the Board had relied on a Board medical advisor who stated that the worker's pain was out of keeping with the biceps injury but that the worker's symptoms were in keeping with the surgical complication - scar entrapment of the lateral cutaneous nerve of the forearm – and that this was a known surgical complication. The WCAT panel found that pain resulting from a surgical complication can be considered "disproportionate," on the basis that although the complication may be one that is known to sometimes result from the surgery, it may be disproportionate because it is not an expected result of the injury and is therefore greater than that reasonably expected given the type and nature of the injury.

The panel determined that the chronic pain matter did not need to be returned to the Board for adjudication as it was implicit in the decision underlying this appeal (which relied on the Board medical advisor's opinion) that an award for chronic pain was considered and rejected.

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Panel: Teresa White, Vice Chair

Introduction

The worker appeals an October 4, 2004 decision of the Review Division of the Workers' Compensation Board (Board) to the Workers' Compensation Appeal Tribunal (WCAT). The Review Division denied the worker's request for review of the Board's April 14, 2004 decision respecting his permanent disability award.

The Board's decision was that the worker was entitled to a permanent disability award based on functional impairment equivalent to 6.36% of a totally disabled person, effective June 27, 2003.

The worker is represented by legal counsel. The employer was notified of this appeal and is participating.

The wage rate and effective date of the award are not in dispute. Neither is the Board's decision that the worker was not entitled to a disability award based on loss of earnings. In addition, the Review Division's conclusion that the worker was not entitled to reimbursement for legal fees has not been the subject of submissions, and on the basis that it is not in dispute, I do not consider it before me.

Issue(s)

The issue is whether the worker's permanent partial disability award was properly determined. This includes consideration of the percentage of functional impairment, including the application of devaluation and enhancement, plus the lack of an award for chronic pain.

Jurisdiction

This appeal is brought pursuant to section 239(1) of the Act.

WCAT may consider all questions of fact and law arising in an appeal, but is not bound by legal precedent (see section 250(1) of the *Workers Compensation Act* (Act)). WCAT must make its decision on the merits and justice of the case, but in so doing, must apply a policy of the board of directors of the Board that is applicable in the case. 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 (section 254 of the Act).

This appeal concerns the worker's permanent disability award. WCAT has no jurisdiction over appeals from decisions concerning the percentage of a worker's disability where the award is based on a rating schedule and the specified percentage of impairment in that schedule has no range, or has a range of 5% or less (section 239(2)(c) of the Act). The worker's permanent disability award in this case was based on Items 8 and 10 of the Permanent Disability Evaluation Schedule (PDES), both of which provide for an award based on a range that exceeds 5%. I thus have jurisdiction regarding the percentage of disability.

Background and Evidence

The worker's compensable injury occurred on October 16, 2002, while he was employed as an operating room aide at an acute care hospital. The worker, who was born in 1962, was transporting a patient on a stretcher. The stretcher wheels became caught in an elevator track. The worker attempted to lift the stretcher and patient. He felt a pop in his left elbow, followed by burning pain.

The worker's injury was determined to be an acute distal rupture of the biceps tendon, which was surgically repaired on October 25, 2002. Post-surgically the worker had some decreased sensation in the distribution of the lateral cutaneous nerve of the forearm. The surgeon reported on November 5, 2002 that this was likely due to some local traction on the nerve.

On December 17, 2002 the surgeon reported that the worker had persisting numbness, but this should not cause any significant functional deficit.

On January 28, 2003 the surgeon reported that the worker continued to have decreased sensation but had full range of motion of his elbow. The worker had some aching discomfort in his wrist and some circulatory irritability in his hand, in that he has a "vasoactive arm with colour change." This suggested that the worker may have a "mild RSD" (reflex sympathetic dystrophy).

On May 13, 2003 the surgeon reported that the worker had some dysesthesia in his left forearm, radial aspect, from the lateral cutaneous nerve of the forearm. This the surgeon hoped would gradually improve, but it was "not significantly disabling to him."

The worker attended an occupational rehabilitation program. He was discharged in June of 2003 as fit to return to work with limitations. The limitations were with respect to his ability to lift heavy items, including transferring patients. It was estimated that it would take the worker approximately four weeks to work up to full job duties.

The worker was examined for permanent functional impairment (PFI) on February 25, 2004. Notably, strength testing could not be completed because the worker was found

to have high blood pressure. For this reason, consistency of effort could not be determined.

The worker reported symptoms of 9/10 during elbow flexion/extension and forearm supination/pronation. The worker also described numbness in his left forearm, burning in his wrist from wearing anything such as a watch, and tingling in his middle, ring and little fingers from swinging his arms while walking.

The physician who signed the PFI report noted that tests for validity of effort could not be completed, but opined that the range of motion values were likely reliable.

The range of motion values found were:

Elbow flexion: 134 degrees left, 144 degrees right.
Elbow extension: 8 degrees left and right.
Elbow supination: 59 degrees left, 79 degrees right.
Elbow pronation: 57 degrees left, 87 degrees right.

The disability awards officer (DAO) reviewed the PFI evaluation, and prepared the PFI review memorandum dated March 30, 004. The review states that the worker did have a permanent impairment of his left arm as a result of the compensable injury. The range of motion results were entered into the Board's disability awards calculator. Impairment due to loss of range of motion was calculated to be 1.47%. The ruptured biceps led to an award of 2%. This resulted in a total of 3.47%.

I note here that the additional amount of 2% for the biceps rupture was shown on the calculation sheets as relating the "shoulder." It was a distal rupture, which according to the Board's "Additional Factors Outline", which is publicly available on the Internet, was equivalent to 2%. A distal rupture, and the surgery to correct it, was to the area of the worker's elbow and not to his shoulder. The PFI examination did not identify (it appears it did not measure) shoulder range of motion. The only indication in the file of possible shoulder problems is the worker's statement that extending his arm overhead causes pain, but it is not apparent where the pain is felt. On that basis, I have concluded there was no impairment of the worker's shoulder.

The DAO noted that policy item #39.10 of the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II) allowed consideration of other variables. The DAO said that for damage to the lateral cutaneous nerve of the forearm, "the loss of range of movement in the forearm of 3.08% will be granted."

The DAO then noted that policy item #39.13; "*Devaluation*," would be applied, resulting in devaluation from 6.55% to 6.36%.

The DAO did not comment with respect to subjective or pain complaints. However, it should be noted that the case manager requested advice from a Board medical advisor in November 2003 respecting whether the worker's pain experience exceeded that which would normally be expected of this type of injury. The Board medical advisor's response was that the worker's pain was out of keeping with the biceps injury per se, but he had suffered a known complication of the surgery, which was scar entrapment of the lateral cutaneous nerve of the forearm. The worker's symptoms were in keeping with that injury.

There is no further indication in the file with respect to the issue of whether the worker's pain was thus considered proportionate or disproportionate to the injury. The DAO's memo does not specifically address chronic pain.

In the Review Division proceeding, the worker provided a sworn statutory declaration. He said:

- He had pain in his left arm, which included dull aching pain in his left forearm, a burning pain in his wrist, and tingling in his middle, ring and little fingers. This pain impairs his sleep.
- His left thumb had been swollen since the injury, which caused discomfort.
- The worker was concerned about loss of sensation and its impact on work.
- The worker had a decreased ability to carry objects with his left arm, to manipulate his arm and to reach above his head.
- The worker has a surgical scar that he is self conscious about and had been the subject of comment from coworkers, patients and the public.

Counsel for the worker provided a June 25, 2004 submission on behalf of the worker. It attached the statutory declaration and a report from the worker's family physician.

Counsel submitted that the permanent disability award was inadequate because it failed to address the scarring, failed to address the additive effect of the nerve injury and the ruptured biceps tendon, and failed to address the subjective components of the injury. Counsel submitted that the range of motion measurements provided an incomplete and inaccurate assessment of the functional disability suffered by the worker.

The June 5, 2004 letter from the worker's family physician states that he assessed the worker on May 25, 2004. The worker complained of ongoing numbness extending from the dorsal mid proximal forearm into his left thumb and index finger. This area had reduced subjective sensation to light touch. Supination was 60 degrees, but the physician's view was that there were zero degrees of pronation. This was contrary to the finding of 59 degrees on the PFI examination.

The worker's physician reported that the worker's leisure activities, including hockey, softball, dirt biking, wrestling a "25 pound salmon," weight training and water skiing were decreased. The worker was also less effective in his work and household chores. Strength, endurance and pain were the limiting factors.

The review officer, in the decision under appeal, decided that the worker should receive, on a judgement basis, an additional 1% for neurological impairment. He did not consider that the Board had "accepted chronic pain" and stated that it remained open to the worker to approach the Board for an initial decision on chronic pain.

The review officer did not agree with counsel for the worker's submission that "enhancement" should be added to the award because of the impact of more than one impairment in the worker's upper extremity. The review officer also concluded that devaluation was properly applied.

The review officer did not address the question of an additional award relating to scarring. He did consider the impact of the injury on the worker's personal life, and concluded that this was not properly the subject of a permanent disability award.

Counsel for the worker's submissions in this appeal were that the review officer erred in failing to address compensation for scarring, failing to apply enhancement, and failing to appropriately apply policy item #39.02. In addition, the review officer failed to consider the evidence of limitations in home and recreational activities as examples or illustrations of loss of capacity and in particular manual dexterity. Further, the report from the worker's family physician should be considered expert evidence, consisting of additional evidence beyond that obtained by the Board.

The employer's representative made submissions in this appeal and in the Review Division proceeding. He submitted that the Board had properly determined the worker's permanent disability award. In particular, the employer's representative submitted that the report of the external service provider that carried out the PFI examination was expert evidence, and that the Board made its decision in accordance with law and policy.

Reasons and Findings

Loss of range of motion/percentage of impairment

The worker's family physician's estimation of the worker's elbow pronation was zero degrees. The PFI examination found it to be 57 degrees. This conflict could be difficult to resolve. However, in this case, there is other evidence on the file that is of assistance.

For example, the orthopaedic surgeon reported on December 17, 2002 that the worker had full pronation, but some discomfort at the end of range. The intermediate report from the occupational rehabilitation program states that the worker's pronation range had improved from 85 to 89 degrees.

Unless the worker's pronation range drastically decreased over time, I consider that the measurements of range of motion taken at the PFI examination are the best evidence available respecting the worker's range of motion. If the worker's range of motion has declined since the PFI examination, it is open to him to seek reassessment.

There is insufficient evidence for me to conclude that the range of motion measurements determined at the PFI examination were incorrect. I have also had reference to the PDES, items A(8) and A(10) and can find no error in the Board's application of that Schedule.

Enhancement

Policy item #39.12 is applicable. It states that the combined effect of two separate disabilities may be greater than the separate effect of each. Therefore, where a worker has an additional disability which pre-existed the injury or the injury causes more than one disability, the Board may, in certain situations, increase the overall percentage of disability that would otherwise be awarded.

The example given is where a worker has an impairment in both arms or both legs. An enhancement factor of 50% of the lesser disability may be added to the total for each. Another example given is where a worker suffers an injury causing total immobility in the right ankle. If, at the time of the work injury, the worker was already suffering from a serious disability involving total immobility in the left knee, the Board may well conclude that having regard to the impaired mobility that the worker was already suffering through the disability in the left leg, the compensable disability in the right ankle results in a greater degree of disability than it would for a person with a normal left leg.

I agree with the review officer that the addition of an enhancement factor was not justified in the worker's case, for the reasons that follow.

The worker's injury was to his biceps tendon. As a consequence of the surgery, he also has some damage to or entrapment of his lateral cutaneous nerve. The result of the injury and the surgery is impairment to the worker's left forearm, including loss of range of motion, some sensory signs and symptoms, and loss of strength and coordination. There is no suggestion that the worker has any significant disability to his right arm or to any other limb. Impairment of his left shoulder is not evident from the file. The effect of the compensable injury is disability to one functional part of the worker's body, which is his elbow and forearm and results from an elbow injury. These are part of a functional unit that was injured in one compensable incident. Although there are several aspects

to the injury, they all result in impairment of function of the left elbow and forearm. The fact that there are several "components" to the injury does not bring into play enhancement, which applies when there is injury to another part of the body.

The worker's appeal respecting enhancement is denied.

Devaluation

Devaluation is addressed in policy item #39.13. The fundamental principle behind devaluation is that the sum of an award for injuries to a part of the body should not be greater than an award for the entire loss of that part of the body. For example, if a worker has a loss of range of motion to the hand and elbow, devaluation is applied, because after the award for the hand is made, only a fixed percentage of the total possible award for total loss of the upper extremity remains.

Devaluation is not normally applied to each aspect of loss of range of motion of a particular joint. For example, the Board does not generally apply devaluation to each of wrist flexion, extension, radial deviation and ulnar deviation. The total award for loss of range of motion of the wrist is not devalued based on the loss of each separate movement.

The problem in this case is that the DAO separated the impairment relating to elbow flexion/extension from the impairment relating to supination and pronation of the forearm. With respect, I consider both of those sets of movements to relate to the loss of range of motion resulting from the elbow injury. That they are related is clear from the fact that the loss of range of motion of all these movements resulted from the surgery, and that all of these movements involve the elbow joint.

I do not consider the evidence to support the DAO's apparent conclusion that the supination/pronation movement was "loss of range of movement of the forearm" that should, for the purposes of devaluation, must be considered separately to the loss of flexion/extension of the elbow because it somehow reflected the lateral cutaneous nerve damage and not the ruptured biceps and the surgery.

The worker' injury was to the area of his elbow. The loss of range of movement of the elbow and forearm, in my view, constitutes one injury and not an injury to two separate parts of the upper extremity such that devaluation should be applied to either or any of them.

The worker's appeal respecting devaluation is allowed. It should not have been applied.

Chronic Pain

Policy item #39.02, "Chronic Pain" states that disproportionate pain, for the purposes of the policy, is pain that is significantly greater than what would be reasonably expected given the type and nature of injury or disease.

The question arises whether pain from a known surgical complication of surgery for the injury could be considered "disproportionate." The policy does not specifically address this issue.

I consider that pain resulting from a surgical complication can be considered "disproportionate," on the basis that although the complication may be one that is known to sometimes result from the surgery, it may be disproportionate because it is not an expected result of the injury and is therefore greater than that reasonably expected given the type and nature of the injury. For example, RSD may be a known potential complication of surgery, but even so, the pain associated with RSD can be the subject of a chronic pain award, as can pain in a surgical scar.

In this case, there was no award made for chronic pain. Based on a review of the file, it seems likely that the reasoning behind the decision not to provide an award for chronic pain was based on the Board medical advisor's comment that the pain the worker felt in his forearm was in keeping with an injury to the lateral cutaneous nerve. The DAO felt that the loss of range of motion of the forearm included compensation for that surgical complication.

I have concluded that although it was not directly reflected in the DAO's memo setting out the award, an active decision was made by the Board not to compensate the worker for chronic pain because the pain he experiences is in keeping with the pain likely to result from the lateral cutaneous nerve entrapment, a known complication of the surgery to re-attach the biceps tendon.

On that basis, I do not agree that the worker must return to the Board for an adjudication of chronic pain. It is implicit in the decision underlying this appeal that an award for chronic pain was considered and rejected, on the basis of the Board medical advisor's opinion that the pain was consistent with the lateral cutaneous nerve entrapment.

The worker has specific chronic pain, meaning that the pain has a clear medical cause (the lateral cutaneous nerve entrapment). Specific chronic pain is defined in policy as disproportionate if it is generalized rather than limited to the area of the impairment, or the extent of the pain is greater than that expected from the impairment.

The worker's impairment has been determined based on loss of range of motion which is the result of the biceps tendon rupture and not the nerve damage. The question is whether the pain he experiences is greater than that expected from the impairment.

I have concluded that the percentage of functional impairment based on loss for range of motion does not compensate the worker for the specific chronic pain he experiences due to the lateral cutaneous nerve entrapment. The worker's complaints relating to the nerve entrapment are primarily subjective. Furthermore, the pain is greater than that which would be expected from the impairment of function flowing from his ruptured biceps tendon, which is the loss of range of motion.

Thus, the worker is entitled to an additional award of 2.5% for specific chronic pain, pursuant to policy item #39.02.

Scarring

Section 23(5) provides for award for disfigurement. Policy item #43.10 notes that section 23(5) establishes three requirements. The disfigurement must be permanent, it must be serious, and it must be one that the Board considers capable of impairing the worker's earning capacity. The policy states that this last requirement is normally assumed in cases of the head, neck and hands. In other cases, a decision must be made which has regard to the age and occupation of the worker, the visibility and extent of the disfigurement and any other relevant circumstances. A disfigurement award may be considered where the appearance of an impairment for which a permanent partial disability award has been granted is disfiguring to an exceptional degree.

Although I acknowledge that the worker has a permanent scar from his surgery, I am not persuaded that the scar is capable of impairing the worker's earning capacity. Given the worker's age, his occupation, and the visibility and extent of the scarring, I consider it unlikely that it would impair his earning capacity. It may make the worker self-conscious at times, but that alone is unlikely to impair his earning capacity to any significant degree.

The worker's appeal regarding an award for disfigurement is denied.

Conclusion

The Review Division decision is varied, in part. The worker's permanent disability award shall be re-calculated on the following basis. Devaluation will not be applied to the loss of range of motion findings respecting loss of elbow range of motion, including supination/pronation. The worker is entitled to an award of 2.5% for specific chronic pain resulting from the lateral cutaneous nerve entrapment. The worker is not entitled to any additional amount for "enhancement" or for disfigurement.

Teresa White

Vice Chair

TW/pm