Noteworthy Decision Summary

Decision: WCAT-2005-03569 **Panel**: Elaine Murray **Decision Date:** July 6, 2005

Chronic Pain – Entitlement to Multiple Awards – Policy Item #39.01 Rehabilitation Services and Claims Manual, Volume I – Section 23(1) of Workers Compensation Act - Practice Directive No. 61 "Pain and Chronic Pain" - Section 28(3) of the Interpretation Act

Where a worker has disproportionate chronic pain arising from more than one body part, policy item #39.01 of the *Rehabilitation Services and Claims Manual, Volume I* (RSCM I) does not limit a worker to one chronic pain award under section 23(1) of the *Workers Compensation Act* (Act). Therefore, to the extent that disability in the workers' compensation system is reflected by an increased percentage of total disability, a worker should receive multiple chronic pain awards where more than one body part is the source of the disproportionate disabling chronic pain.

In this case, the worker suffered several injuries in a 1997 workplace accident. The Workers' Compensation Board, operating as WorkSafeBC (Board), granted the worker a permanent partial disability (PPD) award under section 23(1) of the Act on a loss of function basis for, among other things, a permanent physical impairment of the worker's neck and right little finger. The worker was also assessed for any permanent impairment of his right knee and ankle, but none was found. On appeal to WCAT, the panel considered, among other issues, the appropriateness of the percentage of impairment granted for the worker's neck injury, the worker's entitlement to chronic pain under policy item #39.01 of the RSCM I, and the denial of an award in relation to any right knee or ankle impairment.

On appeal, and applying the test set out in policy item #39.01 of RSCM I, the WCAT panel found that the worker had disproportionate specific chronic pain (chronic pain with clear medical causation or reason that is disproportionate to the associated physical impairment) in his neck, and awarded the worker a 2.5% award for chronic pain for his neck complaints. The WCAT panel found that the worker had non-specific chronic pain (chronic pain that has no clear medical causation or reason and is disproportionate to what would be reasonable expected given the type and nature of the injury) in his knee and leg but found that it was not disproportionate so did not award the worker an additional chronic pain award of 2.5% for his knee or leg.

Although it was not necessary to do so in this case, as the worker was not otherwise entitled to a chronic pain award in relation to his knee or leg, the WCAT panel concluded that it could have granted more than one chronic pain award. The WCAT panel reasoned as follows:

- Neither the Act nor Board policy expressly permits or prohibits multiple chronic pain awards. Board Practice Directive No. 61 "Pain and Chronic Pain" does not address the issue directly but suggests that each injury is assessed for chronic pain separately as it describes a process for determining eligibility for a chronic pain award for "injury 'X'".

- Although policy item #39.01 of the RSCM I uses the singular term "award", generally speaking, enactments are interpreted so that the singularity or plurality of words contained within them is not determinative.

Workers' Compensation Appeal Tribunal 150, 4600 Jacombs Road, Richmond, B.C. V6V 3B1
Telephone: (604) 664-7800; 1-800-663-2782; Fax (604) 664-7898

- It is indisputable that "injury" in section 5(1) of the Act is intended to mean one or more injuries. Section 23(1) in both the former and current version of the Act contemplates that the Board is to estimate the related impairment of earning capacity for *each* disabling permanent injury.

- Placing a limit on the number of chronic pain awards or creating a maximum percentage of disability from chronic pain under each claim would have been a simple matter for the Board. Had the Board wanted to limit the total award for chronic pain for any one claim (or for that matter, for any one worker) to 2.5% of total disability, regardless of the number of injured areas with disproportionate chronic pain, it could have expressly done so.

- If a worker has two separate claims it is possible to receive an award of 2.5% for chronic pain on each claim.

- All scheduled permanent disability awards (those awards based on the Permanent Disability Evaluation Schedule of RSCM I), contain a component for pain. Therefore, where a worker is entitled to an award comprised of several scheduled items, such as the neck and the knee, the worker is being compensated for typical (proportionate) pain in each body part. One can easily infer from this that the Board considers it more disabling to have pain in multiple areas than to have pain in just one area, and that this should be reflected in the compensation scheme. There is no principled reason why the same logic should not apply to disproportionate specific and non-specific chronic pain.

- Chronic pain awards are made where chronic pain is disabling. To the extent that an additional injury gives rise to associated chronic pain it is self-evident that a worker with such problems may be more disabled and should be compensated at a higher level than a worker who has chronic pain associated with a single injury. This principle would apply most easily to situations where the disproportionate chronic pain affects two functionally independent areas of the body.

Workers' Compensation Appeal Tribunal 150, 4600 Jacombs Road, Richmond, B.C. V6V 3B1
Telephone: (604) 664-7800; 1-800-663-2782; Fax (604) 664-7898

WCAT Decision Number: WCAT-2005-03569
WCAT Decision Date: July 06, 2005
Panel: Elaine Murray, Vice Chair

Introduction

In a February 12, 2004 decision, the Workers' Compensation Board (Board) granted the worker a permanent partial disability (PPD) award of 10.57% of total disability resulting from injuries sustained in a motor vehicle accident on December 14, 1997. The worker's award reflects 0.40% for reduced cervical spine range of motion, 0.17% for reduced range of motion of the proximal interphalangeal (PIP) joint of the right little finger, and 10.0% for psychological impairment. The worker was also assessed for any permanent impairment of his right knee and ankle, but none was found.

The Board reconsidered the worker's pension wage rate within 75 days of the February 12, 2004 decision (thus, the pension wage rate is not before me on this appeal). The effective date of the worker's award for neck and right finger impairment is September 1, 1998. March 7, 1999 is the effective date for his award for psychological impairment. The Board concluded that the worker was not entitled to an award on a loss of earnings basis, since the evidence did not support that he would have a loss of earnings in excess of his functional award.

The worker requested a review of the February 12, 2004 decision by the Board's Review Division. The worker submitted that his permanent functional impairment (PFI) examination did not address the full extent of his injuries, since it did not assess his right shoulder, right hip, and low back symptoms. By decision dated August 20, 2004, a review officer confirmed the Board's decision, but recommended that the Board determine whether the worker's right hip, right shoulder, and low back symptoms should be accepted under his claim.

As suggested by the review officer, the Board rendered an October 13, 2004 decision informing the worker that his claim was also accepted for soft tissue injuries to his right hip, right shoulder, and low back. However, the Board officer also concluded that the medical evidence did not suggest he had any permanent impairment from those injuries. As a result, the Board officer informed the worker that he was not entitled to a referral to the Board's Disability Awards Department in relation to his soft tissue injuries. The worker was advised of his right to request a review by the Review Division of the October 13, 2004 decision. He has not done so.

The worker now appeals the August 20, 2004 Review Division decision to the Workers' Compensation Appeal Tribunal (WCAT). The worker, his wife, and the worker's representative, Mr. Jarmson, attended an oral hearing on May 6, 2005. The employer is not participating in this appeal.

Mr. Jarmson seeks an increase in the awards for the worker's neck impairment and psychological impairment. He also requests an award for chronic pain. He does not take issue with the award for right finger impairment. He also does not take issue with the effective dates or the pension wage rate (since the pension wage rate was reconsidered and increased). He did not make submissions concerning the denial of an award for right ankle or knee impairment or the denial of an award on a loss of earnings basis. Finally, he contends that I should assume jurisdiction over the worker's right hip, right shoulder, and low back injuries, and direct the Board to assess whether the worker has any permanent disability arising from those injuries.

Preliminary Matter

Mr. Jarmson said at the hearing that he advised the worker not to request a review of the Board's October 13, 2004 decision, which informed the worker that his right hip, right shoulder, and low back injuries were compensable, but did not result in any permanent impairment. Mr. Jarmson contends that it was unnecessary to request a review of the October 13, 2004 decision, since the pension decision on appeal before me provides jurisdiction to address any permanent impairment arising from the worker's right hip, right shoulder, and low back injuries.

Mr. Jarmson pointed out that he and the worker had been asking the Board for months, before and after the pension decision, to address the worker's right hip, right shoulder, and low back complaints. Mr. Jarmson is of the view that the Board's lack of response to those requests was a "decision by omission", which provides me with jurisdiction.

With respect, I do not agree. I acknowledge that the Board ought to have adjudicated the compensability of the worker's right hip, right shoulder, and low back complaints long before it did. It would have been preferable for the Board to have done so prior to the worker's PFI assessment. Nevertheless, the Board has now adjudicated this matter and rendered a decision that the worker is not eligible for a referral to the Disability Awards Department in relation to his right hip, right shoulder and low back. The worker had the opportunity to request a review of that decision, but did not do so on the advice of Mr. Jarmson.

The decision before me did not address any permanent impairment arising from the worker's right hip, right shoulder, and low back injuries, since those conditions were not accepted on his claim at the time. The fact that those conditions are now compensable does not allow me to ignore the Board's October 13, 2004 decision. While I recognize that it is preferable to provide finality for the worker in this matter, I do not consider that

I have jurisdiction over any aspect of the worker's right hip, right shoulder, and low back injuries. The worker had the opportunity to request a review of the October 13, 2004 decision, and did not do so. If he had, his representative could have asked WCAT to suspend this appeal, if necessary, to await the outcome of any Review Division decision concerning the October 13, 2004 decision. The worker's remaining remedy is to ask the Review Division to grant an extension of time to request a review of the October 13, 2004 decision. Regrettably, I find that I do not have jurisdiction in this matter.

Issue(s)

Did the Board properly determine the worker's PPD award?

Jurisdiction

This is an appeal of a Review Division decision pursuant to subsection 239(1) of the *Workers Compensation Act* (Act).

Section 250 of the Act provides that WCAT must make its decision based on the merits and justice of the case but, in so doing, must apply relevant policies of the Board's board of directors. Section 254 of the Act gives WCAT exclusive jurisdiction to enquire 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.

Background and Evidence

The worker, a then 40-year-old truck driver, sustained multiple injuries in a serious motor vehicle accident in the United States on December 14, 1997. He was hospitalized for over a week because of the severity of his injuries. At the hearing, the worker produced 13 photographs, which showed the extensive damage to the truck he was driving. Mr. Jarmson had reprints made of these photographs after the hearing (now marked as exhibit #1).

The Board initially accepted the worker's claim for a closed head injury, a loss of consciousness, a comminuted fracture of the right fifth metacarpal, a non-displaced fracture of the right proximal tibia, right leg lacerations, a neck strain, and an avulsion fracture to the anterior aspect of his C3-4 discs.

There were difficulties determining whether the Board was responsible for the worker's claim, and he was forced to return to truck driving on September 1, 1998 for financial reasons. The worker did not receive funds from any source until March 1999 when the Board accepted responsibility for his claim and paid him temporary disability benefits from December 15, 1997 to August 31, 1998.

The worker was laid off on January 15, 1999. The worker's employer informed the Board on March 2, 1999 that it would reinstate the worker once he was able to return to work without interruption for medical appointments. The worker did not return to trucking. Instead, he left the province and began working in the oil industry on March 7, 1999 in a project management position (he had done similar work before he was injured). The Board last paid temporary disability benefits to the worker on March 6, 1999.

The worker underwent a neuropsychological assessment on March 3 and 4, 1999, while participating in an evaluation at the Board's head injury program. The neuropsychologist, Dr. B, concluded that the worker had sustained a "substantial" head injury, but had made a significant recovery in terms of higher cognitive functioning (his only measured deficits were speed of mental processing and manual reaction time). According to Dr. B, however, the worker had a number of ongoing behavioural problems arising from frontal lobe dysfunction, such as behavioural disinhibition, irritability, word-finding problems, paraphasic errors, disorganization (with associated attention and memory difficulties), and exacerbation of pre-morbid personality characteristics.

In a September 20, 2000 claim log entry, Dr. B offered her opinion that the worker's symptoms from his head injury had likely plateaued when he was assessed in March 1999.

On December 28, 2000, Dr. MacKenzie, the worker's family physician, reported that the worker's primary concerns were his constant neck pain and residual head injury symptoms. The worker also complained of a constant feeling of numbness in his right lower leg, right lower leg pain, and right knee pain. He described his knee pain as a seven out of ten, which occurred whenever he sat with his knee flexed. Dr. MacKenzie noted that recurrent aching in the area of the worker's lower leg fracture was quite common and he should treat it with Advil or Tylenol. He also told the worker that his right knee pain was consistent with patella femoral syndrome and he should exercise his knee.

The Board approved psychological counselling to allow the worker to address his irritability, and to provide him with stress coping strategies, reassurance and education regarding his ongoing symptoms. The worker attended sessions with Dr. Gervais, a clinical psychologist, from January 25 to September 21, 2001.

Dr. Gervais' reports noted that the worker exhibited behaviour consistent with frontal lobe syndrome, and that the majority of his problems with irritability and anger management appeared to manifest in a family context, including significant conflict with his family on visits home from out-of-province. Dr. Gervais' final report noted that the

worker had experienced increased understanding of the effects of his head injury and shown some improvement in his anger and irritability, but would require continued efforts to manage those concerns.

On December 20, 2003, the worker underwent a neuropsychological PFI assessment, with a Board authorized external service provider (ESP), Dr. Du, a registered psychologist, and his psychology intern, Ms. Lindberg. At the hearing, the worker said that he never actually met with Dr. Du; rather, Ms. Lindberg administered all of the testing. According to the neuropsychological PFI assessment, the worker did not show signs of cognitive impairment on standardized testing; however, he evidenced word-finding difficulties in conversation, consistent with his self-reports. He and his wife also reported functional symptoms, which included behavioural inhibitions, decreased irritability, greater rigidity in interpersonal interactions, and decreased motivation and interest.

The worker's wife gave evidence at the hearing concerning the significant changes that she had witnessed in her husband's behaviour and personality. In particular, she said that if everything does not go his way he starts yelling, screaming and arguing. She said, with reluctance, that he has grabbed her, which he had never done before the accident. She also pointed out that he has little patience for their children, and they no longer want to be at home with him. She said that the entire family relationship has significantly changed.

The neuropsychological PFI assessment described the worker as showing no signs of cognitive impairment on standardized testing; however, he continued to have word-finding difficulties. He no longer had any deficit with speed of information processing, as identified by Dr. B in March 1999. He generally functioned in the high average to superior range across his cognitive skills. Dr. Du was of the opinion that the worker's self-reports of cognitive decline were more likely related to fatigue (from pain), physical disruption, and stress (adjusting to his injuries), rather than a direct result of his brain trauma.

Dr. Du concluded that the worker had mild difficulties with activities of daily living, moderate difficulties in emotional and social functioning, adequate function in the areas of concentration, persistence and pace, and minimal difficulty with work. He was able to function well in his work environment, with the exception of some interference from his increased irritability and lower emotional control.

The Psychological Disability Awards Committee (PDAC) met on January 8, 2004. In a January 9, 2004 memo, the director of Disability Awards wrote that the PDAC had reviewed all information on the worker's file, and their rating was based primarily on the neuropsychological PFI assessment, with "particular regard to the narrative portion of that report dealing with impact on work performance". In keeping with the guidelines

outlined in the Board's "Permanent Disability Evaluation Schedule" (PDES) concerning psychological impairments, the PDAC rated the worker's functional psychological impairment at 10.0% of total.

During the hearing, the worker said that he recognizes that he has a problem with his temper and his patience is limited. He also said that he has to "create" a drive to do things, whereas before his injury, his drive was "natural". He was also concerned with how poor his memory is and how many mistakes he must correct.

The worker attended a PFI evaluation in relation to his physical injuries on December 22, 2003 with Dr. Monk, another Board authorized ESP. The Board asked Dr. Monk to assess the worker's cervical spine, right finger, right knee and right ankle.

During the assessment, the worker said that his main complaints were pain in his lower back, right shoulder, neck, and right calf/knee. Dr. Monk reported that the worker demonstrated objective signs of effort throughout the evaluation and his range of motion findings were considered reliable.

On examination, Dr. Monk measured slight loss of left lateral flexion in the worker's neck, and slight loss of right little finger PIP flexion.

The impairment rating for the worker's reduced ranges of neck and little finger motion were 0.40% and 0.17%, respectively, using the Board's standardized ARCON computerized impairment rating system.

In a February 9, 2004 memo (form 24), a disability awards officer concluded that the worker had a permanent impairment of function. He accepted that the range of motion measurements resulted in 0.57% of total disability, and the worker's psychological impairment was properly rated at 10.0% of total disability. He also concluded that the worker's subjective complaints of pain were limited to his impairment and were not disproportionate to the associated objective findings. As a result, he did not grant an additional award for subjective pain complaints.

The effective date of the worker's 0.57% of total disability award was September 1, 1998. The effective date of his 10.0% of total psychological disability award was March 7, 1999. The disability awards officer also concluded that the worker would not suffer a loss of earnings since he had returned to full-time employment. As previously noted, the worker's wage rate for pension purposes was reconsidered (and increased) after the February 12, 2004 decision was made. This was communicated to the worker in an April 21, 2004 decision.

In the August 20, 2004 decision under appeal, the review officer was in agreement with the percentage of impairment granted by the Board and the conclusion that his ongoing pain complaints were consistent with his objective findings and not disabling to any

greater degree than recognized by the functional award. As earlier noted, the review officer suggested that the Board address the worker's concerns about his right shoulder, right hip, and low back, which the Board did in the October 13, 2004 decision.

Reasons and Findings

The worker's entitlement is adjudicated under the provisions of the Act that preceded changes contained in the *Workers Compensation Amendment Act, 2002* (Bill 49). WCAT panels are bound by published policies of the Board pursuant to Bill 63. Policies relevant to this appeal are set out in the *Rehabilitation Services and Claims Manual, Volume I* (RSCM I), which relates to the former (pre-Bill 49) provisions of the Act, except with respect to the PDES and those policies concerning the application of the PDES, as will be explained below.

Entitlement to a PPD award is based on an assessment of the worker's functional impairment under section 23(1) of the Act (loss of function/physical impairment method) or, if the Board considers it more equitable, on the basis of the worker's projected loss of earnings under section 23(3) of the Act (loss of earnings method). Under section 23(1) of the Act, the impairment of earning capacity is estimated from the nature and degree of the injury.

Section 23(2) of the Act authorizes 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 PDES, found at appendix 4 in the RSCM I. However, appendix 4 in the RSCM I explains that for all section 23(1) assessments and reassessments undertaken with reference to the PDES on or after August 1, 2003, appendix 4 of the PDES in the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II) is applicable, and the appropriate policies in chapter 6 of the RSCM II on the application of the PDES are also applicable. Since the worker's assessment occurred after August 1, 2003, the PDES in the RSCM II is applicable, as are the policies concerning the application of that PDES.

On this appeal, I will address the percentages of impairment granted for the worker's neck injury and psychological condition. I will also address the issue of subjective or chronic pain, the denial of an award in relation to any right knee or ankle impairment, and whether the worker is entitled to an award on a loss of earnings basis. My jurisdiction to address these matters is set out below.

Section 239(2)(c) of the Act provides that a decision of the Review Division may not be appealed to WCAT where it concerns the application of the PDES and the specified percentage of impairment has no range or has a range that does not exceed 5%. The range for impairment of function associated with the cervical spine in items 72 and 73 of Schedule D of the applicable PDES is 0% to 21%.

In considering whether I have jurisdiction to consider an award, I have reviewed the analysis of jurisdiction provided in *WCAT Decision #2004-02317*. In that decision, which considered WCAT's jurisdiction in relation to an appeal concerning permanent disability in the lumbar spine, the vice chair concluded that, for the purposes of section 239(2)(c), the range of specified percentages of impairment in the lumbar spine is 0% to 24%. The vice chair determined that the structure and layout of the PDES, in addition to the preamble to the section involving the spine, recognizes the necessity of global assessment of spine range of motion and the ranges relating to the particular planes of movement can be viewed as components providing guidance in the determination of where the worker's impairment fits into the overall range from 0% to 24%.

I consider that analysis to be equally applicable to claims involving the cervical spine. I find the global assessment of cervical range of motion should be considered for the purposes of section 239(2)(c). I therefore conclude that I have jurisdiction to consider the worker's appeal concerning the extent of the award provided under section 23(1) in relation to his neck impairment.

In addition, the range of impairment for the knee (item 28) in the PDES exceeds 5%, and can range to at least 25%. The range of impairment for the ankle (item 29) also exceeds 5%, and can go to at least 12%. Accordingly, I find that section 239(2)(c) does not restrict my jurisdiction in this appeal concerning any ankle and knee range of motion findings.

Furthermore, the applicable scheduled items (items 77, 78 and 79) under the heading "Psychological Disability" in the PDES include ranges of permanent psychological impairment beyond 5% and can, therefore, be the subject of an appeal to WCAT.

Neck impairment

With respect to any measurable impairment under the PDES, Dr. Monk, the ESP, found that the worker's cervical range of motion was slightly impaired, which resulted in the award of 0.40% of total disability.

Policy item #97.40 of the RSCM I provides that the reports of the ESP are to be considered "expert evidence" and the "primary input" in the assessment of the worker's PFI, and this evidence should not be disregarded without other evidence to the contrary.

No medical evidence or opinion has been provided that challenges the results of the PFI assessment concerning the worker's cervical range of motion. I have examined the whole of the medical evidence, with particular attention to the findings in the PFI examination report and the comments of Dr. Monk. I am also mindful that the PDES provides an award of 21% of total disability when a worker has total immobility of his

cervical spine. I find no error in the assessment of the worker's slightly impaired range of motion at 0.40% of total disability, and accept that it was properly calculated based on the ARCON computerized impairment rating system. I deny this aspect of the worker's appeal.

Awards for subjective complaints of pain and chronic pain are governed by Board policy and are not scheduled awards within the Board's PDES. As the initial adjudication for entitlement of compensation for pain was made by the Board after January 1, 2003, I consider policy item #39.01 of the RSCM I, as it read on January 1, 2003, to be the relevant policy on this appeal. In reaching this conclusion, I have applied the reasoning set out in a prior WCAT finding, *Decision #2004-01842*, which is also available on WCAT's website.

Policy item #39.01 of the RSCM I sets out detailed guidelines and definitions for the assessment of section 23(1) awards for chronic, disabling pain. Under RSCM I policy item #39.01, the worker's neck pain complaints fall into the category of "specific chronic pain", which is pain with clear medical causation or reason, such as pain that is associated with a permanent partial or total physical disability. A worker may have chronic pain that is either consistent with or disproportionate to the impairment. It is only in the latter case that a separate section 23(1) award for chronic pain will be granted to the worker. In such a case, the policy provides for an award of 2.5% of total disability.

Pain is consistent with the associated compensable impairment where the pain is limited to the area of the impairment or medical evidence indicates that the pain is an anticipated consequence of the physical impairment. In these cases, an additional award for the specific chronic pain will not be provided, as it would result in the worker being compensated twice for the impact of the pain.

Pain is considered to be disproportionate to the impairment where 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.

In this case, the worker's neck pain is limited to the specific area of injury; however, his objective physical impairment was only 0.40%. The question is whether the extent of his pain is disproportionate to his 0.40% impairment. In that regard, the worker has consistently complained of significant neck pain since his injury. As he described at the hearing, his pain is a far greater impairment to him than his slight restriction in neck flexion. The evidence does not suggest that he is exaggerating his pain in any manner. The worker said at the hearing that his neck pain is constant and is increasing over time. He said that at times his neck "locks", and when his neck is "really bad" he experiences numbness in his right hand.

In my view, the worker's neck pain is disproportionate to his 0.40% functional impairment. I find that he is entitled to an additional award for his complaints of chronic pain in the amount of 2.5% of total, in accordance with RSCM I policy item #39.01. I allow this aspect of the worker's appeal.

Right knee and ankle

I have reviewed the measurements of the worker's left foot and ankle movement in the PFI evaluation report, which revealed no loss of range of motion. During the hearing, the worker agreed that he had no loss of range of motion in those joints. Accordingly, I see no error in the Board's conclusion that the worker has no measurable impairment in his range of knee or ankle motion.

The worker said that he did not understand why his ankle was assessed, since it has never been a problem. With respect to his right knee, however, he described ongoing knee and lower leg pain, and right calf spasms. These are the same symptoms that he described to the DAMA. He explained that this pain is particularly limiting when he sits for any length of time. For example, his job requires air travel and he finds it difficult to sit on planes because he needs to constantly extend his leg to relieve the pain.

As earlier noted, the policy in item #39.01 of the RSCM I (the following discussion applies equally to the policy in item #39.02 of the RSCM II) sets out guidelines for the assessment of section 23(1) awards for workers who experience disproportionate disabling chronic pain as a compensable consequence of a physical or psychological injury. Chronic pain is defined in policy as pain that persists six months after an injury and beyond the usual recovery time of a comparable injury. Board policy states that where it is determined that a worker is entitled to "a section 23(1) award" for chronic pain, "an award equal to 2.5% of total disability will be granted to the worker".

At issue is whether the worker is entitled to an award for right lower leg and knee pain, in addition to the award of 2.5% that I have granted for his chronic neck pain. In other words, does policy item #30.01 of the RSCM I limit a worker to one award for disproportionate chronic pain or can multiple awards for chronic pain be made under section 23(1) of the Act in those cases where a worker has disproportionate chronic pain arising from distinct injuries?

As a starting point, nothing in the Act or Board policy either expressly permits or prohibits multiple chronic pain awards. I have also reviewed the Board's October 16, 2002 discussion paper on chronic pain[1] to determine if the Board considered the issue of multiple awards for chronic pain or maximum chronic pain awards before the policy was drafted. It does not specifically address that issue.

[1] http://www.worksafebc.com/law and policy/archived information/policy discussion papers/law 60 10 90.asp

In addition, I have considered the Board's Practice Directive #61[2], which addresses pain and chronic pain. Practice directives are not binding policy, but they can provide guidance in the interpretation of policy. The practice directive is silent on this issue, but it suggests that each injury is assessed for chronic pain separately. At page 9, the practice directive outlines what the claims adjudicator in disability awards (CADA) should do when a case manager (CM) accepts that a worker has chronic pain:

> CM: "I have accepted that the worker has permanent chronic (back/knee, etc.) pain due to permanent injury X".
>
> CADA: Will measure "X" injury and decide if pain is specific/nonspecific/proportionate/disproportionate. If the permanent chronic pain is specific and proportionate, a section 23(1) award for injury "X" would suffice. Otherwise, a section 23(1) award for permanent chronic pain will also be considered.

Absent any clear direction on this matter in the Act, Board policy, and other relevant Board documents, I have questioned whether there is any significance in the use of the singular term "award" in policy item #39.01 of the RSCM I. In doing so, I have also considered the use of the singular term "injury" in that policy.

Generally speaking, enactments are interpreted so that the singularity or plurality of words contained within them is not determinative. Section 28(3) of the *Interpretation Act*, R.S.B.C. 1996, c. 238 provides that "[i]n an enactment words in the singular include the plural, and words in the plural include the singular".

Under section 5(1) of the Act, workers are compensated for "personal injury or death arising out of and in the course of the employment". "Personal injury" is defined in the policy in item #13.00 of the RSCM I (it reads the same in the RSCM II) as not being confined to "injuries" which are readily and objectively verifiable by their outward signs.

The above definition implies that the word "injury" can be either singular or plural. Furthermore, applying section 28(3) of the *Interpretation Act*, it is indisputable, in my view, that "injury" in section 5(1) of the Act is intended to mean one or more injuries (subject to any specific exclusions in the Act relating to specific types of injuries). As a result, workers are compensated for each injury that arises out of and in the course of the employment, whether sustained in one incident or several.

---

[2] http://www.worksafebc.com/law_and_policy/practice_directives/compensation_practices/practice_directives/default.asp

Looking at section 23(1) of the Act, under which workers are compensated for permanent disability, I noted that this section of the Act, as it read before the amendments brought about by Bill 49, does not use the term "award". Rather, it provides that where "disability" results from "the injury" compensation resulting from "the impairment" must be paid.

Section 23(1) of the Act, as it reads as a result of Bill 49, also does not use the term "award". It provides that the Board must pay the worker compensation for "a…disability" that results from "a worker's injury". To do so, the Board must estimate "the impairment" of earning capacity arising from "the injury".

Clearly, the words "injury", "disability" and "impairment of earning capacity" in section 23(1) of both Acts are used in a singular sense. However, given the definition of personal injury in the policy, the purpose of the workers' compensation scheme, and section 28(3) of the *Interpretation Act*, I consider that section 23(1) in both Acts contemplates that the Board is to estimate the related impairment of earning capacity for each disabling permanent injury.

Generally speaking, the issue of whether a worker ought to receive multiple chronic pain awards raises a fundamental issue about the nature of pain. For instance, when a person is injured in more than one area of the body, resulting in different sources of pain, one has to ask whether the magnitude of that person's pain would be any different if they only had pain arising from one area of the body. Assuming that the disabling effect of pain increases with its magnitude, answering this question in the affirmative suggests that chronic pain emanating from more than one area of the body is more disabling than chronic pain emanating from a single area and ought to be compensated with a higher award.

In my view, the answer to this question can be implied from the Board's pain policies when considered as a whole. The Board is very careful in its policies to distinguish between chronic pain that is proportionate to an injury and pain that is disproportionate to an injury. In policy items #22.35 and #39.01 of the RSCM I the Board emphasizes that specific chronic pain that is proportionate to an injury cannot be compensated by way of a separate chronic pain award because proportionate chronic pain is fully compensated for by the section 23(1) functional award that a worker receives. Policy states that an additional award for specific chronic pain would result in the worker being compensated twice for the impact of pain.

I note that being compensated twice is not a concern in the case of non-specific chronic pain, since policy item #39.01 of the RSCM I suggests that non-specific chronic pain exists in the absence of any objective measurable impairment. In cases of non-specific chronic pain, an award may be granted where the pain is "significantly greater" than

what would be reasonably expected given the type and nature of injury or disease. Determining whether pain is "significantly greater" remains a challenge, but there is no concern in those cases with compensating a worker twice for the impact of pain.

Returning to the matter of specific chronic pain, since the policy in item #39.01 of the RSCM I states that the section 23(1) award will be considered to appropriately compensate the worker for the impact of proportionate chronic pain, this suggests that all scheduled awards, as found in the PDES, contain a component for pain. Therefore, where a worker is entitled to an award comprised of several scheduled items, such as the neck and the knee, the worker is being compensated for typical (proportionate) pain in each body part. In essence, one can easily infer from this that the Board considers it more disabling to have pain in multiple areas than to have pain in just one area, and that this should be reflected in the compensation scheme.

If I am correct, then there is no principled reason why the same logic should not apply to disproportionate specific and non-specific chronic pain. Applying that logic, a worker who experiences disproportionate chronic pain emanating from more than one injured body area should be considered more disabled than a worker with chronic pain emanating from a single area. Thus, to the extent that disability in the workers' compensation system is reflected by an increased percentage of total disability, a worker should receive multiple chronic pain awards where more than one body part is the source of the disproportionate disabling chronic pain.

Chronic pain awards are made where chronic pain is disabling. To the extent that an additional injury gives rise to associated chronic pain makes it self-evident that a worker with such problems may be more disabled and should be compensated at a higher level than a worker who has chronic pain associated with a single injury. This principle would apply most easily to situations where the disproportionate chronic pain affects two functionally independent areas of the body.

In deciding this matter, I am also mindful that if a worker has two separate claims (one for his knee and the other for his neck) it is possible to receive an award of 2.5% for disproportionate disabling chronic pain on each claim.

Finally, I note that placing a limit on the number of chronic pain awards or creating a maximum percentage of disability from chronic pain under each claim would have been a simple matter for the Board. Had the Board wanted to limit the total award for chronic pain for any one claim (or for that matter, for any one worker) to 2.5% of total disability, regardless of the number of injured areas with disproportionate chronic pain, it could have expressly done this.

In summary, neither the Act nor Board policy expressly permits or prohibits multiple chronic pain awards. In my view, awarding a worker multiple chronic pain awards under section 23(1) of the Act, under the same claim, is consistent with the Board's general approach to pain and the assessment of physical impairment. Furthermore, that approach is consistent with the Act and Board policy.

In the absence of any statutory provision or Board policy that prohibits WCAT from awarding more than one chronic pain award, I find that multiple awards are consistent with the general principles of workers' compensation, which recognize that a worker should receive compensation proportional to the level of disability caused by a workplace injury or an occupational disease.

I now turn to the worker's case, and find that his knee and leg pain should be categorized as non-specific chronic pain. The policy in item #39.01 of the RSCM I defines non-specific chronic pain as pain that exists without clear medical causation or reason; it continues following the recovery of a work injury. The worker's pain is limited to the area of his injury, but there is no clear medical cause or reason for this pain since his fracture and lacerations have healed. The question is whether his pain is significantly greater than what one would reasonably expect, given the type and nature of the injury. If so, his pain could be considered disproportionate and he would be eligible for consideration of a permanent chronic pain award.

Dr. MacKenzie is the only physician to address the cause of the worker's right leg and knee pain. His December 28, 2000 report does not suggest that the worker's knee and leg pain is unusual for his injury, even though there is no clear medical cause or reason for it. Thus, there is insufficient evidence to conclude that the worker's knee and leg pain is significantly greater than one could reasonably expect given his injury. I find that it is not disproportionate.

Accordingly, while I accept that the Act and policy allow me to make multiple chronic pain awards, I do not find that the worker's chronic right leg and knee pain is disproportionate to his injury, as required under the policy in item #39.01 of the RSCM I. I deny this aspect of the worker's appeal.

Psychological Injury

Policy item #38.10 of the RSCM II provides that the determination of whether there is a permanent psychological impairment and the severity of the impairment is made by either a Board psychologist or a Board authorized ESP. Once the evaluation is completed, the claim is referred to the PDAC to assess the percentage of disability resulting from the permanent psychological impairment.

Scheduled awards for psychological disability are set out in items 77 to 79 of the PDES. Item 77 concerns aphasia and communication disturbances. Item 78 concerns disturbances of mental status and integrative functioning. Item 79 concerns emotional (mental) and behavioural disturbances. The categories and descriptions in the PDES were based on the American Medical Association *Guides to the Evaluation of Permanent Impairment* – 5th Edition (AMA Guides). The Board follows the principles of assessment in that publication in assessing permanent psychological impairment.

The AMA Guides explain that four main categories exist that assess many areas of function: (1) ability to perform activities of daily living; (2) social functioning; (3) concentration, persistence, and pace; and (4) deterioration or decompensation in work or work-like settings.

The neuropsychological PFI assessment indicated that the worker had the following: (1) mild difficulties with activities of daily living; (2) moderate difficulties in emotional and social functioning; (3) adequate function in the areas of concentration, persistence, and pace; and (4) minimal difficulty with work. The worker did not show signs of cognitive impairment on testing, but did exhibit some difficulty in word-finding. The PDAC considered that the worker's impairment should be assessed under emotional and behavioural disturbances (item 79). While I recognize that the worker has some minor cognitive difficulties, primarily on self-report, I agree that the worker's psychological disability is appropriately assessed under item 79 in the PDES.

Item 79 of the PDES sets out the following impairment levels related to activities of daily living, social functioning, concentration, persistence and pace, and work adaptation:

- Mild - impairment levels are compatible with most useful functioning: 0 to 25%.

- Moderate - impairment levels are compatible with some, but not all useful functioning: 30 to 70%.

- Marked - impairment levels significantly impede useful functioning: 75 to 95%.

- Extreme - impairment levels preclude most useful functioning. 100%.

The PDAC assessed the worker as having a mild impairment, which warranted an award of 10.0% of total. Mr. Jarmson submits that the worker's award should be at the high end of the mild range, and seeks an award of 25% of total. He asks that I pay specific attention to the reports of Dr. Gervais and the Board's head injury program, and not just the assessment of Dr. Du, especially since Ms. Lindberg was the only person to evaluate the worker.

The PDES explains that disability ratings greater than 0% are made in 5% increments. The question is whether 10.0% is a fair and accurate assessment of the percentage of the worker's psychological impairment, within the mild range. The PDAC did not provide analysis or reasons for choosing 10.0%, other than stating that it paid particular attention to the impact of the worker's head injury on his work performance.

Of the four main categories used to assess the worker's function, I am mindful that he had minimal or no impairment in two of them (concentration, persistence and pace, and work). Of the two remaining categories, the worker showed mild difficulties with activities of daily living and moderate difficulties with emotional and social functioning, consistent with his evidence and that of his wife.

The PDAC granted an award at the low end of the mild impairment category. I have questioned whether that is appropriate, given Dr. Du's conclusion that the worker had moderate impairment of his social functioning. However, in light of the evidence that the worker had few difficulties in the other areas categories of function, I find that it would not be appropriate to rate the worker's impairment at the high end of the mild category.

I place weight on the fact that the PDAC considered all evidence on the worker's claim file and the impact of the injury on the worker's overall functioning. The PDAC did not solely rely on the neuropsychological PFI assessment. Nevertheless, I consider the evidence provided by the worker and his wife at the WCAT oral hearing generally accords with Dr. Du's assessment, Dr. Gervais' reports, and the evaluations of the head injury unit. I do not consider that any compelling evidence was provided that challenges or disagrees with the results of the neuropsychological PFI assessment.

I again note that RSCM I policy item #97.40 provides that the report of an ESP takes the form of expert evidence which, in the absence of other expert evidence to the contrary, should not be disregarded.

Finally, RSCM II policy item #38.10 provides that the PDAC is to assess the percentage of disability resulting from the psychological impairment. Although the PDAC provided little in the way of reasons for its assessment, it has experience in assessing the percentage of psychological impairment and, without compelling evidence to the contrary, I accept its assessment. Accordingly, I find that the worker's permanent psychological impairment was properly assessed at 10.0% of total. I deny this aspect of the worker's appeal.

Loss of Earnings

Mr. Jarmson did not make any submissions on this matter. My review of the file does not suggest that the worker is suffering a loss of earnings. He has worked steadily since March 1999, and has not advised the Board that he is earning less than he did as a result of his injuries. Accordingly, I find no reason to alter the Board's conclusion that the worker is not sustaining a loss of earnings, and deny this aspect of the worker's appeal.

Conclusion

I vary the August 20, 2004 Review Division decision. I find that the worker is entitled to an additional award of 2.5% for chronic pain complaints.

The worker's permanent address is in British Columbia; however, he works in Alberta and only returns home approximately once a month for two days at a time. He flew from Alberta to attend the oral hearing on May 6, 2005. He seeks payment of his return airfare.

Section 7(1) of the *Workers Compensation Act Appeal Regulation* provides that WCAT may order the Board to reimburse a party to an appeal expenses associated with attending an oral hearing if the party is required by WCAT to travel to the hearing.

Item 13.22 of WCAT *Manual of Rules of Practice and Procedure* (MRPP) states that oral hearings will normally be held in British Columbia locations closest to the community where the appellant resides. However, if WCAT chooses (i.e. not at the request of the appellant) to schedule a hearing at a location that is not the nearest hearing location to the appellant, WCAT will order reimbursement of the appellant's expenses regardless of the outcome of the appeal, unless there is evidence that the party engaged in fraud or misrepresentation.

Item 13.22 of the MRPP further states that where the appellant has moved without notifying WCAT and the oral hearing was scheduled in the location where they formerly lived, WCAT will not normally award reimbursement of the appellant's travel expenses. It also indicates that reimbursement of a party's travel expenses from outside the province will generally be limited to the portion of travel within British Columbia, unless WCAT specifically asks the party to attend a hearing.

Mr. Jarmson completed the worker's notice of appeal on September 21, 2004. He requested that an oral hearing be held in Richmond and noted the worker's address as being in British Columbia (Richmond would be the closest community to where the worker has his permanent address). On January 12, 2005, WCAT informed the worker and Mr. Jarmson that the hearing would be held in Richmond. At no time prior to the

hearing did Mr. Jarmson contact WCAT to request a change in venue closer to Alberta or advise WCAT that the worker was only in British Columbia on such a limited basis.

In these circumstances, I find that the worker is not entitled to reimbursement of his return airfare. He is, however, entitled to payment of that portion of his mileage expenses from the location of his residence in British Columbia and return beyond 48 kilometres, in accordance with the tariff established by the Board. No other expenses were requested and none are awarded.

Elaine Murray
Vice Chair

EM/ml