Noteworthy Decision Summary

Decision: WCAT-2005-05357 **Panel**: Sherryl Yeager **Decision Date:** October 12, 2005

Transitional Provisions – Onset of Permanent Disability – Section 35.1(4) of the Workers Compensation Amendment Act, 2002 – Policy Item #1.03 of Rehabilitation Services and Claims Manual

The worker suffered a compensable shoulder injury in March 2002. He was advised that his condition was likely permanent in July 2002. The panel held that, as there was no change in the worker's condition between March and July 2002, there was an indication the injury was permanently disabling before the June 30, 2002 transition date and thus the former provisions of the *Workers Compensation Act* (Act) applied.

The worker was employed as a millwright. The Workers' Compensation Board (Board) accepted his claim for a right shoulder rotator cuff tendonitis/tendonopathy. The worker initially injured his right shoulder in January 2002 and again in March 2002. An orthopaedic surgeon assessed the worker on May 30, 2002 and suspected right shoulder rotator cuff tendonitis. An MRI on June 14, 2002 showed some thickening of the shoulder tendons consistent with tendonopathy. The orthopaedic surgeon re-assessed the worker on July 25, 2002. He observed the worker's shoulder was about the same, and advised the worker that his shoulder would likely never be normal. The worker underwent a functional capacity evaluation. The results indicated he could not safely return to his pre-injury occupation. The Board granted the worker a Permanent Disability Award (PDA) of 5.1%. The worker disputed his award and requested a review by the Workers' Compensation Review Division (Review Division). The Review Division upheld the Board's decision. The worker appealed to the Workers' Compensation Appeal Tribunal.

The panel considered the issue of whether the worker's permanent disability first occurred prior to or after the transition date of June 30, 2002, for the purpose of determining whether the former provisions or the current provisions of the Act applied. Policy item #1.03(b)(3) of the *Rehabilitation Services and Claims Manual* provides that if an injury occurred before June 30, 2002 but "the first indication that it is permanently disabling" occurs after June 30, 2002, the current provisions apply. In this case, the worker was assessed by the orthopaedic surgeon both before and after the transition date. It was not until the follow-up appointment was booked, after the investigative MRI, that the orthopaedic surgeon provided an opinion that the worker would likely have a permanent functional impairment. He also noted that there was no change in the worker's condition from his first to the second assessment. The panel found that the timing of the follow-up assessment, after the transition date, was more reflective of administrative realities than any change in the worker's condition due to treatment. There was no evidence the worker's shoulder symptoms improved substantially after the MRI. Therefore, the panel was satisfied a permanent disability had occurred prior to the transition date and the former provisions of the Act applied.

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Panel: Sherryl Yeager, Vice Chair

Introduction

The worker was employed as a millwright in 2002. On January 17, 2002 he injured his neck and shoulder. He continued working at light duties, however reinjured his neck and shoulder in March 2002 and was unable to continue working. The Workers' Compensation Board (Board) accepted his claim for a right shoulder rotator cuff tendonitis/tendonopathy. The worker received temporary disability wage loss benefits until October 20, 2002. The Board accepted the worker had a permanent functional impairment as a result of his injury and paid a permanent partial disability award of 5.1% on July 13, 2004.

The worker requested a review of this decision. A Review officer confirmed the Board's decision in *Review Division Decision #22315*, dated February 7, 2005. The worker has appealed this decision.

Issue(s)

Was the worker's permanent partial disability award an accurate reflection of the economic loss resulting from the injury? The worker disputed only his functional award and entitlement to a loss of earnings award.

Jurisdiction

This appeal was filed with the Workers' Compensation Appeal Tribunal (WCAT) under section 239(1) of the Workers Compensation Act (Act).

This is an appeal by way of rehearing, rather than a hearing *de novo* or an appeal on the record. WCAT has jurisdiction to consider new evidence, and to substitute its own decision for the decision under appeal.

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 pension award in this case was based on item #6 of the "Permanent Disability Evaluation Schedule" (PDES), which sets out a range of 0 to 35% for immobility of the shoulder. I therefore have authority to consider the review officer's decision regarding the percentage of disability awarded to the worker.

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Background and Evidence

The following is a summary of the evidence from the worker's claim file that is relevant to this appeal.

The worker's medical history is significant for multiple myocardial infarctions due to hereditary heart disease, as well as transient ischemic attacks. The worker had a coronary bypass in November 1998, and several knee operations. He used anti-cholesterol and anti-platelet medications.

The worker injured his posterior right shoulder/neck area on January 17, 2002. He described the incident as falling forward while picking up a grinder and cord with his left hand, while his tool bag was over his right shoulder. He felt pain in his right shoulder/neck when he jerked back to correct himself. His physician, Dr. Eddy, diagnosed a strained neck, upper back and right shoulder muscle. The worker was referred for physiotherapy. He continued to report pain and weakness in the shoulder and headaches over the following three months, but continued working at light duties.

On March 15, 2002 Dr. Eddy queried a torn rotator cuff and requested assessment by an orthopedic surgeon.

The worker reported to Dr. Eddy on April 2, 2002 that he had slipped at work on March 29, 2002 and reached back to catch himself with his right arm. He felt an increase in pain in the right shoulder and right side of his neck and ribs. Dr. Eddy observed the worker had decreased range of motion of the neck and shoulder, muscle spasm on the trapezius area, and abduction of the shoulder was limited to 15 degrees. He considered the worker disabled and requested assessment by an orthopedic surgeon on an urgent basis.

The orthopedic surgeon, Dr. Werry, assessed the worker at the Visiting Specialists Clinic on May 30, 2002. He observed the worker had pain with abduction or elevation and forward flexion above shoulder level. Dr. Werry observed there was mild tenderness in the worker's shoulder with moderately positive impingement signs. He suspected the worker had right shoulder rotator cuff tendonitis. He doubted there was a significant rotator cuff tear because of the absence of muscle wasting and the preservation of relatively good motion with normal rhythm. He suggested an MRI to assist in the prognosis and therapy efforts.

An MRI was performed on June 14, 2002. No definite rotator cuff tear was observed. There was some thickening of shoulder tendons consistent with tendonopathy.

Dr. Werry re-assessed the worker on July 25, 2002. He observed the worker's shoulder was about the same, with positive impingement signs with any abduction or elevation of the limb above mid-chest level. He advised the worker that "his shoulder will likely never be normal but that it is appropriate to return to work if the pain is manageable."

On September 11, 2002, the case manager advised the employer's representative that no permanent condition had been accepted on the claim, however medical input would be sought regarding arranging a modified light duty graduated return to work.

On September 12, 2002, a Board team assistant recorded that a progress report would not be submitted by the physiotherapy team, as they considered the worker able to return to his regular duties full-time with no restrictions.

A nurse advisor reviewed the graduated return to work offered to the worker and provided a comment on September 16, 2002. She noted the worker had not progressed with six months of physiotherapy treatment. She believed the light duties exceeded the worker's physical abilities, and a graduated return to work may not be successful. She noted the employer's expectation that after a four week graduated return to work the worker would return to regular duties.

A physiotherapy report was provided on September 17, 2002. The report indicated that the worker had received six weeks of treatment, and his shoulder abduction was 2/3 of full and weak against resistance. The worker advised he would not be able to undo a lug nut at work. He had limited strength. The physiotherapist recommended a Board rehabilitation service and assessment by an orthopedic specialist.

On September 24, 2002, a medical advisor provided an opinion that the clinical situation regarding the worker's right shoulder remained unchanged. He had the same physical examination abnormalities. MRI studies indicated chronic changes involving three of the four tendons/muscles in the rotator cuff. Dr. Werry had indicated that the worker's shoulder would likely never be normal, and the medical advisor concurred with this opinion. The worker would have restrictions handling heavy weights and for sustained activities at or above shoulder level. He should avoid circumduction movements.

A team meeting was held on October 1, 2002. It was determined the worker was at medical plateau, and had a permanent functional impairment. He was entitled to vocational rehabilitation to assist in a return to work with the injury employer. The team noted that the worker would have difficulties returning to his pre-injury position. For the purpose of the referral to Disability Awards, the team noted the medical advisor's opinion of September 24, 2002 that the worker had persistent physical findings and chronic MRI abnormalities.

The worker underwent a two-day functional capacity evaluation in November 2002. The worker was observed to exert good effort. There was no pain exaggeration, and his perceived and functional abilities were consistent. The test results indicated the worker did not meet the physical demands of his occupation as a millwright. He was able to perform light and some medium strength physical demands, while his job was rated as "heavy" under the National Occupational Classifications (NOC) guidelines.

On April 28, 2003, the worker underwent a psychovocational assessment to assist in career planning. The assessor noted the worker's report of intense headaches around the right side of his neck and behind his right eye, which had increased in frequency to the point the pain was continuous for six weeks. The worker also had a history of migraines that occurred every other month on average. The assessor recommended the worker seek supervisory positions in maintenance or construction shops, or work as a machine operator. With further training the worker could do well as a construction inspector or civil and structural engineering technologist.

On July 3, 2003 the worker's vocational rehabilitation consultant (VRC) advised him labour market information research indicated that there were opportunities as a mechanical planner, maintenance planner, industrial maintenance planner and maintenance supervisor that would replace his pre-injury earnings. Job search benefits to assist him in a return to work in these areas would be provided.

The worker provided numerous job search sheets documenting his employment search. He also provided letters from his physician who indicated severe headaches were hampering his ability to drive for extended periods and look for work.

The Board advised the worker on September 22, 2003 that his headaches would not be accepted as a compensable consequence of his work injury. This decision was upheld by a review officer on March 29, 2004 in *Review Division Decision #10060*. The worker subsequently appealed this decision to WCAT. A vice chair confirmed the Board's decision on March 29, 2004 in *WCAT Decision #2004-05140*.

On January 26, 2004 a review officer confirmed the Board's decision of July 3, 2003 that labour market information research indicated that there were opportunities as a mechanical planner, maintenance planner, industrial maintenance planner and maintenance supervisor that would replace the worker's pre-injury earnings. Therefore the worker had no further entitlement to vocational rehabilitation benefits.

A permanent functional impairment evaluation of the worker was conducted on June 21, 2004 by a Disability Awards medical advisor (DAMA). The worker reported his shoulder was always sore and this increased with use. Above shoulder activity such as throwing a ball or waving his arm was aggravating, as was carrying heavier objects in a dependent position. The worker did not use ice, heat or massage to treat his symptoms. The worker reported taking morphine for his headaches. He was using his left hand for more tasks such as chores around the house and driving. He had stopped

golfing, playing hockey and basketball and martial arts. The DAMA observed the worker's right shoulder was slightly higher than the left. The worker put forth excellent effort throughout the examination. There was no significant tenderness in the shoulder. There was some crepitus with movement of the shoulder and some impairment in the range of motion of the shoulder. There was some reduction in grip strength, less than 15% of strength compared to the left side. The DAMA found no additional factors to warrant an award other than the measured impairment.

The total impairment in flexion, extension, abduction, adduction, and external rotation equalled 5.10% on the Board's PDES.

A Disability Awards officer (DAO) considered the worker's pension entitlement on July 13, 2004, under the former provisions of the Act. The DAO determined that the worker's subjective complaints of soreness, discomfort and loss of strength in his shoulder were consistent with the objective findings and were consistent with the scheduled award. The loss of strength did not exceed that which would be expected with the degree of loss of range of motion measured. No additional award would be provided for loss of strength. The worker's pension would be based on 5.10% of total disability.

The worker's wage rate for pension purposes was set at $4,704 per month, based on his earnings in the one year prior to injury.

Oral Hearing

He believed his shoulder condition was the same in April 2002, and at the permanent functional impairment evaluation as it was in June of 2002. He described his symptoms as a constant dull ache, like a bruise. When he moved the shoulder, the pain became the same as if someone was pushing against the shoulder. The worker said he had headaches that he believed were associated with the pain in his shoulder.

He said Dr. Werry told him nothing could be done for his shoulder and the injury would only get worse. The worker said he had difficulty with vertical movements with his shoulder and reduced strength.

As a result of his injury he could not golf, garden or play with his son. He was no longer able to enjoy his hobby of working on his car. The headaches that were brought on by use of his arm caused him to limit using the limb. The more he used the arm, the less strength he had in it.

The worker disputed the permanent functional impairment evaluation results because he had not used the shoulder prior to testing, and his wife drove him to the appointment. Therefore his shoulder was in the best possible condition at the time of the assessment.

The worker said that after his vocational rehabilitation benefits were concluded in August 2003, he continued to look for work. The worker said he never received an

employability assessment from the VRC. He sent out 730 applications and heard back from only three employers, who advised him they were not hiring or he was not qualified. The worker said he applied at manufacturing companies, fabricators, production plants, and the wharves. He cold-called and applied in person for jobs as a production supervisor or in maintenance scheduling. He noted that this kind of work he was not supposed to do because of stress and his heart condition. He had a total of nine heart attacks, and was supposed to stay away from stress. The worker was angry that the VRC had him do research into retraining, then declined to pay for upgrading because of the length of time it would take him to get into the drafting program he suggested. He believed he needed further training in order to obtain positions the VRC had identified.

Although he had worked in purchasing for a metal fabricator in the past, and taught himself estimating when he owned a concrete pouring company, he had to quit these positions because of stress. Work as a mechanical planner, setting up projects, involved a lot of pressure and stress. Very few ever came up in the paper. The worker said that five to ten positions came up per month. Many of the jobs called for computer training or other skills that he did not have. The worker said he stopped driving for a period in July 2003 during his job search because of his headaches. The worker said he declined to pursue a supervisor position in October 2003 because travel was a requirement. He could not take the position as it required him to travel too far from the Lower Mainland hospital he must attend because of his heart condition.

The only area he had been able to find work in was as a millwright. He found a position in November 2004 as a fitter/machinist, earning $25.60 an hour. He was let go from that position because of his headaches. The worker said that he'd lost two jobs as a millwright because of his headaches, which caused him to miss a day every two weeks or so. He was working as a millwright at the time of the hearing. He worked with a partner, two days and two night shifts. He was going to be replaced in this position because he would not agree to hire on. He did not like the company and could not tolerate the headaches.

He was taking rapid release morphine for these headaches, however had started using Percocet for them when he was at work. The worker disagreed with the Board and WCAT decision that his headaches were not caused by his compensable injury. He had been advised by Dr. Robinson that the headaches were definitely due to nerve damage in his neck from the injury. He was still waiting to get on the list for cervical blocks for his headaches.

Submissions

The worker's representative challenged the veracity of the Board's Applied Rehabilitation Concepts (ARCON) testing equipment and computerized calculation methods. He argued that the testing was not approved by the Act or policy, yet was accepted as determinative. Only the PDES was determinative. He referenced policy #97.40 of the *Rehabilitation Services and Claims Manual*, *Volume II* (RSCM II) which required the Board to look at other variables, including the worker's evidence, when assessing a permanent partial disability award, and argued that the worker's loss of strength was not considered.

He believed the 5.1% that was awarded should be the starting point for the worker's percentage of total disability. He requested the worker receive 50% of a 35% shoulder complete immobility award, based on his level of impairment. The worker had never received an employability assessment, nor had he received any retraining. The identified positions were not reasonably available to him, as evidenced by the lack of an interview in three years. The worker's representative argued the worker was virtually unemployable, and was doing a job that medically he should not be doing.

The worker's representative argued the evidence supported a conclusion that the worker was permanently disabled as of the MRI of June 10, 2002, and therefore the former provisions of the Act applied.

The employer's representative submitted that the Board officer erred in applying the former provisions of the Act to the worker's pension entitlement. She submitted that the current provisions of the Act should apply, as there was no evidence that the worker's condition would result in a permanent functional impairment until after June 30, 2002 (the transition date).

She noted the transition rules set out in policy #1.03 of the RSCM direct that the decision as to whether there is a permanent functional impairment must be based on the available medical evidence. She noted that Dr. Werry's report in May 2002 doubted there was a significant tear in the worker's rotator cuff. It was not until July 25, 2002 that Dr. Werry indicated the worker's shoulder would not be normal. She argued that tendinitis, in the absence of a tear or surgery, was not generally considered a permanent injury. As there was no medical evidence of permanent impairment prior to the transition date, the file should be referred back for a formal assessment of the worker's loss of earnings entitlement under the current provisions.

The employer's representative argued the worker's functional award was appropriate and should not be altered. She noted it was significant that the worker was currently employed and earning $29 an hour and that it was not his shoulder that was bothering him, his headaches were his primary concern. She also questioned how the worker would undergo any schooling given his description of the severity and frequency of his headaches.

The worker's representative rebutted that it could be argued the worker's injury was permanent from the first diagnosis. The date of the MRI would not change the outcome, as the condition was present from the date of injury. He argued the employer's representative was not a medical expert capable of giving evidence on whether a rotator cuff tear or tendinitis were permanent conditions.

Findings and Reasons

The *Workers Compensation Amendment Act, 2002* (Bill 49) resulted in significant changes to the law and policy concerning permanent disability awards, effective June 30, 2002 (the transition date).

The Act as it read prior to the transition date is referred to as the former provisions. The Act as it read after the transition date is referred to as the current provisions.

Subsection 35.1(4) of the transitional provisions in Bill 49 provides that if a worker's permanent disability "first occurs" on or after the transition date as a result of an injury that occurred before the transition date, the current provisions of the Act apply to the permanent disability, subject to subsections (5) to (8).

Policy #1.03 of the RSCM provides rules for determining whether the former provisions or the current provisions apply to a worker's permanent disability award. Policy #1.03(b)(3) of the RSCM provides that if an injury occurred before June 30, 2002 but "the first indication that it is permanently disabling" occurs after June 30, 2002, the current provisions apply, as follows:

> Under this rule, for an injury that occurred before June 30, 2002, where the first indication of permanent disability also occurs before June 30, 2002, the permanent disability award will be adjudicated under the former provisions. Where the first indication of permanent disability is on or after June 30, 2002, the award will be adjudicated under the current provisions, using the modified formula described in (i) and (ii) above. The determination of when permanent disability first occurs will be based on available medical evidence.
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> An example of when this rule applies is where a worker, injured before June 30, 2002, shows no signs of permanent disability before that date. However, on or after June 30, 2002, the worker has surgery, which first causes permanent disability. The permanent disability award will be adjudicated under the current provisions, using the modified formula.

The review officer found that the former provisions applied to this worker's appeal as it became apparent before the transition date that the worker had a permanent disability. This appears to be a standard paragraph, as there was no analysis of the evidence relied on to reach this conclusion.

Prior to Bill 49, Board policy directed that a worker's condition was considered "permanent" after the date of medical plateau. Medical plateau was defined as the point at which there were no further treatment options, or likelihood of a significant change in the worker's condition, within the next 12 months. Permanent partial disability awards were and continue to be payable as of the date following medical plateau, which is the point when temporary disability benefits are concluded.

As a result of Bill 49 and the transitional provisions regarding permanent partial disability awards, there has been considerable discussion regarding the question of when permanent disability "first occurs." Adjudicators at WCAT and the Review Division have considered permanent disability to first occur when so indicated by a physician on a progress report, the date a claim is referred to Disability Awards, the date of a permanent functional impairment evaluation, or the date of medical plateau. They have also considered a permanent disability first occurred prior to the transition date if the medical evidence indicates the compensable pre-June 30, 2002 injury resulted in a significant condition that required surgery. This is so even if the surgery occurred after June 30, 2002, as the presence of the condition that needed repair was suggestive a permanent functional impairment would result.

In some instances, it is obvious that there will be a permanent disability resulting from a workplace injury, such as an amputation or spinal injury. Soft tissue injuries generally resolve, but some, as in this case, do not. Often, considerable time is spent attempting to obtain a clear diagnosis or provide treatment when a soft tissue injury does not improve. There may be organizational delays in setting up a team meeting at which it is determined a worker's condition is plateaued, then referring a worker's claim file to Disability Awards, or arranging the permanent functional impairment evaluation, and then issuing the pension.

I have also referred to prior WCAT decisions on this issue, namely *WCAT Decision #2005-02722, #2005-02953 and #2005-00770*. These are available at www.wcat.bc.ca. Decisions of WCAT are not binding on me and I refer to them for guidance only.

In *WCAT Decision #2005-02722*, the vice chair wrote;

> The Act does not define what a permanent disability is or when one should be considered to "first occur," nor does it specify when a permanent disability award should be made. The Act simply states that a permanent disability award is compensable and specifies how it is to be quantified. To determine the timing of the permanent disability award one must look at

> policy. In any event, the timing of a permanent disability award is not determinative of when a permanent disability "first occurs."
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> …
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> One could make the decision that until the disc was excised, the worker's injury could not be considered a permanent disability. Moreover, to consider a strain as a permanent condition from the date of injury would preclude any concept that individuals can, and do, recover from soft tissue injuries. However, policy item #1.03(b)(3) also sets out that the determination of when permanent disability first occurs will be based on available medical evidence.

The vice chair went on to conclude that as the Board medical advisor opined the herniation was caused by the compensable injury, and the herniation required surgical repair, the permanent disability occurred at the time of injury, and the former provisions of the Act should apply.

In *WCAT Decision 2005-02953*, the worker was injured in 2001, and was considered medically plateaued after the transition date, in September 2002. The employer took the position that as the disability was temporary until the point the worker was placed on vocational rehabilitation benefits, the current provisions of the Act should apply. The vice chair provided a lengthy analysis of the policy and Board practice directive #38A (which uses the phrase "first indication of permanent disability" rather than "first occurs"). She concluded that if the legislative intent was to use the plateau date as the date of the first indication of disability, the transition provision would have made specific reference to this date. The vice chair believed that the plateau date was merely an indicator for pension calculation purposes, but did not reflect the date on which a permanent disability was first indicated. She noted that administrative matters and delays in treatment may prolong the decision that a worker has reached medical plateau, although the condition has been stable for several months.

The vice chair found that the first indication of a permanent disability was an MRI in 2001 which documented a large full-thickness rotator cuff tear. The worker had a continuity of symptoms from the date of injury until his permanent functional impairment evaluation. Although surgery after June 30, 2002 had improved his condition, he was left with residual symptoms. She confirmed the Board's decision that the former provisions applied to the worker's pension entitlement.

In *WCAT Decision #2005-00770*, the vice chair found that although the worker's injury occurred on May 9, 2002, it was initially diagnosed as a soft tissue injury, namely a bilateral shoulder strain and upper back strain. It was not until July 2002 that the worker was diagnosed with shoulder tendinitis superimposed on chronic bilateral adhesive capsulitis and other conditions. An MRI in August 2002 noted moderate supraspinatus tendinitis. The worker underwent a number of medical investigations, none of which

were definitive of a more serious condition. The medical advisor opined in December 2002 that it was not known if the worker's left shoulder condition was permanent. The worker was not medically plateaued by the Board until 2003. The Board had adjudicated the worker's pension under the former provisions of the Act, but did not provide any detailed reasoning as to how the conclusion was reached that first indication of disability was prior to June 30, 2002. The vice chair found that the first indication of a permanent disability was after June 30, 2002, and the current provisions of the Act and the RSCM ll applied to the worker's pension entitlement.

In the matter before me, the worker was assessed by Dr. Werry before and after the transition date. It was not until the follow-up appointment was booked after the investigative MRI, that Dr. Werry provided an opinion the worker's shoulder would likely have a permanent functional impairment. He also noted that there was no change in the worker's condition from his first to the second assessment. The MRI was prior to the transition date and indicated tendonopathy in three of the four muscle/tendon groups that comprise the shoulder joint. The worker was not considered medically plateaued until a team meeting in October 2002, although there were concerns about his ability to perform his job duties prior to that date.

I believe it is important to note that the worker had not one, but two injuries, the first in January 2002 and the next in March, 2002. The worker's physician first requested an orthopedic consultation in March 2002, prior to this second fall, and three months after the initial injury. Dr. Werry observed impingement signs but did not believe a rotator cuff tear was present at the May 30, 2002 assessment. The tendonopathy confirmed by MRI would obviously have been present at Dr. Werry's first assessment. The timing of the follow-up assessment, after the transition date, is more reflective of administrative realities than any change in the worker's condition due to treatment. Dr. Werry opined the worker would be left with changes in his shoulder. He also did not offer a surgical option. While the employer's representative submits this indicates the worker's condition was not significant and was expected to resolve, the alternate interpretation would be that nothing further could be done to improve the worker's condition and it was permanent in May 2002.

The worker's physical presentation, namely his reported symptoms and demonstrated limitation in range of motion in the shoulder, did not change significantly after the initial injury, other than to worsen following the re-injury. The medical reports on file indicate a similar restriction in range of motion in May 2002 to that recorded at the permanent functional impairment evaluation in 2003.

On the basis of the medical evidence, I consider the worker's restricted left shoulder range of motion has resulted from the tendonitis/tendonopathy. This condition was caused by the compensable injury in January and March 2002 and evident on MRI on June 14, 2002. There is no evidence it improved substantively after that date. Therefore, I am satisfied a permanent disability had occurred prior to the transition date, and the worker's permanent disability award entitlement is properly considered under the former provisions of the Act, in conjunction with Board policy as contained in the RSCM I.

Section 23(1) of the Act provides that where an injury results in an impairment in earning capacity, the worker is entitled to a pension based on 75% of the estimated loss of average earnings resulting, and is payable for life. This is commonly referred to as the "functional award."

Section 23(3) of the Act provides that if the amount of the difference between the average weekly earnings the worker is considered capable of earning after the injury compared to earnings prior to the injury is greater than the functional award, the worker will receive 75% of this amount. This is commonly referred to as the "loss of earnings award."

Section 23(2) of the Act provides that the Board may compile a rating schedule of impairment of earnings capacity, which may be used as a guide when determining the compensation payable in permanent disability cases.

The method for assessing a scheduled award after August 30, 2003 is set out in Chapter 6 and Appendix 4 of the RSCM ll. The Board's (PDES) is also contained at Appendix 4. The version of the manual and PDES in effect on the date the worker's permanent partial disability award was assessed are available through the Board's website (www.worksafe.bc.ca). The Board has authority under section 23(2) of the Act to create this schedule for the purpose of assessing a worker's percentage of functional impairment. This schedule is the basis for all functional awards.

This worker's permanent functional impairment evaluation was conducted using the ARCON testing system. This methodology encompasses symptoms experienced by the worker, together with specific testing protocols, recognising restrictions in range of motion are caused in part by the level and nature of symptoms. Test results include the evaluator's observations and any required additional non-range of movement testing. Testing tools attached to a computer electronically capture data from the tests performed. Computerized goniometer measurements record "active" or worker demonstrated movements. The equipment was designed to factor out simple human discrepancies that arise by any individual medical examiner's techniques in reference to determining a level of disability. There is no direct assistance by the clinician or physician to get better movement by reason of passive maximums. The recorded restrictions encompass the effect of any symptoms on the worker's direct demonstration of movements.

The computerized goniometer range of motion measurements are entered for calculation by the Automated Impairment Rating System (AIRS) computer software program which calculates award entitlement in accordance with the Board's PDES. The calculation is based on the recorded restriction in range of motion in the affected limb or joint and compared to the worker's own range of motion in the opposite unaffected limb or joint. In the case of bilateral injuries, the norms based on the average population are utilized for comparison.

The percentage of total disability for a complete immobility of the shoulder in the PDES is 35%.

Policy #97.40 of the RSCM I directs that a permanent functional impairment evaluation or assessment by a DAMA take the form of expert medical evidence that should not be disregarded. A Board officer remains able to exercise discretion and award a different percentage if the officer believes the disability is less or greater than the amount reflected by the percentage of impairment.

I have manually checked the calculations to determine the worker's pension entitlement, based on the recorded restriction in range of motion in movement in his shoulder, using the Board's formula for determining the percentage of total disability (Normal Range – Measured Range/Normal Range) x %. Normal range is that measured in the unaffected limb. The appropriate percentages are available in Appendix 4 at item #6 of the PDES. My manual calculations were exactly the same as those computed by the Board's ARCON AIRS software program, and totalled 5.10%.

Policy #39.10 establishes that the PDES is a set of guidelines, not fixed rules, and Board officers have discretion to alter an award if there are other variables relating to the degree of physical impairment that are not reflected in the range of motion measurements.

The Board may utilise the "Additional Factors Outline" (AFO) to assist in determining percentages of disability in this regard. The AFO is available at www.worksafebc.com.

The AFO provides that in **rare** cases, where the DAMA believes the loss of strength is an impairment not represented by other assessment methods, the loss of strength may be rated separately. The provided example where this may be applied is in the case of a severe muscle tear that heals leaving a palpable defect. The AFO provides a table of disability percentages for strength reduction, which it cautions is only to be applied on the rare occasion when the DAMA feels there is strong, consistent, objective evidence of weakness not taken into account by the amputation, the impairment of motion, not limited by pain and not covered by peripheral nerve ratings. In addition, there must be a clear pathological explanation for the weakness.

When I calculate the worker's measured strength based on the table contained in the AFO (normal – measured/normal) x 100, the average result is less than 15%. This falls

below the minimum of 20% in the AFO table to qualify for an award. The worker's injury is also not one that would meet the criteria set out for an additional award beyond that resulting from the PDES.

The worker argued that he was not tested when his shoulder was sore, and his impairment is much greater at that time. This is a question of functionality, which the Board assesses separately from the permanent functional impairment. In other words, the degree to which an injury impacts an individual's ability to perform their occupation or job tasks is determined by a functional capacity evaluation or similar worksite assessment to determine restrictions and limitations. This worker underwent a functional capacity evaluation in November 2002 and the results indicated he could not safely return to his pre-injury occupation. The Board accepted these results and provided the worker assistance in a return to work in alternate employment. This therefore is recognition of the functional limitations resulting from the injury and is distinct from the permanent functional impairment.

The vast majority of workers are assessed for permanent functional impairment by a DAMA or an independent evaluator using ARCON AIRS, as set out in policy #97.40. The level of impairment in range of motion resulting from the tendinitis is measured based on the PDES in the same manner for all workers in an effort to achieve some consistency in what is an arguably an imperfect system due to the fact all individuals experience pain differently.

The worker did not provide any medical evidence to contradict that of the permanent functional impairment evaluation. He believed his award should be higher due to his loss of strength in the shoulder. I have reviewed the permanent functional impairment evaluation and the medical assessments of the worker contained on the Board file. I find no reason to disturb the percentage of impairment awarded based on loss of range of motion in the shoulder.

The worker's representative requested an additional award to reflect the worker's pain complaints. Board policy on chronic pain is set out at policy #39.01 of the RSCM I, which establishes the guidelines for determining if a worker is entitled to an award of 2.5% for chronic pain resulting from a compensable injury. In summary, pain that persists for six months after the date of injury, and is in the anatomical area of the injury, and is consistent with the nature of the injury does not merit an additional award. The results of the pain are reflected in the percentage of functional impairment established by the reduced range of motion. Non-specific chronic pain that exists without clear medical causation or reason and that is disproportionate to the impairment can be considered for an award. Pain is considered disproportionate 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.

The evidence to be considered in a chronic pain assessment includes:

i) The findings of any multidisciplinary assessments.
ii) Information provided by the worker's attending physician as well as any other relevant medical information on the claim.
iii) The worker's own statements regarding the nature and extent of the pain.
iv) The worker's conduct and activities and whether they are consistent with the pain complaints.
v) In cases of specific chronic pain, the Board officer will consider the extent of the associated physical or psychological permanent impairment and whether the specific chronic pain is in keeping with the particular permanent impairment.

The policy directs that the evidence must be carefully weighed when making a chronic pain award, and includes the findings of any multi-disciplinary assessments, information from the worker's physicians, the worker's own statements, conduct and activities, and whether the chronic pain is consistent with the impairment.

I have considered the evidence regarding the worker's pain in his shoulder, and find insufficient evidence to warrant a chronic pain award. The worker has not required multi-disciplinary treatment, has never been diagnosed with chronic pain or chronic pain syndrome, and his reported level of pain is not disproportionate to the injury. He does not take medication or other treatment for the shoulder. I find the worker is not entitled to an additional 2.5% for chronic pain.

I deny the worker's appeal of the functional award.

Regarding the worker's entitlement to a loss of earnings award, I refer to policies contained in the RSCM I, as the worker's pension entitlement is established under the former provisions.

Policy #40.11 of the RSCM I requires an employability assessment be completed by the VRC and provided to the worker for comment 30 days prior to a decision being made on entitlement to a permanent partial disability award. In this case no formal employability assessment was performed, nor was the worker provided an opportunity to comment on the decision that he would not experience a loss of earnings.

Policy #40.12 of the RSCM I sets out the criteria for determining when an occupation is physically suitable and reasonably available. The first item under this policy states:

> Where the worker is doing his or her best to maximize earnings, and is following the advice of the Rehabilitation Consultant, and is presenting himself or herself in good faith to obtain a job at the highest level of earnings **among the jobs that the worker is fit to undertake**, then the earnings level in the job that is actually obtained is generally the earnings level that should be taken, unless there is evidence that this position is transitory and that jobs at another level of earnings will be available to the worker in the near future. (emphasis added)

This policy goes on to direct that a worker's long-term earnings projections must reflect jobs that are physically suitable and reasonably available to the worker in the long term. The policy states: "…if there are always numerous better qualified applicants and the realities are that a worker with the particular disability is not likely to obtain such a job that is not a reasonably available job." A job may be suitable but not immediately available due to the economic climate, but this position would continue to be considered suitable in the long term.

I am satisfied that the worker sought employment in a thorough and diligent manner in the identified occupations, without success, due to his lack of computer and transferable management skills. Although he did not pursue some opportunities due to travel requirements or concerns about stress, this was in relation to pre-existing non-compensable health concerns. These health problems did not limit his employment prior to the compensable injury, and any occupation identified for the worker subsequent to his injury must therefore be mindful of these conditions. I find that jobs in supervisory roles such as mechanical planner, maintenance planner, industrial maintenance planner and maintenance supervisor are not reasonably available to the worker in the absence of further upgrading.

The employer's representative objected to the worker's entitlement to a loss of earnings award on the basis that he has returned to work at his pre-injury occupation and is earning a significant income, despite his physical limitations. She noted that his evidence at the oral hearing indicated that the daily headaches, which are non-compensable, were the reason he chose not to continue with the employer. He was managing to perform the job duties of a millwright despite his shoulder limitations.

This is an argument with significant merit. However, I have concerns about the long-term viability of the worker's employment as a millwright, even if he did not experience the non-compensable headaches. I note that policy #40.12 of the RSCM I directs the Board to use a worker's earnings from employment obtained "among the jobs that the worker is fit to undertake." The medical advisor indicated on September 24, 2002 that the worker had limitations in the use of his shoulder. The functional capacity evaluation, performed in November 2002, confirmed that the worker could not physically perform his pre-injury occupation. I note that safety concerns due to the worker's limitations in his shoulder were mentioned at several points in the functional capacity evaluation.

I place no evidentiary weight on the comment in the Board file recorded September 12, 2002 that the physiotherapist declined to submit a report as he considered the worker fit to return to work without limitations. This remark is not consistent with the findings of the functional capacity evaluation, the worker's physician, or Dr. Werry. It is also not consistent with the comments on the physiotherapy report that was submitted on September 17, 2002, which indicated the worker had restrictions in strength and range of motion, and recommended referral to a Board rehabilitation program and an orthopedic specialist. The remark is so disparate that I question whether the log entry may be in regard to another claimant and entered into this worker's claim file in error.

Despite the worker's ability to perform work to date as a millwright but for the non-compensable headaches, I find insufficient evidence to support a conclusion this is a durable, safe, or long-term occupational option for him. I note that the evidence indicates the worker was a motivated individual who participated fully in his vocational rehabilitation and assessments. I find no evidence to support a conclusion that he is 100% unemployable, as advanced by his representative. The worker's return to employment as a millwright was necessitated by financial need after an extended, unsuccessful job search, not personal preference for this type of work. Should he further aggravate the permanent functional impairment in his shoulder by working in this occupation, he may be in a situation where he can not find any suitable employment.

I allow the worker's appeal to the extent that I find the identified positions of supervisory roles such as mechanical planner, maintenance planner, industrial maintenance planner and maintenance supervisor are not reasonably available to him in the absence of additional skill development. Although the worker has returned to work as a millwright in order to earn income, this is an occupation that was previously determined by the Board to exceed his physical capabilities. I find that the issue of the worker's entitlement to a loss of earnings award must be revisited by the Board in light of these findings. Any determinations should include a formal employability assessment as set out in policy #40.11 of the RSCM I.

The worker indicated that he has medical evidence confirming damage from the compensable injury to his nerves in his posterior shoulder and neck area are causing his headaches. An appellant may request a reconsideration of a WCAT decision on the basis of new medical evidence or concerns medical evidence was overlooked. The worker was advised at the oral hearing of this option.

Conclusion

I vary the decision of the Board set out in *Review Division Decision #22315*. I find employment in the occupations identified by the VRC are not reasonably available to the worker at this time or in the foreseeable future. The worker's return to employment as a millwright is not a sustainable option in the long-term. Therefore I direct that the Board revisit the issue of the worker's entitlement to a loss of earnings award under section 23(3) of the Act. The Board may wish to provide the worker with vocational rehabilitation to mitigate any loss of earnings.

The worker requested reimbursement of expenses for travel to the oral hearing. These are awarded, within the limits of Board tariffs.

Sherryl Yeager
Vice Chair

SY/aa