Noteworthy Decision Summary

Decision: WCAT-2007-00171 **Panel**: Janice Leroy **Decision Date:** January 17, 2007

Chronic Pain – Assessing Expert Evidence - Section 23(1) of the Workers Compensation Act –Item #39.01 of the Rehabilitation Services and Claims Manual, Volume I

This decision is noteworthy as an example of how to assess the relative merits of expert evidence when determining whether a worker is entitled to an additional permanent disability award for chronic pain pursuant to section 23(1) of the *Workers Compensation Act* (Act) and item #39.01 of the *Rehabilitation Services and Claims Manual, Volume I.*

The worker injured his right Achilles tendon at work. The Workers' Compensation Board, operating as WorkSafeBC, (Board) accepted his claim. The worker developed post-phlebitic syndrome. The Board provided the worker with a permanent partial disability award for his post-phlebitic syndrome, equivalent to 6.0% of total disability. The Board subsequently denied the worker an additional award for chronic pain (Board Decision). The Board accepted that the worker had chronic pain, but did not accept that it was disproportionate to his compensable condition as required by Board policy. The Board concluded that the 6.0% award appropriately compensated the worker for his chronic pain. The Review Division of the Board (Review Division) confirmed the Board Decision. The worker appealed the Review Division decision to WCAT.

The worker argued that the Board Decision failed to take into account both his statements about his own condition and the medical evidence relating to his persisting symptoms and his attempts to alleviate them. He argued that his attending physician's medical opinion was the most significant and corroborating statement supporting a determination that his chronic pain was specific and disproportionate. The worker argued that the Board's internal medicine specialist did not consider whether his pain was disproportionate, but had merely described the worker's then current medical presentation and rated it for permanent disability award purposes.

The panel denied the worker's appeal. She found that the worker's chronic pain was not disproportionate and that the worker was thus fully compensated by his permanent disability award of 6.0%. The panel found that the criteria for an additional award for chronic pain under item #39.01 of the Act had not been met.

As the issue to be determined was whether the worker's chronic pain was disproportionate, the panel wrote to the Board's specialist and the worker's attending physician and asked them to describe the pain experience typically associated with a post-phlebitic syndrome of the nature and degree the worker experienced.

Ultimately, the panel preferred the Board specialist's opinion over that of the attending physician's because the Board specialist likely had treated more post-phlebitic patients and thus was in a better position to gauge how much pain was typical of a given degree of objective impairment. The Board specialist described the post-phlebitic syndrome as persistent pain and associated edema and specifically stated that he took the worker's level of pain into account when he rated the worker's impairment. The panel felt the attending physician was comparing the worker's current presentation to that of a post deep vein thrombosis patient with only minimal or no symptoms of post-phlebitic syndrome.

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Introduction

The worker is a now 51-year-old police officer, who suffered a work-related right Achilles tendon rupture on August 16, 2000. He underwent a successful repair of the Achilles tendon but went on to develop a deep vein thrombosis in the right leg, followed by post-phlebitis syndrome or chronic venous insufficiency. The worker returned to modified duties with the police department employer.

In March 2003 an officer in the Disability Awards Department (DAO) of the Workers' Compensation Board, operating as WorkSafeBC (Board), awarded the worker a permanent disability pension on a functional impairment basis, based on an impairment rating of 6% of total disability for his permanent post-phlebitic syndrome. The worker requested a review of the pension award, but later withdrew the request.

In October 2004, and again in February and August 2005, the worker requested compensation for chronic pain.

In a decision letter dated October 25, 2005, a DAO accepted that the worker suffered from chronic pain, but concluded the worker's pain was an anticipated accompaniment to the post-phlebitis syndrome for which he had been awarded the 6% pension, so he was not entitled to an additional award for chronic pain.

In a Review Division decision dated April 4, 2006, a review officer with the Review Division of the Board confirmed the DAO's decision.

The worker appealed the review officer's decision to the Workers' Compensation Appeal Tribunal (WCAT). Although notified of the worker's appeal, the employer did not file a notice of appearance or otherwise participate in the appeal.

The worker asked to have his appeal adjudicated based on the claim file evidence and written submissions, and his representative filed a submission dated September 15, 2006. I have reviewed the documentary material and am satisfied the appeal can be fairly decided in the manner requested, without an oral hearing.

Issue(s)

The issue is whether the worker is entitled to an additional permanent disability award for chronic pain, or in other words, whether the worker's chronic pain is disproportionate to the accepted permanent impairment.

Jurisdiction

The worker's injury occurred before June 30, 2002, which was the transition date for relevant changes to the *Workers Compensation Act* (Act) as set out in Bill 49, the *Workers Compensation Amendment Act, 2002.* Because the injury and first indication that it was permanently disabling predated the transition date, this appeal is adjudicated under the legislative provisions in effect prior to the Bill 49 amendments.

Section 239(1) of the Act states that, with limited exceptions (which do not apply to this appeal), final decisions made by review officers in reviews under section 96.2 may be appealed to WCAT. Section 253(1) provides that WCAT may confirm, vary or cancel the appealed decision or order.

WCAT panels must apply applicable policies of the board of directors of the Board. The policies relevant to this appeal are set out in the *Rehabilitation Services and Claims Manual, Volume I* (RSCM I).

Background and Evidence

Dr. G, the Board's internal medicine consultant, conducted an at-Board examination on March 8, 2002, to evaluate the worker's post-phlebitic syndrome. In his report of that date, Dr. G reported that at present, the worker's major problem was pain and swelling in the right foot, which occurred daily, usually within 30 minutes of arising in the morning. The worker reported that the right foot felt "engorged" and he developed discomfort in the heel region and on the dorsum of the foot. Sitting down with his foot elevated above heart level improved the situation, and walking would often temporarily help. The worker had associated right calf cramps, worse at night. If he stopped while walking, for instance to chat with someone, his foot would become painful and he would have to move on or sit down. However, sitting was just as bad as standing and foot discomfort developed within a few minutes. He routinely carried around a small folding campstool that he used to raise his leg whenever he sat down. The worker said he had no leg pain, apart from recurrent right groin discomfort.

On examination there was brawny discolouration of the right foot extending from the dorsum of the foot through the ankle and the lower leg to the level of the knee. Petechial haemorrhages were associated with the discolouration to the level of the knee. There was a trace of non-pitting edema of the dorsum of the right foot and ankle. The circumference of the right ankle was 1 cm greater than the left, indicating persistent edema. By history the persistent edema became progressively worse throughout the

day so it would be much worse by night time. The right calf appeared to be somewhat atrophic and measured 2 cm smaller than the left side. There was full range of motion in the knee and ankle joints.

Dr. G told the worker he could anticipate some gradual improvement in leg symptoms over the next several years, as collateral venous drainage developed; however, his medical condition would not likely change enough for him to continue as a police officer.

The Board psychologist conducted a psychological assessment with the worker on April 25, 2003. In her report of that assessment Dr. M, psychologist, wrote that the worker saw himself as having chronic pain in his foot and sciatica. During the assessment he rated his pain at a level of one on a scale of zero to ten. He felt that the worst his pain had been in the previous two weeks was a level of eleven. His usual level of pain was a five, although at work it ranged from seven to ten. During the assessment he kept his leg rested on a campstool, which he carried with him so that he never had to leave his leg down in one position. He found it hard to get comfortable at night due to leg pain, which was worsened by any stationary position and by standing or sitting with his leg down. The pain was lessened by elevation, by having a wedge cushion on his bed, by using a special stocking, by walking, and by having a variety of activities. He also took Tylenol No. 3. The pain had an aching characteristic and was throughout his right leg, worst at the lower end.

In September 2003 the worker successfully completed a graduated return-to-work program to a suitable new position with the injury employer.

On February 23, 2004 Dr. G undertook a permanent functional impairment evaluation. He reported the worker's advice that his symptoms were largely unchanged since the March 2002 examination. He continued to have pain in his lower leg, ankle, and the top of the right foot. He had a burning sensation, particularly on the dorsum of the right foot while standing. He continued with right ankle swelling, which worsened throughout the day. He tended to do better if he was able to sit, stand, and walk interchangeably. The symptoms were worse with prolonged sitting or standing. He now had better support stockings and support boots, which helped some. He was taking Advil and Tylenol No. 3 for pain.

On examination the worker had full range of motion in both ankles. There was no measurable difference in the diameter of the foot, ankle, and calf bilaterally.

The worker continued to have some brawny discolouration in the posterior aspect of his right ankle, posterior to the medial malleolus. There were no petechial haemorrhages. There was no pitting edema.

Dr. G reported his impression that the worker had made a complete recovery from the tendon surgery. "He does have the residual effects of post-phlebitic syndrome, which will be persistent."

In a claim log memo dated February 24, 2004, Dr. G said that based on the American Medical Association *Guides to the Evaluation of Permanent Impairment*, Fifth Edition (AMA Guides), the worker qualified for a class 2 lower extremity impairment due to peripheral vascular disease, characterized by persistent phlebitic symptoms and edema, incompletely controlled by elastic support stockings, which corresponded with an impairment range of 10% to 39% of the lower extremity. He said that in his opinion the worker had a 15% impairment of the lower extremity due to the chronic post-phlebitic syndrome, which corresponded with a 6% impairment of the whole person.

In a pension review memo dated February 26, 2004, a DAO reviewed Dr. G's evaluation report and said he agreed with his recommendation concerning the level of impairment. The DAO then issued a decision letter dated March 23, 2004, advising the worker that he had been awarded a permanent disability pension on a functional impairment basis, based on an impairment rating of 6% of total disability, effective from April 8, 2004, applied against the statutory maximum wage rate.

In a letter dated August 30, 2004 the worker's family physician, Dr. James, said the worker experienced chronic pain associated with post-phlebitic syndrome, which was exacerbated by periods of standing or sitting. The pain occurred daily and began as soon as he left his bed. Extended periods of standing and sitting caused significant edema in his lower right leg regardless of the support stockings, and as a result he regularly relied on Tylenol No. 3 for pain management. He said the worker's condition was "by no means typical or minor in nature."

In letters to the Board dated October 15, 2004, February 16, 2005, and August 8, 2005, the worker said he understood that he had not been compensated for chronic pain, and asked the Board to review his file and specifically address the matter of chronic pain.

In a memo dated October 25, 2005, the DAO considered the worker's request for a specific award to recognize his chronic pain. The DAO reviewed Board policy on chronic pain at items #22.35 and #39.01 of the RSCM I, and concluded that although the worker's pain symptoms met the definition of chronic pain, and were permanent, the pain complaints were specific in nature and consistent with the accepted diagnosis of post-phlebitic syndrome, and were an anticipated consequence of the accepted impairment; they were consistent with the permanent functional impairment as assessed and awarded. He said the existing award of 6% was based on the worker's chronic pain and other symptoms; the worker had already been compensated for his chronic pain, so any additional award for chronic pain would result in the worker being compensated twice for the impact of the pain.
The DAO then issued the decision letter of October 25, 2005 under appeal, denying separate pension entitlement for chronic pain.

In support of his application for review of the DAO's decision on chronic pain, the worker filed a letter from Dr. James dated January 9, 2006. Dr. James said it appeared "that the determination did not totally reflect the degree of pain and functional disability that [the worker] has experienced. It is felt that the pain is out of proportion to the degree of injury suffered." He advised that the worker still had persisting pain of the right leg, which was constant and required the daily use of analgesics, and he also experienced coldness, blanching, and numbness of the right foot, lower leg, and ankle. He said he felt that the worker was suffering a complex regional pain syndrome, and also had muscular and range of motion impairment in the right ankle and foot, with right calf wasting and weakness, which limited his function.

Dr. James said that in view of the persisting problems and with the additional diagnosis of "sympathetic dystrophy and chronic pain syndrome," he recommended the worker be referred to a pain clinic for evaluation and a definitive diagnosis, and recommendations for treatment. He further recommended that the worker's pension settlement be reviewed, saying he did not feel that it fully reflected the degree of disability and pain that the worker was experiencing.

In an accompanying letter the worker wrote that he suffers daily terrible pain, which he will have to endure for the rest of his life. The pain begins the moment his foot touches the floor. By the time he has walked from his bedroom to the shower he is in pain, as gravity works against dysfunctional venous valves, engorging his lower leg, ankle, and foot. He said that although support stockings minimize edema and force the blood to take collateral routes, it does not stop edema or the subsequent pain. Thus, he wrote, he could sit for short period but had to vary his routine and walk off the edema as it became intolerable. He said his leg is constantly cold, and is noticeably thinner than the right leg, with reduced strength. He said the swelling is not periodic but continuous, and is only minimized by his proactive efforts. The worker said he believes his pain is disproportionate to his injury, which was a severed Achilles, which should have healed within six months.

In his submission to the Review Division the worker's representative referred to item #97.32 of the RSCM I, which provides that a worker's statement about his or her own condition is evidence insofar as it relates to matters that would be within the worker's knowledge, and should not be rejected simply by reference to an assumption that it must be biased by self-interest. Nor need such a statement be corroborated. A conclusion against the statement of a worker about his or her own condition may be reached if the conclusion rests on a substantial foundation, such as clinical findings,

other medical or non-medical evidence, or serious weakness demonstrated on questioning the worker, or if the statement relates to a matter that could not possibly be within his or her knowledge.

The worker's representative said the DAO's conclusion that the worker's chronic pain is expected and consistent does not take the worker's statement into account, or the medical documentation of his persisting symptoms and attempts to alleviate them. He said Dr. James' medical opinion is "the most significant and collaborating statement supporting the determination that [the worker's] chronic pain is specific and disproportionate." He went on to say that the determination of whether a person's experience of pain is disproportionate must be highly subjective.

The review officer confirmed the DAO's chronic pain decision in the review decision of April 4, 2006 that is under appeal.

In his submission to WCAT dated September 15, 2006, the worker's representative said that Dr. G provided an assessment and evaluation of the worker's condition and current status, without consideration of whether it represented disproportionate chronic pain, whereas Dr. James directly responded to the question of whether the worker's experience of pain was disproportionate; his opinion should be accepted.

Reasons and Findings

Permanent disabilities are generally rated based on the ratings set out in the Permanent Disability Evaluation Schedule (PDES) at Appendix 4 to the RSCM I. However, item #39.50 of the RSCM I provides that when, as here, the impairment is not covered in the PDES, and there is nothing in the PDES to guide selection of a rating in the particular case, the DAO must use his or her own judgment to arrive at a percentage of disability appropriate to the particular claimant's impairment. Regard will be had to the permanent functional impairment evaluation, if any, the circumstances of the claimant, medical opinions of Board or non-Board doctors, and to schedules of disability used in other jurisdictions.

Dr. G used the AMA Guides to determine the permanent impairment associated with the worker's post-phlebitic condition. Chapter I of the AMA Guides discusses the philosophy, purpose, and appropriate use of the AMA Guides. It explains, at page 10:

> Physicians recognise the local and distant pain that commonly accompanies many disorders. Impairment ratings in the *Guides* already have accounted for commonly associated pain, including that which may be experienced in areas distant to the specific site of pathology. For example, when a cervical spine disorder produces radiating pain down the arm, the arm pain, which is commonly seen, has been accounted for in the cervical spine impairment ratings.

This means that in general, disability ratings set out in the AMA Guides recognize the degree of pain that would typically be expected in the presence of the objective impairment.

However, in cases where a worker suffers from chronic pain, as defined in item #39.01 of the RSCM I, an additional award to recognize the effect of the chronic pain on earning capacity can be made. Item #39.01 sets out guidelines for assessing the degree of permanent impairment associated with disproportionate and disabling chronic pain as a compensable consequence of an injury. There are two categories of chronic pain, defined as follows:

- Specific chronic pain, which has a clear organic cause and persists for more than six months and beyond the normal recovery time for the underlying injury; and,

- Non-specific chronic pain has no clear organic cause and has gone on for longer than six months and the claimant has recovered from the compensable injury itself.

If a worker experiences disproportionate specific or non-specific chronic pain as a consequence of a work injury, and the claim is accepted for permanent chronic pain, the DAO may award a section 23(1) award for chronic pain equal to 2.5% of total disability. Disproportionate specific chronic pain is pain that is generalized rather than limited to the area of the impairment, or is greater than what would be expected from the impairment. However, if specific chronic pain is consistent with the associated compensable physical impairment; that is, if it is limited to the area of the impairment, or if medical evidence indicates that the degree of pain he or she experiences is an anticipated consequence of the physical impairment, the pain is not considered to be disproportionate, and the impairment rating determined by the schedules will be considered to appropriately compensate the claimant for the impact of the chronic pain. Any additional award would result in the claimant being compensated twice for the impact of the pain.

The accepted permanent condition, and that which Dr. G rated based on the AMA Guides, is post-phlebitic syndrome. The Merck Manual of Diagnosis and Therapy, on line at http://www.merck.com/mmpe/sec07/ch081/ch081c.html (last accessed November 22, 2006), explains that chronic venous insufficiency is impaired venous return, sometimes causing lower extremity discomfort, edema, and skin changes, and post-phlebitic syndrome is symptomatic chronic venous insufficiency. Causes are disorders that result in venous hypertension, usually through venous damage or incompetence of venous valves, as occurs after deep venous thrombosis (DVT). Treatment is compression, wound care, and, rarely, surgery. Symptoms include a sense of fullness, heaviness, aching, cramps, tiredness, and paresthesias in the legs; these symptoms worsen with standing or walking and are relieved by rest and elevation.

Pruritus may accompany skin changes. Signs occur along a continuum: no changes to varicose veins (rare) to stasis dermatitis on the lower legs and at the ankles, with or without ulceration.

In his submissions to the Review Division the worker wrote that he suffers daily terrible pain, which begins the moment his foot touches the floor as his lower leg "engorges," and that his leg is constantly cold.

The worker believes his experience of pain is disproportionate to what would be expected from his permanent venous insufficiency. However, the review officer inferred, from Dr. G's comment that the worker "does have the residual effects of post-phlebitic syndrome, which will be persistent," that the worker's experience of continuing pain in the lower leg, ankle and top of the right foot, which worsened with static standing or sitting, and a burning sensation, particularly on the dorsum of the right foot on standing, as set out in Dr. G's report, was typical of or consistent with the diagnosed post-phlebitic syndrome. The worker's representative said the review officer ought not to have drawn that inference, that Dr. G merely described the current presentation and rated it, without considering whether the worker's pain was disproportionate.

I wrote to Dr. G seeking clarification of what pain experience would typically be associated with a post-phlebitic syndrome of the nature and degree the worker experiences, and his advice about how he would compare the worker's pain experience to the typical experience. Dr. G responded in a memo dated December 4, 2006. He said:

> Basically, Post Phlebitic Syndrome is persistent pain and associated edema of the affected extremity. The worker's level of pain was taken into consideration in the Class 2 impairment of 15%. It was the worker's chronic pain level which qualified him for this Class 2 rating, so any additional awards for pain would not seem to be justified.

The worker's representative did not file a submission in response to Dr. G's letter.

Dr. James said the pension award did not totally reflect the degree of pain and functional disability that the worker had experienced, and he felt that the worker's pain was out of proportion to the degree of injury suffered. It was not clear from Dr. James' letter that he understood the test was whether the pain was disproportionate to the ultimate impairment, in this case chronic venous insufficiency, rated at 6% of total disability, rather than whether it was disproportionate to the pain that would be expected post Achilles rupture. I wrote to Dr. James and asked him to clarify what degree of pain he felt would be typical or expected from chronic venous insufficiency of the nature and degree the worker suffers, and advise how he would compare the worker's pain experience to the typical experience. I advised Dr. James that I recognized he had recently diagnosed complex regional pain syndrome, or reflex sympathetic dystrophy,

but the pension award before me relates to the worker's condition as of the effective date of the pension, April 8, 2004, so the question of whether the worker's pain experience is disproportionate to what would be expected from post-phlebitis syndrome rated at 6% of the whole person must be answered based on his presentation at that time. I advised that if there has been a significant change in the worker's permanent condition since that date, the appropriate course would be to file progress reports with the Board advising of the significant change.

Dr. James responded in a letter dated December 8, 2006. He said that in his opinion the worker's protracted and severe pain has been out of proportion to the degree of injury he suffered and the subsequent deep vein thrombosis that developed. Further, the worker still experiences:

- decreased strength in his right lower leg, which is obviously wasted, and this in turn leads to occasional giving out with prolonged walking,

- and continuous swelling, only partially controlled by use of a support stocking.

Dr. James said the worker now has symptoms consistent with complex regional pain syndrome, such as branching coldness, with cyanosis, followed by erythemia upon re-warming. He said:

> In my experience, with Post Phlebitic Syndrome I have seen both extremes. The majority of patients experience little or no pain and this tends to resolve after 2 to 3 months when there is recanalization of the vessel. I have had the unfortunate experience in a *[sic]* least one situation where the patient has gone to develop Post Phlebitic Syndrome with associated reflex sympathetic dystrophy. The patient was in continuous pain, which eventually necessitated her to be referred to the Pain Clinic at St Paul's Hospital.

The worker's representative did not file a submission in response to Dr. James' letter.

The five classes of lower extremity impairment due to peripheral vascular disease set out in the AMA Guides are graded by the severity of claudication, edema, or evident vascular damage. A condition falls into Class 2 if:

- the patient experiences intermittent claudication on walking at least 100 yards at an average pace, or

there is persistent edema of a moderate degree incompletely controlled by elastic supports, or

- there is evidence of vascular damage.

Pain in general, apart from after walking, is not a characteristic by which the impairment is rated. However, as previously discussed, the ratings set out in the AMA Guides recognize the degree of pain that would typically be expected in the presence of the objective impairment, and the question before me is whether the worker's pain is disproportionate to what would be expected in the presence of the objective impairment (incompletely controlled edema).

With the greatest respect to Dr. James, I think he is comparing the worker's current presentation to that of a post deep vein thrombosis patient with only minimal or no symptoms of post-phlebitic syndrome, rather than comparing the worker's presentation in April 2004 to that of a patient with symptomatic post-phlebitis syndrome impairment rated at 15% of the lower extremity. As a specialist in internal medicine, Dr. G has likely treated a good many more post-phlebitis patients than Dr. James has treated, and is thus in a better position to gauge how much pain is typical of a given degree of objective impairment. Dr. G agrees that the worker has chronic pain along with his chronic edema; he said that basically, post-phlebitic syndrome is persistent pain and associated edema. He specifically stated that he took the worker's level of pain into account when he rated his impairment at 15% of the lower limb value.

In the circumstances I prefer Dr. G's opinion over that of Dr. James, and find the worker's chronic pain was fully accounted for in his impairment rating of 6% of total disability.

If Dr. James' diagnosis of complex regional pain syndrome is confirmed, the worker might wish to apply to the Board for a reopening of his claim, to recognize the new symptoms and diagnosis.

Conclusion

The appeal is denied. The review officer's decision is confirmed.

Expenses

No appeal expenses were requested or otherwise apparent. None are ordered.

Janice A. Leroy
Vice Chair

JAL/jkw

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