WCAT Decision Number: WCAT-2007-02447
WCAT Decision Date: August 16, 2007
Panel: Guy Riecken, Vice Chair

Introduction

On April 21, 1993 the worker was working as a self-employed shake blocker when he injured his low back. The Workers' Compensation Board, now operating as WorkSafeBC (Board), accepted his claim for a lumbar strain, a L4-5 disc herniation, and an L4-5 discectomy and laminectomy on May 7, 1993. In November 1995 the Board granted the worker a permanent partial disability (PPD) award based on a permanent functional impairment (PFI) of 2% of total disability effective May 2, 1994. In 1996 the Board accepted a recurrence of the L4-5 herniation and a repeat discectomy on August 14, 1996 with spinal fusion. The claim was not referred to the Board's Disability Awards Department at that time.

In May 2004 the worker sought to have a new claim accepted for increased low back symptoms (2004 claim) or to have the 1993 claim reopened. The Board disallowed the 2004 claim and declined to reopen the 1993 claim for further temporary disability (wage loss) benefits. In the course of reviewing the 1993 claim file at that time it was observed that the claim had not been referred to Disability Awards following the 1996 surgery, and a referral was made. On July 19, 2005 the Board assessed the worker's PFI at 4% based on the one-level fusion, and granted an increase in his PPD award of 2% effective May 19, 1997.

The worker appeals two decisions by review officers the Board's Review Division:

- *Review Decision #R0053421*, dated December 14, 2005, in which a review officer confirmed the Board's April 26, 2005 decision not to reopen the worker's 1993 claim for further compensation for the symptoms in April 2004; and

- *Review Decision #R0056987*, dated February 28, 2006, in which a review officer confirmed the Board's July 19, 2005 decision regarding the increased PPD award.

The worker also appealed *Review Decision #23062* in which a review officer confirmed the Board's August 9, 2004 decision to disallow the 2004 claim for a new low back injury. That appeal is the subject of a separate decision and is not addressed in this decision.

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

Issue(s)

1. Whether the worker's 1993 claim should be reopened for further compensation for his increased low back and leg symptoms from April 2004 onward. The worker's position is that if there was not a new injury in April 2004, there was a significant worsening of the compensable condition from his 1993 claim.

2. Whether the 2% increase in the PFI award in 2005 accurately reflects the increased impairment of earning capacity resulting from the worker's injury and the 1996 repeat surgery with one-level spinal fusion. The worker's position is that his functional impairment is greater than the 4% PFI recognized by the Board and that he should receive a loss of earnings award.

Jurisdiction and Procedure

The appeals of the review officers' decisions were filed with the Workers' Compensation Appeal Tribunal (WCAT) under section 239(1) of the *Workers Compensation Act* (Act).

WCAT must make its decision on the merits and justice of the case, but in so doing, must apply a policy of the board of directors of the Board that is applicable in the case.

Because the worker's injury and permanent disability occurred before June 30, 2002, the transition date for changes to the Act under the *Workers Compensation Amendment Act, 2002* (Bill 49), the former (pre-Bill 49) provisions of the Act apply to the worker's PPD entitlement. However, the current provisions of the Act apply to the issue of whether the worker's 1993 claim should be re-opened for further compensation as of April 2004. Unless otherwise noted, the applicable policies for both issues are found in the *Rehabilitation Services and Compensation Manual, Volume I* (RSCM I).

These are appeals by way of rehearing, rather than hearings *de novo* or appeals on the record. WCAT has jurisdiction to consider new evidence, and to substitute its own decision for the decision under appeal.

The worker and his representative attended an oral hearing on May 15, 2007. A separate hearing was held on the same date for the appeal regarding the 2004 claim. That appeal was heard separately because the employer in the 2004 claim was not the worker's employer at the time of the 1993 claim and is not a party to these appeals. The worker's representative (who was also present at the other hearing) asked that I consider the evidence from both hearings in deciding these appeals related to the 1993 claim, and I have done so.

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Background and Evidence

The worker underwent a PFI medical examination at the Board on January 17, 1995 by Dr. B, a disability awards medical advisor (DAMA). Dr. B recorded measurements of the worker's spine that showed moderate reduction in lumbar extension. Movements in the other planes were within the normal range. Dr. B thought that some reduced sensation over the right lateral calf and dorsal aspect of the right foot related to an old left ankle laceration. In his memo accompanying his report Dr. B recommended a PFI rating of 2%.

In a memo dated July 10, 1995 (memo #33) a disability awards officer (DAO) assessed the worker's PFI as 2% for reduced lumbar extension, including consideration of subjective complaints. A loss of earnings assessment was deferred until it was determined whether vocational rehabilitation (VR) assistance would enable the worker to return to employment without a loss of earnings.

The Board provided VR assistance including support in a cabinet making apprenticeship training program.

The claim was reopened for further wage loss benefits as of July 7, 1996 due to a recurrence of the L4-5 disc herniation. The worker underwent repeat surgery, this time with a fusion at L4-5 on August 14, 1996, by Dr. Preto, orthopaedic surgeon. Dr. Preto's February 25, 1997 follow up report indicated that x-rays on that date revealed no abnormalities related to the bone graft, no spondylolisthesis and no abnormal movement. On April 6, 1997 Dr. Preto reported that the fusion was solid and the worker could proceed with physiotherapy.

The worker continued to receive wage loss benefits until shortly after he completed a multidisciplinary rehabilitation program in May 1997. The discharge report from that program stated that there were no contraindications to the worker re-entering the workplace in the new occupation of cabinet maker. He was functioning at the low end of the medium strength category. He was discharged to return to a six-week second year apprenticeship training course at BCIT. After completion of that course on June 20, 1997 he would resume full-time work as an apprentice cabinetmaker.

After his apprenticeship, the worker continued to work for the company he was apprenticed with (AC Company). At the oral hearing he confirmed that he worked there until going to work with another company (the employer under the 2004 claim) in January 2000.

In June 1998 the worker saw Dr. Fisher, his family physician, about pain in his back. He reported increased numbness and tingling in the right calf. On examination Dr. Fisher noted a spasm in the lower lumbar area and limited movement. He referred the worker to Dr. Preto.

Dr. Preto assessed the worker on June 29, 1998. The worker described standing at a bench recently when he developed acute spasm in the lumbosacral area with radiation to the left lower extremity. By the time he saw Dr. Preto he was much better. On examination he appeared better. X-rays revealed a solid fusion and no evidence of instability above or below the fusion. Dr. Preto recommended that the worker be restricted from lifting more than 30 pounds and avoid undue torsional strain of the lumbar spine.

An October 15, 1998 CT scan report described the following: a mild diffuse disc bulge at L3-4 that minimally flattened the thecal sac without evidence of herniation or central stenosis; moderate osteoarthritis of the L3-4 facet joints, a right side epidural scar at L4-5 without evidence of a recurrent disc herniation or central or foraminal stenosis; posterior bony fusion at L4-5 that appeared solid; and marked osteoarthritis of the L5-S1 facet joints.

At the hearing the worker stated that except for a few weeks in early 2002, prior to April 2004 he did not lose any time from work due to his back problems after he started working for the current employer in January 2000.

Dr. Fisher's reports from March 2002 describe low back pain and stiffness and numbness in the right thigh. Dr. Fisher diagnosed a back strain. The worker received physiotherapy. Dr. Fisher noted the worker was off work from March 11 to 25, 2002.

The worker made a claim for his back problems in March 2002. The Board consolidated the claim with the 1993 claim and denied a reopening on the basis that the increased symptoms were a normal fluctuation of the back condition for which he received a PPD award.

At the hearing the worker's evidence included a description of his work duties since January 2000. These included carrying sheets of plywood and manufactured fibreboard (MDF) to the work area of the shop, cutting the sheets of plywood and MDF on a table saw, and making doors, tables, desks and other wood products. His regular work day was eight and one-half hours. The worker described his back condition as "all right" since he started this job in 2000, but said he had what he described as the "occasional twinge." He was off work for about three weeks in March 2002 because of his back. The Board denied temporary disability (wage loss) benefits for that period. Since returning to work in 2002 he said his back had been "fine," and he would take only non-prescription regular strength Tylenol or Ibuprofen for his pain. He would take them when he got up in the morning and twice more during the day, two pills each time. He did not miss work due to pain other than the three weeks in 2002. Some days when his back bothered him more he avoided heavier work such as carrying plywood and MDF. He estimated that the plywood sheets weighed 40 to 60 pounds each and the MDF sheets weighed over 100 pounds.

The worker also described his activities in April 2004 which he thought led to further back problems. These included operating a vibrating soil compactor for part of a day, likely April 7, 2004. On that morning he carried about ten to twelve sheets of three-quarter inch plywood from a wall rack to the table saw. He cut the sheets and then went to run the compactor over the surface of the soil outside. He operated it twice over the course of the day for a total of between three and four hours. In the afternoon he also cut more plywood. He wet down the soil with a high pressure hose. He did not experience symptoms when using the compactor, but by the end of the work day was stiff and sore. He acknowledged that this was expected after a day of cutting plywood and other work activities. He was possibly a bit more sore than usual that day. The next day when at work his back and lower legs were sore. It was noticeably worse than normal. He continued to work and found that every day after that he got a little worse. He went to see his physician.

A typed note dated April 13, 2004 in the clinical records of Dr. Fisher indicates that he saw the worker that day about back pain that had recurred. The pain went down his leg. The worker described burning pain since operating some machinery at work. He also reported urinary incontinence. A corresponding handwritten note in the clinical records indicates that the worker said he had run a compactor the previous Wednesday and his back was getting slowly worse. A burning pain down the right leg to the two outside toes was noted. The worker had rested over the weekend, but there was no change.

In his May 3, 2004 report to the Board Dr. Fisher noted that the worker's previous back claim and that he had experienced a recurrence since driving a machine. Dr. Fisher diagnosed sciatica. He referred the worker to Dr. Preto.

The worker last worked in the cabinet making company on April 28, 2004.

In his May 4, 2004 consultation report Dr. Preto indicated that the worker reported he had been doing well until three weeks previous when he operated the compactor. The worker now complained of severe low back pain with bilateral leg pain, worse on the right than the left and early incontinence. On examination the worker moved very gingerly. He had 90 degrees of straight leg raising. There was a slightly positive femoral stretch test on the right. The x-rays showed a well fused L4-5 space with a widely open intervertebral foramina and no evidence of spinal stenosis. Dr. Preto arranged an MRI and recommended the worker take six weeks off.

The worker spoke to a case manager at the Board on July 5, 2004. The case manager's memo in the electronic claim log indicates that the worker did not notice anything during the day he operated the compactor, but the next day his legs and back started hurting. He always had pain due to his 1996 fusion surgery, but this was worse. The pain began in the low back and pelvis area and then the nerves got irritated causing leg pain. He thought the vibration of the machine affected his osteoarthritis. He told his employer about it the next day, but continued to work until April 28, 2004.

He did not see a doctor immediately because he is stubborn and thought the pain would get better like it had in the past after a weekend of rest. Riding the compactor was not part of his regular duties.

In a memo in the 2004 claim dated August 4, 2004, Dr. B2, a medical advisor at the Board, reviewed the worker's 1993 claim, including the PFI medical examination in January 1995, and the medical and other information from the 2004 claim. Dr. B2 referred to a lack of support in the medical literature for whole body vibration as a cause of the worker's complaints. Dr. B2 was of the opinion that it was less than 50% likely that the work activity of operating the vibrating compactor was associated with a new back injury. It was more likely that the increased symptoms experienced in April 2004 were related to a fluctuation in the condition for which the worker received a PPD award under the 1993 claim.

The case manager relied on Dr. B2's August 4, 2004 opinion in the decision not to allow the new claim. At that time there was no decision on reopening the 1993 claim.

An MRI report from August 12, 2004 described a moderate broad-based disc bulge at the L3-4 level causing moderate spinal stenosis with no definite nerve root impingement. It also noted evidence of the previous surgery at the L4-5 level with no evidence of a residual disc herniation or significant scarring surrounding the thecal sac. Moderate facet degenerative changes were noted at the L5-S1 level.

In his August 27, 2004 consultation report Dr. Preto expressed surprise that in light of a history that included the 1996 disc excision and spinal fusion the worker was still in a job in which he was lifting heavy sheets of plywood and MDF. He was still off work at that time. On clinical examination there was no evidence of weakness and the worker could walk well and sit comfortably for a while. Dr. Preto noted the MRI findings. He commented that the L4-5 was solid and there was no recurrent disc. There were no indications for surgery, epidural steroids or facet blocks. Dr. Preto was of the opinion that the worker should be retrained to work in a fairly sedentary occupation without lifting. The worker had unrealistic expectations in terms of what he could lift, and should not be lifting over 30 or 40 pounds, and should not be lifting heavier products with awkward manoeuvres. The worker should be retrained for a more sustainable occupation.

The worker remained off work and Dr. Fisher submitted reports through early 2005 indicating that the worker was medically incapable of working full duties full time and requesting a referral for an assessment in the Board's Visiting Specialists Clinic (VSC). The Board did not make a referral.

A memo dated April 6, 2005 regarding a team meeting quotes Dr. B2 as stating that the worker's condition did not differ significantly from that described in his PFI examination in 1995. The case manager relied on this opinion and the previous opinion regarding a fluctuation in the compensable condition in the decision not to reopen the 1993 claim.

In a letter dated June 13, 2005 Dr. Preto reported that the worker was experiencing ongoing bilateral leg pain and mechanical low back pain. He was unable to work as a cabinet maker. He asked that the worker be referred to the Board's VSC for a consultation. Dr. Preto thought that the present problem of osteoarthritis of the apophyseal joints and disc protrusion at the L3-4 level was related to the compensable claims and a VSC referral was reasonable.

In relation to the 2005 reassessment of the worker's PPD award, the worker's previous representative submitted to the Review Division a report from Dr. Fisher dated December 4, 2005. Dr. Fisher reported that based on his measurements, the worker had no lumbar flexion, 15 degrees of lumbar extension, 30 degrees of right lateral flexion, and left lateral flexion equivalent to the measurement from the PFI evaluation. Dr. Fisher opined that the worker's reported pain is consistent with his injury, his operative findings and the imaging studies.

The worker's representative provided the following documents to WCAT:

- January 12, 2007 report from Dr. Remick, psychiatrist; and
- May 3, 2007 functional capacity evaluation (FCE) report from an occupational therapist (OT).

Dr. Remick diagnosed a major depressive disorder, single episode and a chronic pain syndrome involving the worker's low back. He thought the depressive disorder was a consequence of the chronic pain syndrome. He prescribed Fluoxetine (an antidepressant medication) and cognitive behavioural therapy.

The OT conducted a FCE on April 23, 2007. He expressed the opinion that the worker's limitations for lifting, carrying and body positions mean that he is not able to carry out all of the requirements of cabinet making on a competitive and sustainable level, and in particular does not have the capacity to lift and carry sheets of plywood and MDF and to install cabinets at a competitive and sustainable pace.

Findings and Reasons

Issue 1 - Reopening

Under section 96(2) of the Act the Board may reopen a matter that has been previously decided by the Board or an officer or employee of the Board if, since the decision was

made in that matter,

(a) there has been a significant change in a worker's medical condition that the Board has previously decided was compensable, or

(b) there has been a recurrence of a worker's injury.

Under section 96(3) if the Board determines that the circumstances in subsection (2) justify a change in a previous decision respecting compensation or rehabilitation, the Board may make a new decision that varies the previous decision or order.

RSCM I item #C14-102.01 provides that a "significant change in a worker's medical condition" means a change in the worker's physical or psychological condition, not a change in the Board's knowledge about the worker's medical condition. A "significant change" would be a physical or psychological change that would, on its face, warrant consideration of a change in compensation or rehabilitation benefits or services. In relation to permanent disability benefits, a "significant change" would be a permanent change outside the range of fluctuation in the condition that would normally be associated with the nature and degree of the worker's permanent disability.

Consideration of reopening a matter under section 96(2) is limited to the injuries and medical conditions accepted under the claim. The worker's claim was accepted for the L4-5 herniation, the L4-5 discectomy and laminectomy in 1993, the recurrence of the L4-5 herniation in 1996 and the repeat surgery with fusion at L4-5 in 1996. The medical imaging studies at various times have identified problems at other levels of the spine, particularly a broad-based disc bulge at L3-4 and moderate degenerative changes at L5-S1. Those findings have not been accepted under the claim.

The worker is seeking a reopening of wage loss benefits from the time he went off work in late April 2004. The previous Board decision on the matter of wage loss that is relevant to this issue is the decision to terminate wage loss benefits when his condition had stabilized in May 1997 following the August 14, 1996 back surgery. That is when he last received wage loss benefits. The issue is whether, since May 1997, there has been a significant change in the accepted medical condition or a recurrence of the compensable injury.

In comparing the worker's condition in April 2004 (and the subsequent months) with his condition in May 1997 (and the subsequent months) I have considered the descriptions of his subjective symptoms in the medical reports, the examination findings and the medical imaging reports as well as the worker's evidence. The worker's evidence indicates that his subjective pain experience has worsened somewhat. The imaging studies and examination findings do not show that there has been a significant change in the medical conditions accepted under the claim or a recurrence of a compensable injury.

In April 1997 Dr. Preto reported that the L4-5 fusion was stable. A CT scan done in October 1998 showed that there was an epidural scar on the right side of L4-5, without evidence of a recurrent disc herniation or central or foraminal stenosis. The CT scan report said that the posterior bony fusion at L4-5 appeared solid. The August 2004 MRI obtained by Dr. Preto described a solid fusion at the L4-5 level. The MRI report did not suggest a recurrence of the L4-5 injury or a significant change at the L4-5 level since the examinations and imaging studies in 1997 and 1998.

Dr. Preto's reports of his examinations in May to August 2004 did not describe clinical findings consistent with a recurrence of L4-5 injury or a significant deterioration at that level. However, in light of the restrictions associated with the worker's injury and surgery, Dr. Preto was surprised that he was lifting heavy weights at work. He described the situation as "coming to a head" when the worker operated the soil compactor. I consider this to be consistent with the work activities around that time (including compacting soil) drawing to the worker's attention his pain levels. In the decision in the appeal of *Review Decision #23062* I found that the worker did not suffer a new compensable injury in April 2004. I found that his increased symptoms were better understood as a feature of his 1993 compensable injury and related surgeries.

At stated in the claim log entry for the April 6, 2004 team meeting, Dr. B2 did not see evidence in the May 2004 and subsequent medical reports that the worker's condition differed significantly from that described in his PFI medical examination of 1995. The claim log entry does not indicate whether Dr. B2's comments were with respect to the objective findings in the medical reports only or also with respect to the worker's reports of pain and disability. Dr. B2 did not comment on the fact that the worker had undergone a one-level fusion in 1986, and he did not compare the post-fusion medical findings to the 2004 findings.

These circumstances raise the question of whether evidence of increased pain and disability in the absence of objective findings of change can support a reopening.

The Board has published a number of practice directives and best practices information sheets (BPIS) on various compensation issues. BPIS #6 "Reopenings," discusses the general intent of section 96(2) and the decision-making process in reopening matters. It states the following with respect to the evidence to be considered in relation to a possible reopening:

> Whether or not the deterioration of a worker's compensable medical condition is significant enough to meet the legislative reopening test is an adjudicative issue. A Medical Advisor can give an opinion on whether the medical condition has changed and in what way it has changed, but deciding whether that change is "significant" is a decision to be made by the claim owner.

> Although evidence of such a change would be ideal, the reopening criteria do not require a measurable variation in the essential nature or characteristics of the worker's compensable condition (i.e., a demonstrable change in pathology). Since WorkSafeBC officers are basically considering changes in the degree of disability for the worker's compensable condition, significant changes in a worker's physical restrictions and/or limitations can be sufficient to warrant reopening a matter previously decided. For example, wage loss benefits are terminated when a worker with a compensable soft tissue injury returns to work. After several days back at work the worker experiences significantly increased pain and on the advice of his doctor takes a few more days off work. The officer can choose to reopen the decision to terminate wage loss benefits based on the worker's report of significantly increased pain.

It is clear that the Board's policies, both at the time of the original PPD award in 1995 and at the time of the reopening decision in 2005, recognized that disabling pain is compensable. Under RSCM I policy items #22.35 and #39.01, both effective from January 1, 2003, a worker's pain symptoms may be accepted as compensable where medical evidence indicates that the pain results as a consequence of a work injury or occupational disease. Pain is defined as: "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage" and "includes cognitive, affective, behavioural and physiological components." Under those policies compensation may be paid for either temporary disabling pain or chronic pain. Pain is not compensated as a psychological condition. Under item #39.01 as it read prior to January 1, 2003, a worker could be compensated in a PPD award for subjective complaints, including pain, if they were disabling to an extent greater than recognized by an award for objective impairment. That policy was in effect at the time of the worker's 1995 PPD award, and the DAO took the worker's subjective complaints into account in the original 2% PFI award.

I find that the analysis in BPIS #6 with respect to reopening for significantly increased disabling pain is consistent with the Board's policies on compensable pain and the policy on reopenings. While policy item #C14-102.1 defines "significant change in a worker's medical condition" as a physical or psychological change, it does not expressly include a requirement for objective evidence of a change in pathology. The definition of pain in #22.35 excludes pain as a psychological condition, and although it includes components that are not physical, it recognizes that pain is a sensory experience that includes some physiological components. I conclude that for the purposes of policy item #C14-102.01 a significant change in a worker's pain can be considered to be a physical change that may support a reopening. I adopt the analysis in BPIS #6 with respect to the possibility of reopening based on a worker's report of significantly increased pain.

I find the worker's evidence concerning his increased pain starting in April 2004 to be credible. I note none of the physicians who have assessed the worker at various times

since the 1993 injury have noted exaggerated symptoms, pain behaviour, or nonorganic signs. On the whole his pain has been consistently reported over the years in terms of its nature and location. In the appeal hearing related to the 2004 claim, the employer stated that the worker had complained about his pain on an ongoing basis and that sometimes he left work early because of it. He referred to the worker's time cards as showing variation in the hours worked due to fluctuations in his back pain. The worker attributed the fluctuations in his hours to the fact that he did not like to start a new project near the end the day and would sometimes leave early rather than start a new project. The time cards show considerable variation in the hours worked from day to day, but do not show wide variations in the total number of hours worked each month. At the hearing the employer did not dispute that the worker told him in April 2004 that his back was bothering him, or that the worker was experiencing increased pain at the time he went off work at the end of April. I found the worker's evidence at the hearing to be internally consistent and consistent with his previous statements to his physicians and the Board. I accept as factual the worker's description of his increased symptoms starting in April 2004.

Under policy item #C14-102.1, for the worker's reports of increased pain to justify a reopening, they must involve more than a fluctuation that would normally be associated with the nature and degree of his permanent disability.

Aside from the two flare-ups in 1998 and 2002, the medical and other evidence shows a gradual increase in the worker's reported pain from 1996 onward. In the post-surgical follow-up reports on October 1, 1996 and April 8, 1997 Dr. Preto described the worker as doing well. These brief reports do not mention low back pain. However, at the time he was assessed for the interdisciplinary rehabilitation program in April 1997 the worker reported a constant low grade back pain which was centered around his surgical scar. He also had radicular pain down the lateral aspect of his right leg into the first and second toes. His pain was increased by driving or prolonged sitting and also by lumbar extension. At the time of the assessment it was also noted that his medical history was significant for three operative procedures on his left knee and reconstructive surgery on right ankle after a laceration. He continued to report similar pain symptoms on discharge from the program in May 1997. Both at the beginning and the end of the rehabilitation program the worker was managing his back pain without the use of medications.

The worker sought medical attention for flare-ups of pain in 1998 and 2002 that have already been discussed. Following each of these his symptoms settled and he returned to work. However, as he explained at the hearing, he had begun to use non-prescription pain medication on a daily basis and on some days avoided the heavier aspects of his job when the pain was worse.

When the worker first sought medical attention in April 2004 the pain was described as a burning pain that went down his leg. The worker was prescribed narcotic medication (Oxycocet) by Dr. Fisher or Dr. Coward in late April or the beginning of May, 2004,

something that he did not normally take for his back pain. On May 4, 2004 when he saw Dr. Preto he said he had been managing well until three weeks earlier, and reported that he now had "severe" low back pain with bilateral leg pain, worse on the right than the left. Dr. Preto described the worker as extremely painful, particularly in the right lower extremity. There was a slightly positive femoral stretch test.

At the hearing the worker acknowledged that prior to April 2004 he had ongoing low back pain, but said he said it was "fine," which I understand to mean that he had been able to cope. He described his pain as much worse at the end of April 2004. He was no longer able to carry out the full duties in his job as a cabinet maker.

The evidence is somewhat ambivalent with respect to whether there have been changes in the medical restrictions associated with his compensable back condition between May 1997 and April 2004. The May 26, 1997 multidisciplinary report from a team that included a physician, two physical therapists and a VRC, did not include recommendations for restrictions. The worker was described as functioning at the low end of the medium strength category, and it was recommended that he would benefit from a graduated return to work. However, there were no medical contraindications for the worker resuming employment as an apprentice cabinet maker. The physical demands of that occupation were not described in that report or in other reports at that time. I note that the OT who prepared the May 3, 2007 FCE report described demands of National Occupational Classification (NOC) codes 7272.7441, cabinet maker/installer, as medium to heavy. The OT referred to the NOC definition for heavy level work as requiring lifting 10 to 20 pounds constantly, 20 to 50 pounds frequently and 50 to 100 pounds occasionally.

Dr. Preto did not identify medical restrictions or limitations in his follow-up reports after the 1996 surgery. However on August 27, 1998, after the worker had a flare up of back pain, Dr. Preto indicated that the worker should be restricted from lifting more than 30 pounds and from undue torsional strain. Dr. Preto repeated this in his reports after the worker went off work in 2004, and on August 27, 2004 commented that the worker had been unrealistic in his expectations with respect to lifting, but was now satisfied that he should not be lifting the heavy sheets of composite wood products. Dr. Preto's reports do not indicate a change in the medical restrictions associated with the compensable back condition, but reflect the worker's decreased tolerance from April 2004 onward for working at a level that was beyond the recommended medical restrictions.

Although it is from 2007, three years since he stopped working as a cabinet maker, the May 2007 FCE report confirms that the worker did not demonstrate the ability to work at a productive and competitive pace in tasks requiring medium to heavy lifting. This report, in which the OT found the worker gave a strong and consistent effort, is consistent in a decline in the worker's tolerance for medium and heavy strength activities since May 1997.

The worker's increased pain symptoms from late April 2004 onward are reflected in the change in his use of medications. At the conclusion of the multi-disciplinary rehabilitation program in May 1997 the worker was described as coping with his constant low back pain without medications. At the hearing he described using non-prescription pain medication (Ibuprofen and extra-strength Tylenol) on a daily basis as needed during the time he worked for the most recent employer (January 2000 to April 2004). Around the time he went off work at the end of April 2004, he was prescribed Oxycontin for his low back pain, and this continued at the time of the PFI evaluation on May 26, 2005, when he reported that he was taking 800 milligrams of Ibuprofen three to four times daily as well as Oxycontin two tablets daily for low back pain.

The duration of the worker's increased low back pain in 2004 is not consistent with previous flare ups that have been characterized as normal fluctuations in his compensable condition. In 1998 when he sought medical attention for an episode of severe back pain, by the time he saw Dr. Preto (within a few weeks) he reported he was improved. In March 2002 the episode of increased pain took him off work for about three weeks. After that his physician described him as able to return to work. Both of those episodes lasted for weeks, not months. Once he went off work at the end of April 2004 Dr. Preto initially recommended that he stay off for six weeks. On August 27, 2004 Dr. Preto recommended that the worker return only to a fairly sedentary occupation without lifting. On February 1, 2005 Dr. Fisher reported that the worker was much worse, and remained incapacitated by back pain. He was not medically capable of working full duties full time. Given the relative short duration of the previous flare ups, and the severity and duration of the increased symptoms from late April 2004 onward, I do not accept the opinion of Dr. B2 in the 2004 claim file that the increase in symptoms was another fluctuation in the condition for which the worker received a PPD award.

Considering the evidence as a whole I find that the worker had a significant increase in the pain associated with his compensable low back condition that was beyond the usual fluctuations that he experienced from time to time. I find that the increase in pain resulted in an increase in the worker's level of disability (reflected in a decreased tolerance for the heavier aspects of his job) such that by the end of April 2004 he was unable to perform on a full time basis the full duties of his cabinet maker position. I conclude that the claim should be reopened for wage loss benefits as a result of his increased level of disability from the time he went off work in late April 2004.

The worker's appeal with respect to the reopening of his claim is allowed. He satisfies the criteria for reopening wage loss benefits under section 96(2) of the Act. I leave it to the Board to determine the nature and extent of his entitlement, including whether the increased symptoms are permanent.

Issue 2 – PPD Award

Under section 23(1) of the Act, where a PPD results from a worker's compensable injury, the Board must estimate the impairment of the worker's earning capacity from the nature and degree of the injury and pay the worker compensation based on the estimate of the loss of earning capacity resulting from the impairment. This is generally referred to as the functional method of assessing PPD awards.

Under section 23(2) of the Act, the Board has established a "Permanent Disability Evaluation Schedule" (PDES) as a rating schedule of percentages of impairment of earning capacity for specified injuries or mutilations which may be used as a guide in determining the compensation payable in permanent disability cases. The version of the PDES in Appendix #4 of the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II) applies to the worker's increased PPD award, since his reassessment was undertaken after August 1, 2003, the date on which the PDES was amended. Item #76(c) of the PDES provides an impairment rating of 4% for each level of spinal fusion. Item #77 provides for an impairment rating of up to 24% for immobility of the lumbar spine (0 to 9% for flexion, 0 to 5% for extension, and 0 to 5% each for right and left lateral flexion). Where, as in this case, there is a PFI rating available for both surgical impairment (fusion) and anatomic impairment, the award is based on the greater of the two.

The process for assessing permanent disability under section 23(1) is set out in RSCM I items #38.10, #39.00, #96.30 and #97.40. PFI medical examinations are carried out by DAMAs or external service providers. The report of a DAMA or external service provider takes the form of expert evidence, which in the absence of expert evidence to the contrary, should not be disregarded.

In this case the PFI evaluation in relation to the worker's reassessment was undertaken by Viewpoint Medical Assessment Services Inc., an external service provider. The May 26, 2005 report included the following measurements by the PFI clinician for the worker's lumbar spine mobility: flexion 63 degrees, lumbar extension 14 degrees, left lateral flexion 31 degrees and right lateral flexion 20 degrees. Dr. Stewart-Paterson, the PFI physician, reviewed the measurements as well as the effort and consistency values, and opined that the range of motion measurements were reliable and befitted the diagnosis provided. The DAO used these measurements to calculate an impairment rating of 3.2% (0.00% for flexion, 2.20% for extension, 1.00% for right lateral flexion and 0.00% for left lateral flexion. Since item #76(c) provides a larger impairment rating of for a one-level fusion (4.00%), the DAO determined that the worker was entitled to 4.00%.

In his December 4, 2005 report Dr. Fisher stated that he measured the worker's lumbar flexion at 0 degrees, extension at 5 degrees, right lateral flexion 30 degrees and a measurement for left lean that is similar to the value for right lean in the Viewpoint evaluation. Dr. Fisher questioned whether the left and right lean values had been reversed in the Viewpoint report. Dr. Fisher also stated in his report that he is not an expert in this area and does not feel qualified to provide an expert medical-legal opinion with regard to the Board's disability evaluation process or to challenge the calculations the Board used to determine the worker's level of impairment. He also acknowledged that he is not familiar enough with the ARCON inclinometer (the instrument used by Viewpoint and other external service providers to measure spine mobility) to determine if it was applied correctly by the evaluator. Dr. Fisher felt, however, that he was able to provide accurate observations of the worker's lumbar range of motion and to comment on his disability.

It is clear from his report that Dr. Fisher did not use the same method to measure lumbar range of motion as the ARCON inclinometer method used by the external service provider. He acknowledged that this may account for the differences in the measurements. I consider this to be likely. Although Dr. Fisher professed not to have expertise in the ARCON assessment methodology, he offered a number of comments that suggest that it may not be an accurate way to measure spine mobility. In particular, he noted that it is dependant on where the evaluator positions the inclinometer on the person's body, and if it is placed as shown in the illustrations in the PFI evaluation report, it would result in mobility of other parts of the spine, such as the thoracic spine, as well as the hips, being included in the measurements for the lumbar spine. In light of Dr. Fisher's acknowledged lack of expertise with the ARCON system used by the Board's external service providers to assess functional impairment, and the fact that he used a different method to measure the worker's spine mobility, I find that Dr. Fisher's report does not provide sufficiently reliable expert evidence to warrant overlooking the findings in report from the Board's external service provider. I accept the Viewpoint PFI evaluation as reliable, and I find that the DAO properly applied it in calculating the worker's PFI. I agree with the DAO that the worker is entitled to the 4% PFI based on the one-level lumbar fusion.

RSCM I item #39.01 was amended on January 1, 2003, replacing the policy on subjective complaints with a new policy on chronic pain. The new chronic pain policy applies to new claims received and all active claims that were awaiting an initial adjudication of chronic pain on January 1, 2003. The DAO who assessed the worker's PFI in 1995 referred to the worker's subjective complaints in his PPD assessment. The DAMA noted the worker's reports of constant low back pain radiating to the hips and occasionally down the right lateral thigh to the calf. In his January 17, 1995 memo the DAMA assessed the impairment at 2% and noted that symptoms related to the low back had impacted the worker's activities of daily living and potential work duties to a significant degree. In his July 10, 1995 memo the DAO reviewed the DAMA's findings and performed his own calculations. He concluded that taking into account the

measurements and the worker's subjective complaints, an award based on a PFI of 2.00% was warranted.

The former RSCM I item #39.01 provides that in making a determination under section 23(1), the decision-maker will enquire carefully into all circumstances of a worker's condition resulting from a compensable injury. Both the objective medical findings and the worker's subjective complaints of pain will be considered. In all cases a decision must be made on the particular facts of the claim as to whether or not a disability exists. Where there is appropriate medical evidence to support the subjective complaints, having regard to the worker's particular circumstances, the decision-maker can grant an award if the subjective complaints are likely to affect the worker's earning capacity.

Although the DAO's memo did not include a detailed analysis of the factors under the former item #39.01, I find that the DAO considered and reached a decision regarding the worker's entitlement for his pain complaints. The DAO had before him the DAMA's report on the worker's subjective complaints and the comment in the DAMA's memo on the effect of the symptoms on the worker's ability to work. The DAO commented that he considered the subjective complaints in rating the PFI at 2.00%. This supports the conclusion that the subjective complaints, including pain, were addressed in the 1995 PPD decision. The decision was that the subjective complaints, including pain, were compensated within the 2.00% award. I find that the worker's claim was not awaiting an adjudication of chronic pain on January 1, 2003 and that the former provisions of item #39.01, "Subjective Complaints," apply to his entitlement under section 23(1) of the Act.

With regard to subjective complaints, in the July 11, 2005 PFI memo the DAO stated that:

> In terms of this review it is recognized that the granting of a Section 23(1) functional award for permanent physical disability recognizes and takes into account there is an impact of subjective pain on a worker's general affected functioning and that is considered consistent with the existence of an identified permanent impairment.
>
> This impairment rating of 4% is considered to reflect the reasonable and anticipated symptoms and effects attributable to the nature of the injury. It is considered that this award is compatible with awards being granted for persons with similar disability. With respect to the actual surgical date, his recovery went well and by reason of the present medical information is certainly equal to the identified surgical value. That value has not changed with respect to lumbar fusion effective as of the spinal schedule as adopted in 1990 recognizing the first current schedule guidelines.
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> [reproduced as written]

It is not clear from this whether or not the DAO considered whether the worker should receive an additional percentage for subjective complaints as part of PFI reassessment. I find the DAO's words ambivalent, equally consistent with having considered an award for subjective complaints and with not having done so. The situation is complicated by the fact that the post-fusion PFI assessment was not undertaken until 2005.

At the time of the 2005 reassessment the worker's 1993 claim had not been reopened as a result of his increased low back pain. Because I have found that the claim should be reopened for the increased back pain, and left it to the Board to determine the nature and extent of the resulting entitlement, I find that in considering the worker's entitlement, the Board should determine whether the worker is entitled to an increased PFI rating in recognition of the effect of his subjective complaints on his functional abilities.

RSCM I item #39.10 provides that the PDES is a set of guide-rules, not a set of fixed rules. The decision maker is free to apply other variables in arriving at a final award, provided the "other variables" relate to the degree of physical or psychological impairment, not other variables relating to social or economic factors.

"Other variables" are not defined in item #39.10. The Board has created an Additional Factors Outline (outline) to assist in assessing possible awards under item #39.10. In light of the DAMA's findings that there was no weakness or neurological deficits related to the workers' compensable back condition, and Dr. Preto's similar finding in his August 2004 report, I find that an award under item #39.10 for other variables is not warranted.

Section 23(3) of the Act provides that, instead of a functional impairment award under section 23(1), the Board may award compensation for a PPD based on the difference between the worker's pre-injury average earnings and the average amount which the worker is earning or able to earn in some suitable occupation after the injury. This is generally referred to as the loss of earnings method of assessing PPD awards. In making a loss of earnings award under section 23(3), the Board must consider the worker's fitness to continue in his or her pre-injury occupation or his capacity to adapt to an alternate suitable employment.

RSCM I items #40.00, #40.10, #40.12, #89.00 and #89.10 apply to the determination of whether the worker should receive a loss of earnings award. Item #40.00 describes the projected loss of earnings method for assessing PPD awards under section 23(3) of the Act. Item #40.10 describes the assessment formula for such awards. This policy requires the decision maker to arrive at a conclusion regarding suitable occupations that the worker would be expected to undertake over the long-term future in considering the worker's post-injury earnings potential. In reaching this conclusion, evidence considered by the decision maker includes evidence about the worker's limitations resulting from the compensable injury, including relevant medical evidence. It also involves consideration of the worker's fitness for different types of employment and the

evidence of the VRC about the suitability of the worker for jobs that could reasonably become available. Earnings that maximize the worker's long-term potential will be selected from the jobs that are suitable and reasonably available.

Item #40.12 provides that in advising on the suitability of the worker for reasonably available jobs, the VRC must have regard to the limitations imposed by the residual compensable disabilities of the worker and assess the worker's earnings potential in light of all possible VR measures that might be of assistance to the particular worker.

In this case the DAO stated in the 2005 form 24 that loss of earnings consideration had no application because of the Board's VR assistance in accessing a field of employment with long-term earnings potential greater than his actual pre-injury earnings.

The DAO did not address the fact that the worker's circumstances had changed since the VR plan was formulated and the original PPD award was assessed in 1995. In 1995 the loss of earnings decision was deferred pending the VR activities. Following the VR assistance the worker had obtained employment with earnings that exceeded his actual pre-injury earnings. However, at the time of the 2005 reassessment, the worker was no longer working in the occupation of cabinet maker. He related this to his increased pain. Dr. Preto had emphasized his recommendation that the worker be restricted from lifting more than 30 to 40 pounds and from movements involving undue torsion of the spine. It is clear that the worker's job from 2000 to April 2004 included lifting more than 30 to 40 pounds. Dr. Preto expressed the view that the worker had held unrealistic expectations of being able to continue working in a job that required lifting 60 to 100 pound sheets of plywood and MDF. In the 2005 assessment the DAO did not address the issue of whether the worker has restrictions or limitations that prevent him continuing in the occupation of cabinet maker.

In light of the evidence in Dr. Preto's 2004 and 2005 reports and the 2007 FCE provided by the worker's representative I find that the loss of earnings provisions under section 23(3) are applicable to the worker's PPD reassessment in 2005. The Board is required to undertake an assessment to determine whether the worker will suffer a loss of earnings as a result of his compensable back condition, and in particular to address Dr. Preto's recommended restrictions and the limitations described in the FCE report.

With regard to Dr. Remick's January 12, 2007 consultation report, neither the Board's August 9, 2004 and July 19, 2005 decisions, nor the review officers' January 25, 2005 and February 28, 2006 decisions addressed a chronic pain syndrome or a major depressive disorder. Those matters are not before me in this appeal and I make no findings with respect to them. It is open to worker to request the Board to determine whether they should be accepted as compensable sequela of his back injury.

The worker's appeal with respect to the reassessed PPD award is allowed in part. In light of the reopening of the claim for the increased symptoms in April 2004, the Board is required to determine, as part of the 2005 reassessment, if the worker is entitled to an

increased PFI rating in recognition of the effect of his subjective complaints on his functional abilities.

Conclusion

I vary *Review Decisions #R0053421* and *#R0056987.* In summary:

- The appeal of *Review Division #R0053421* is allowed. The 1993 claim should be reopened for further compensation with respect to the increased symptoms in April 2004. It is left to the Board to determine the nature and extent of the worker's entitlement to further compensation, including whether the further symptoms are permanent.

- Neither the chronic pain syndrome nor the major depression diagnosed by Dr. Remick have been adjudicated by the Board. They are not before me as issues in this appeal. It is open to the worker to ask the Board to determine whether they are accepted under his claim.

- The appeal of *Review Division #R0056987* is allowed in part. The 4% PFI rating for the one-level lumbar spine fusion is confirmed. The former version of RSCM I item #39.01, "Subjective Complaints", applies to the reassessment of the worker's PPD award. In light of the reopening of the 1993 claim for increased symptoms in April 2004, the Board is required to determine whether an increased PFI award is warranted for the increased symptoms from April 2004 onward. The Board is required to undertake an assessment to determine whether the worker will suffer a loss of earnings as a result of his compensable back condition, and in particular, to address Dr. Preto's recommended restrictions and the limitations described in the FCE report.

The worker's representative requested that the worker be reimbursed for the May 3, 2007 FCE report. I found the FCE report helpful in considering the appeal. The OT's invoice is for $1,590.00. Item #13.23 of the WCAT *Manual of Rules of Practice and Procedure* provides that WCAT will generally limit the amount of the reimbursement of expenses to the rates or tariff established by the Board for this purpose. The worker's representative did not provide reasons why this general practice should not be followed in this case, and I am not aware of any from my review of the FCE report and the other evidence. I find that the worker should be reimbursed by the Board for the expense of the FCE report, subject to any schedule or tariff of fees the Board has for such reports, and I make an order accordingly.

The worker's representative also requested that he be reimbursed for the expense of attending the oral hearing, including travel expenses. In light of the outcome of the appeal, I find that he should be reimbursed for his expenses in travelling to the hearing

from his home, subject to the Board's tariff for such expenses, and I make an order accordingly.

Guy Riecken
Vice Chair

GR/mm/jd

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