**WCAT Decision Number:** WCAT-2015-03295
**WCAT Decision Date:** October 29, 2015
**Panel:** Dana G. Brinley, Vice Chair

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## Introduction

[1] In July 2010, the worker, while employed as a production support worker, was crushed between a metal bin and a guard rail when a loader ran into the bin. The Workers' Compensation Board, operating as WorkSafeBC (Board), accepted the worker's claim for multiple conditions, including a pelvic fracture and a right L5 transverse process fracture. The worker had two surgeries – in 2010 and 2012.

[2] In February 2013, when the Board concluded temporary disability wage loss benefits, the Board also accepted a number of permanent conditions, including a fractured pelvis (with associated chronic pain), post-traumatic stress disorder (PTSD), major depressive disorder (MDD), chronic orchitis, bilateral S1 neuropathy, as well as chronic low back pain.

[3] After the worker participated in a permanent functional impairment evaluation, in June 2013, a Board disability awards officer established the worker's permanent partial disability award, effective March 14, 2013, at 13.9% of total disability, pursuant to section 23(1) of the *Workers Compensation Act* (Act).

[4] She granted 5% award for the worker's permanent psychological disability; 6.4% for range of motion impairment in the worker's hips including bilateral enhancement subsequent to the pelvic fracture; and 2.5% for disproportionate non-specific chronic pain (lumbar spine, pelvis, lower extremities and chronic orchitis).

[5] The worker requested a review of that decision by the Board's Review Division.

[6] A review officer, in his December 19, 2014 finding, after considering submissions, varied the Board's pension decision.

[7] He confirmed the range of motion impairment rating regarding the worker's pelvic fracture, but found the worker was entitled to an additional award of 2.5% for lower back pain, but not to a separate award for any chronic pain associated with the pelvic fracture. He also found the worker was entitled to an additional award of 2.5% for the S1 neuropathy. He also found the chronic orchitis entitled the worker to an additional award of 2.5%, but the worker was not entitled to any additional award for what was described as cold intolerance. Finally, the review officer confirmed the psychological award of 5%.

[8] The worker now appeals to the Workers' Compensation Appeal Tribunal (WCAT). He disputes only certain aspects of the Review Division finding, believing he is entitled to an increased permanent pension award for the sexual dysfunction (chronic orchitis), cold intolerance and for the psychological conditions.

[9] During the WCAT appeal process, the worker was represented by legal counsel. The employer, although invited to do so, did not participate.

[10] Because legal counsel, on the notice of appeal, did not request an oral hearing, in March 2015, a WCAT assessment officer determined the appeal would proceed by way of written submissions. Accordingly, legal counsel sent in an extensive submission in late June 2015.

[11] Later that month, a WCAT appeal coordinator determined that all submissions were complete and the appeal was assigned to me for a decision.

[12] According to item #7.5 (Appeal Method) from WCAT's *Manual of Rules of Practice and Procedure* (MRPP), generally WCAT will conduct an appeal by written submission where the issues are largely medical, legal or policy based and credibility is not at issue.

[13] I agree that an oral hearing is not required, because there does not appear to be any significant issue of credibility and there are no significant factual issues in dispute. Therefore, I dealt with this appeal after I reviewed all the claim file information and all written submissions.

**Issue(s)**

[14] The issue in this appeal relates to whether the worker is entitled to a permanent partial disability award for the sexual dysfunction and cold intolerance, and also whether he is entitled to an increased permanent disability award for his psychological condition (PTSD and MDD), pursuant to section 23(1) of the Act and applicable Board policy.

[15] According to item #3.3.1 from WCAT's MRPP, generally WCAT will restrict its decision to the issues raised by the appellant; the appellant is entitled by right to a decision on the issues expressly raised.

[16] Because the worker, through legal counsel, only took issue with certain aspects of the Review Division finding and the Board's original pension decision, I did not address any other issues over which I had jurisdiction.

**Jurisdiction**

[17] The worker appeals a December 19, 2014 Review Division finding (*Review Reference #R0179012*) pursuant to section 239(1) of the Act.

[18] WCAT may consider all questions of fact and law arising in an appeal, but is not bound by legal precedent (see section 250(1) of the Act). WCAT must make its decision on the merits and justice of the case, but in so doing, must apply a policy of the board of directors of the Board that is applicable in the case. WCAT has exclusive jurisdiction to inquire into, hear and determine all those matters and questions of fact, law and discretion arising or required to be determined in an appeal before it (section 254 of the Act).

[19] This is a rehearing by WCAT. WCAT reviews the record from previous proceedings and can hear new evidence. WCAT also has enquiry power and the discretion to seek further evidence, although it is not obligated to do so.

[20] The standard of proof required in this appeal is proof on a balance of probabilities, subject to section 250(4) of the Act. That section provides that where the evidence supporting different findings on an issue in an appeal respecting the compensation of a worker is evenly weighted, the issue must be resolved in a manner that favours the worker.

[21] The relevant policy related to this appeal is found in the Board's *Rehabilitation Services and Claims Manual, Volume II*.

**Background and Evidence**

[22] The worker participated in a permanent functional impairment evaluation, conducted by a disability awards medical advisor, on June 19, 2013. The worker's complaints and the results of that examination are set out in the disability awards medical advisor's report.

[23] In October 2013, the worker participated in a psychological assessment, conducted by Dr. Bubber.

[24] In a comprehensive report, Dr. Bubber, in part, noted the worker had attended a pain and medication management program and also had been engaged in treatment sessions with a clinical counsellor around the time he began a graduated return to work.

[25] Dr. Bubber described the worker's current psychological functioning, as well as his activities of daily living. She also conducted a collateral interview with the registered clinical counsellor. Based on her assessment, Dr. Bubber diagnosed the worker with a MDD (single episode in partial remission) and PTSD (in partial remission). She noted the worker's chronic physical pain had taken a "toll", including his sense of sexuality. She noted the worker credited much of his improvement to the counselling. However, Dr. Bubber, like the clinical counsellor, remained concerned about the possibility of relapse or decompensation, both in the worker's mood and post-traumatic anxiety. She thought the worker would benefit from ongoing treatment sessions and deferred to the clinical counsellor regarding an end date, which likely would depend on the variability level of the worker's mood. She also thought the MDD mildly impaired the worker's

activities of daily living. Pain was a factor in his ability to engage in sexual activity, but as a consequence, his interest and sense of sexual identity had been negatively impacted. The worker's interests in other activities were also diminished. The PTSD only occasionally impacted the worker's sleep.

[26] In terms of social functioning, Dr. Bubber thought the MDD had a mild to moderate impact and the PTSD had no impact, noting to the worker's credit, he maintained a work relationship with the individual who was responsible for the 2010 incident. Despite the worker's improvement level, Dr. Bubber thought the worker was at a moderate risk for deterioration regarding the MDD. Should the worker receive negative feedback about his work performance, or if the worker would experience another injury, these would worsen the psychological conditions. Additionally, Dr. Bubber thought the worker was at a moderate to high risk for deterioration with respect to PTSD, if he was in a position where there was physical risk, noting the worker remained hyper-vigilant to his safety in the workplace. If there was a "close call" or immediate risk of danger, the worker would likely experience "significant intrusive ideation" not only to that incident, but also to the originating 2010 incident.

[27] In April 2014, the Board Psychological Disability Awards Committee (PDAC) reviewed the worker's level of functional psychological impairment.

[28] As set out in the corresponding memorandum and based on the Board's guidelines (noting a PDAC rating is intended to compensate for the overall impact of the injury on psychological functioning), the PDAC rated the worker's compensable functional psychological impairment at 5%.

[29] A disability awards officer then, in late April 2014, completed a "Loss of Function Review" for pension purposes.

[30] As set out in her corresponding memorandum, after considering the permanent functional impairment evaluation and the PDAC's recommendations, she established the worker's permanent partial disability pension award at 13.9%, retroactive to March 14, 2013.

[31] The disability awards officer issued her May 13, 2014 decision letter under appeal.

[32] The clinical counsellor continued to see the worker and provide a number of "mental health treatment reports".

[33] For example, in February 2015, she reported, in part, the worker was "upset" due to another accident at work and the worker was quite concerned regarding safety issues in the workplace. The worker described having nightmares again and did not want to talk to his family about this issue. The counsellor also noted the worker continued to experience testicular pain, which impacted his sexual functioning, and his pain and fatigue made it difficult for him at work. The counsellor supported the attending

physician's recommendations that the worker was not capable of working more than two days in a row without needing a break. Finally, the counsellor noted that Board-sponsored treatment would expire April 1, 2015 and she recommended an extension.

[34] In mid March 2015, a Board psychological advisor reviewed the worker's claim.

[35] As set out in his corresponding memorandum, he noted the clinical counsellor had been meeting with the worker for approximately 2.5 years and had been providing supportive counselling for the worker's mild symptoms. The psychological advisor was not able to contact the counsellor by telephone. With respect to whether he would support an extension of service, he noted it was reasonable to gradually decrease counselling involvement over an extended period of time – 6 to 12 months. He deferred to the case manager as to whether this therapy should be with the existing clinical counsellor or a new provider, noting that if the worker changed therapists, the "tapering period" would be prolonged; a number of sessions would be needed with a new therapist to develop a relationship with the worker.

[36] It then appears the Board approved a five-month extension to the end of September 2015, with the existing clinical counsellor.

[37] The review officer, after considering submissions, varied the Board's pension decision, but confirmed some aspects of that decision.

[38] The review officer confirmed the permanent functional impairment rating for the worker's pelvic fracture, while finding the worker was entitled to a 2.5% award for lower chronic back pain. He was not entitled to a separate award for the chronic pain associated with the pelvic fracture. Regarding the permanent S1 neuropathy, the review officer found the worker was entitled to a separate award of 2.5%.

[39] Regarding the worker's sexual dysfunction (chronic orchitis), the review officer found that condition did not warrant an additional award. Rather, that condition should be considered under the chronic pain policy. Since the worker's pain was in a functionally independent area, the review officer found that condition entitled the worker to a separate award of 2.5% (without causing any sexual function impairment).

[40] Additionally, the review officer determined, after considering the Board's Additional Factors Outline (AFO), the worker was not entitled to an additional award for cold intolerance, because the evidence did not support an additional impairment as in the case of a hand injury, where cold affects manual dexterity.

[41] Finally, the review officer considered the psychological evidence, particularly the opinion provided by Dr. Bubber, indicated the worker's symptoms were mild. While Dr. Bubber recommended additional treatment, she did not expect ongoing treatment, noting she expected there would be an end date. The review officer considered the worker's return

to work suggested that a different job or accommodation was not necessary (the worker had reduced his workweek to four shifts per week, related to his chronic pain). He recognized Dr. Bubber also felt there was an increased risk of decompensation, but noted that risk was under very specific circumstances. Overall, he thought there was little risk for decompensation, which was supported by the worker's durable return to work. He confirmed the 5% pension award for the worker's psychological conditions.

*Evidence at WCAT*

[42] Legal counsel, in his June 23, 2015 written submission, asserted the worker's sexual dysfunction arising from the chronic orchitis warranted an additional award of 2 to 3%. He asserted this condition results in sexual dysfunction noting the worker's pain when ejaculating constitutes a sexual dysfunction as defined by Board policy item #39.43 – the ability to engage in sexual activity. In the alternative, he thought the psychological award could be increased to reflect the worker's symptoms. He referred to the clinical counsellor's reports in this regard, as well as Dr. Bubber's psychological assessment.

[43] As to the worker's cold intolerance, he asserted that based on prior WCAT decisions (including a noteworthy WCAT finding in 2010), he submitted the worker's cold intolerance symptoms, based on that criteria, deserve a moderate award between 0.5 and 1.5%. He again referred to the clinical counsellor's information and specifically a medical-legal letter submitted in October 2014 to the Review Division. He noted the worker's attempts to keep himself warm at work, pointing out the use of the worker's pelvis is integral to the work performance, because it is utilized in nearly every kind of movement and work activity. He referred to the job site visit report in this regard (August 2011).

[44] With respect to the worker's psychological condition, after referring to Dr. Bubber's report and the clinical counsellor's October 2014 letter, he outlined ten areas of the worker's current distress affecting the psychological condition. He asserted the clinical counsellor's opinion and factual evidence should be given significant weight, because she has been the worker's counsellor on a regular basis for a number of years. He asserted that when the Board's psychological guidelines are considered, the worker's symptoms are not minor. Certain components are in fact severe and the worker is at significant risk for decompensation. He submitted a pension rating for the worker's psychological condition should be between 20 to 25%, with reference to the Board's psychological guidelines for that category. He referred, in part, to the counsellor's February 2015 report, noting that continued treatment and support was likely and the Board had approved further therapy. He suggested the combined effects of both the PTSD and MDD must be considered.

**Reasons and Findings**

[45] Section 23(1) of the Act is the mandatory provision that must be applied in the assessment of permanent partial disabilities and the percentage of disability determined

for a worker's condition under section 23(1) reflects the extent to a particular injury is likely to impair a worker's ability to earn in the future. Section 23(1) awards also reflect such factors as short-term fluctuations, and reduced prospects of employment (provided by Board policy item #39.00).

[46] Board policy item #39.10 (Permanent Disability Evaluation Schedule (Schedule)) notes that the Schedule is a set of guidelines and not a set of fixed rules. The Board is free to apply other variables but other variables refer to variables relating to the degree of physical or psychological impairment.

[47] Board policy item #39.43 (Sexual and Reproductive Function) provides that where a compensable injury has resulted in impairment in sexual function, the American Medical Association *Guides to the Evaluation of Permanent Impairment* (AMA Guides) is used to assist in determining the appropriate percentage of disability.

[48] The Board's AFO also provides adjudicative guidance. The AFO refers to the AMA Guides, noting in part that under neurological sexual conditions, a grade 1 condition is defined as where sexual functioning is possible, but with varying degrees of difficulty with erection or ejaculation.

[49] The Board's PDAC Section 23(1) Guidelines provides adjudicative guidance, with respect to the determination of a worker's percentage of disability under the Schedule for psychological conditions.

[50] A permanent functional impairment rating range of 5 to 25% reflects certain conditions in the "mild" category where a worker's impairment levels are compatible with most useful functioning. For example, in the 5% range, there would be minor residual symptoms; no or little significant increased risk of decompensation; accommodation of different jobs would likely attenuate psychological impairments. Within the 10 to 15% range, there would be minor residual symptoms; some increased risk of decompensation under a stressful situation; accommodation of different jobs would likely not completely attenuate psychological impairment; and only sporadic continued treatment would be likely. A rating of 20 to 25% range required mild residual symptoms; moderate risk of decompensation under stressful situations; accommodation of different jobs would not significantly attenuate psychological impairment; and likely continued treatment and support.

[51] I find the preponderance of evidence indicates the worker is entitled to an increased permanent partial disability award of 10%. The worker's permanent partial disability award for his psychological condition would therefore total 15%, based on the Board's guidelines. Additionally, I find the worker is not entitled to a permanent partial disability award for either his reported cold intolerance or the chronic orchitis (sexual dysfunction). I allow the worker's appeal to this extent and I vary the review officer's finding.

[52] While I acknowledge legal counsel's submissions, with respect to the worker's reported sexual dysfunction, like the review officer, I am satisfied the worker's permanent chronic orchitis condition and any sexual dysfunction related does not warrant an additional award under Board policy item #39.43, because that condition does not result in difficulty with erection or ejaculation, based on the considerations outlined in the AFO. In this regard, I note the review officer found the worker's sexual dysfunction and the concomitant disproportionate pain entitled the worker to a separate award of 2.5% under the chronic pain provisions.

[53] My finding in this regard is also supported by the Board medical advisor's opinion in August 2013. After noting the worker had been assessed by a urologist, the Board medical advisor indicated the worker's testicular pain (orchitis) prevented the worker from enjoying intercourse.

[54] Regarding the worker's reported cold intolerance, after considering the 2010 WCAT noteworthy decision, as well as legal counsel's submissions, like the review officer, while I acknowledge the worker likely had increased symptoms in the workplace, I am not persuaded an additional impairment is warranted. As noted by the review officer, this is not a case such as in a case of a hand injury, where cold affects manual dexterity and as a result affects the worker's ability to perform work-related duties and affects the worker's ability to earn.

[55] Regarding the worker's psychological conditions, like legal counsel, after considering the psychological evidence and opinion evidence, I am persuaded that a 5% award is inadequate given the guidelines provided by the PDAC Section 23(1) Guidelines and the ranges defined in the those guidelines.

[56] I have the benefit of some additional information since the review officer's December 2014. More recently, reports from the clinical counsellor relate to, in my view, an increased risk of decompensation under stressful situations and suggests the definition of decompensation within the 5% category is entirely inadequate. I am satisfied the worker's situation falls within the 10 to 15% category in this regard, because I accept the overall evidence strongly suggests there is increased risk of decompensation under stressful situations.

[57] While legal counsel asserted that a 20 to 25% range was appropriate, I reject that suggestion, particularly given the clinical counsellor's report and the indication that continued treatment and support would not likely extend beyond later in 2015 and that continuing clinical counselling sessions to date have been mostly supportive and have been an opportunity for the worker to "vent".

[58] I also considered the psychological advisor's recent March 2015 review, which suggests the worker has been presenting with "mild" symptomatology, since Dr. Bubber's assessment in October 2013. That opinion is consistent with Dr. Bubber's view that the worker's MDD constituted a mild impairment with respect to activities of daily living and

was mild to moderate impact on the worker's social functioning. I am also mindful Dr. Bubber noted the PTSD had no impact on the worker's social functioning and only impacted the worker's activities of daily living occasionally when he had nightmares.

[59] Therefore, on balance, I find the worker's section 23(1) permanent partial disability award for his psychological condition is captured by the criteria outlined in the Board's guidelines in the 10 to 15% range and the worker's overall psychological pension award is best reflected by a 15% award in total.

**Conclusion**

[60] For the above-noted reasons, I allow the worker's appeal in part and I vary the review officer's December 19, 2014 finding. I find the worker is entitled to an increased psychological award of 10% for his psychological condition, resulting in an overall psychological award of 15%. However, I find the worker is not entitled to additional pension award for either the reported chronic orchitis (sexual dysfunction) or cold intolerance, pursuant to section 23(1) of the Act and applicable Board policy.

[61] There was no request for any appeal expenses and as none are apparent, I make no additional finding in that regard.

Dana G. Brinley
Vice Chair

DGB/ml