DECISION OF THE WORKERS' COMPENSATION APPEAL TRIBUNAL

WCAT Decision Number: A1607061
WCAT Decision Date: April 12, 2018

Introduction

[1] The worker, while employed as a truck driver, sustained a left knee injury in 2012, during a workplace incident. The Workers' Compensation Board (Board), operating as WorkSafeBC, accepted his claim, after two left knee surgical repairs (December 2012 and September 2013), for a permanent aggravation of pre-existing degenerative changes in the anterior and posterior horn of the medial meniscus. The Board also accepted chronic pain. The worker received temporary disability wage loss benefits until March 2014. Thereafter, the Board granted the worker a permanent partial disability pension award equal to approximately 11.98% of total disability, effective March 2014.

[2] In early 2015, the worker's representative asked the Board to adjudicate a number of additional conditions under the claim.

[3] Eventually, a Board case manager issued a June 1, 2016 decision letter.

[4] As set out, she decided to accept a patellar tendon tear as a compensable condition, but declined to accept a third meniscal tear as a consequence of Board-sponsored treatment in January 2014. Additionally, the case manager declined to provide any further temporary disability wage loss benefits or physiotherapy treatment coverage.

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

[6] A review officer, in a November 23, 2016 finding, confirmed the Board's decision regarding the compensability of a third meniscal tear and the worker's entitlement to coverage for further physiotherapy treatment. However, she referred the issue of entitlement to further wage loss benefits back to the Board for further determination, in light of the acceptance of the new compensable condition—the patellar tendon tear.

[7] By way of implementation, another Board case manager, in a February 10, 2017 decision letter, concluded the left partial patellar tendon tear had considered resolved by June 6, 2014. Therefore, the worker was entitled to temporary disability wage loss benefits to that date.

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

[9] A different review officer, in a September 14, 2017 finding, decided the patellar tendon injury had not resolved by June 4, 2014 and was temporarily disabling up to August 7, 2014. Parenthetically, the review officer noted the worker had received vocational rehabilitation

benefits past August 7, 2014 and, as such, his decision might not result in any further benefit entitlement. He left that to the Board to determine, in any event.

[10] The worker now appeals both review officers' findings to the Workers' Compensation Appeal Tribunal (WCAT). During the WCAT appeal process, the worker continues to be represented by legal counsel. Although invited to do so, the accident employer is not participating.

[11] Because the worker, through his legal counsel, did not request an oral hearing, a WCAT assessment officer determined the appeals would be "joined" and would proceed by way of written submissions.

[12] Accordingly, legal counsel provided a written submission, along with additional evidence.

[13] In late September 2017, and based on section 246(2)(c) of the *Workers Compensation Act* (Act), I asked a WCAT appeal coordinator to contact the worker's treating orthopaedic specialist, Dr. Lee, because I wanted to Dr. Lee to provide additional medical opinion evidence.

[14] Dr. Lee's subsequent October 20, 2017 letter to WCAT was then disclosed. In January 2018, legal counsel indicated he did not have any further submissions to make.

[15] For reasons later set out in this finding, I have decided to refer a matter back to the Board for determination and suspend the current appeals until the Board makes that further determination. Based on section 246(3) of the Act, this decision is therefore an interim decision. I will take the Board's further determination into account in deciding the original appeals, as described in WCAT's *Manual of Rules of Practice and Procedure* (MRPP) at item #8.4.1.

Issue(s)

[16] The issues in this appeal relate to:

- the compensability of an additional left knee meniscal tear;
- the worker's entitlement to further wage loss benefits; and,
- the worker's entitlement to additional coverage for further physiotherapy treatment.

[17] Based on my section 246(3) referral back to the Board, I will also need to consider, pursuant to section 96(2) of the Act, whether the Board may reopen a matter that had previously been decided by the Board, if there had been a significant change in the worker's medical condition that the Board had previously decided was compensable, or there had been a recurrence of the worker's injury.

Jurisdiction

[18] The worker appeals two Review Division decision findings – November 23, 2016 (*Review Reference #R0209188*) and September 14, 2017 (*Review Reference #R0221911*) pursuant to section 239(1) of the Act.

Background and Evidence

[19] The case manager, in a lengthy May 25, 2016 memorandum, again reviewed the worker's claim and asked a Board medical advisor for a further opinion related to legal counsel's January 2015 request for a new decision related to the acceptance of new injuries, payment of temporary total disability benefits, and payment of health care benefits, including physiotherapy.

[20] In part, the case manager noted the Board had received reports from the worker's attending physician, Dr. Lee, and an August 2014 MR arthrogram which indicated a suspected small new tear at the superior aspect of the posterior horn of the medial meniscus. The case manager also acknowledged a prior WCAT decision in 2015, which upheld the original plateau date and stabilization of the permanent conditions by March 30, 2014. She also noted the worker had been assessed for a permanent functional impairment pension in March 2015, some many months after the "new injuries" were noted. She did not think that accepting the "new injuries" would allow for further temporary wage loss benefits, or would change the outcome of the permanent functional impairment assessment.

[21] Board medical advisor Dr. Meetarbhan, in a May 29, 2016 response memorandum, specifically considered the incident report dated January 2014 when the worker alleged that he had "tweaked" his knee during exercises. After referring to the scanning results, Dr. Meetarbhan mentioned those findings needed to be correlated to be meaningful. The medical advisor could not confirm the worker did or did not have a tear. The evidence suggested this was not clinically significant anyway, using either a biological or biomechanical model. The medical advisor could not conclude the worker sustained a new meniscal tear as a result of the "mechanism of injury" at the occupational rehabilitation 2 program, in January 2014. It was more likely than not that if a tear was present, it was representative of the natural progression of the worker's pre-existing degenerative condition in the left knee. The medical advisor went on to indicate that further physiotherapy was unlikely to improve pain or function, since the worker already had the benefit of an active program and physiotherapy is considered a "passive modality."

[22] The case manager then issued the June 1, 2016 decision letter under appeal.

[23] In part, the case manager mentioned she could not conclude there was "clearly a new meniscal tear" and this would therefore not be accepted as another injury. The Board had already accepted a permanent aggravation of pre-existing degenerative changes in the anterior and posterior horn of the medial meniscus in the left knee. Whether or not there was a "new tear" was a moot point. The case manager went on to accept the left patella tear, but concluded that that tear had healed, according to scanning in late August 2014. Based on the June 2015 WCAT finding, the case manager could not consider payment of any temporary disability benefits beyond March 30, 2014. She also did not approve any further physiotherapy under the claim (the case manager referred specifically to Board policy #101.01 and 22.00).

[24] The review officer, in her November 23, 2016 finding, regarding the compensability of the third meniscal tear, in part, noted that Dr. Lee, in August 2016, recommended a further surgical procedure – an arthroscopic debridement. Dr. Lee indicated that irregularity could be coming from post-surgical changes from the previous arthroscopies. Because the review officer noted Dr. Lee did not mention a tear and did not address the distinction between a possible new injury and the natural progression of the worker's pre-existing degenerative condition, the review

officer gave Dr. Lee's opinion little weight. She determined the worker had not sustained a third meniscal tear as a consequence of treatment for the compensable left knee injuries.

[25] The same review officer, after finding the Board had the jurisdiction to adjudicate the worker's further wage loss benefits, because the Board had accepted a new compensable condition – the patellar tendon tear – referred that matter back to the Board for adjudication. She also found that further physiotherapy treatment was not reasonably necessary to address the worker's compensable permanent left knee condition.

[26] That finding was subsequently implemented by the Board and varied by the review officer's subsequent September 14, 2017 decision.

Evidence at WCAT

[27] The worker's representative, in his brief July 20, 2017 submission, mentioned that because the subject matter of the appeal was outside the area of the worker's attending physician's expertise, WCAT should request a medical-legal report from orthopaedic specialist, Dr. Lee, who performed surgery on the worker's left knee.

[28] Legal counsel attached a copy of Dr. Lee's operative report, dated June 17, 2017, with respect to the June 12, 2017 left knee arthroscopy, with partial medial meniscectomy.

[29] In part, intraoperatively, Dr. Lee noted the medial meniscus had a "bit of tear particularly in the medial and posterior horn," which was debrided. (It appears the Board also received a copy of the operative report in late July 2017).

[30] In my September 21, 2017 memorandum, I asked the WCAT appeal coordinator to contact Dr. Lee, because I wanted Dr. Lee to provide a reasoned medical opinion regarding whether the worker sustained a third meniscal tear, which more than likely resulted from his activity in the occupational rehabilitation 2 program, on January 20, 2014. I also wanted Dr. Lee to comment on whether that, as a result of that additional injury, the worker was further disabled and required additional physiotherapy. I enclosed relevant information for Dr. Lee's review. I also noted I was aware of the June 12, 2017 left knee surgery and Dr. Lee's intraoperative findings.

[31] Shortly thereafter, Dr. Lee, in a brief October 20, 2017 report, after considering the mechanism of stretching the hamstring, without any significant twisting or torqueing motion (at the occupational rehabilitation 2 program in January 2014), agreed that other than the temporal relationship of the worker's increasing pain after the incident, it would be difficult to draw a causal relationship between the stretching exercise and the third meniscal tear. The "third" tear was more likely the result of the natural progression of degeneration due to both the aging process and the two previous arthroscopies.

[32] As to whether as a result of that additional injury, the worker was further temporarily disabled and required additional physiotherapy, Dr. Lee, in part, mentioned that after a review of the two MRI scans – July 2016 and September 2017 – the radiologists' reports, as well as his intraoperative photos, his operative findings were consistent with the MRI – the meniscal tear found was partly attributed to the previous meniscectomy. The meniscal tear could also be attributable to degenerative changes, which by nature are generally the typical pattern of a

horizontal intrasubstance tear, without fragment displacement. Dr. Lee noted that these tears can be attributed to the previous meniscectomy, as well as a global degenerative process. Furthermore, Dr. Lee noted that he debrided the scar tissues around the arthroscopy port hole – the various scar tissues he had thought was the source of the worker's pain. Dr. Lee's hope was after all non-operative options were exhausted – including a cortisone injection and extensive physiotherapy – the arthroscopy would be the last resort in trying to help the worker manage his knee pain. With respect to physiotherapy, Dr. Lee agreed that a reasonable amount of post-surgical physiotherapy (three to six months) would be beneficial in terms of regaining the range of motion and muscle strength. He agreed with Dr. Meetarbhan that any additional physiotherapy beyond that initial period would likely not yield much benefit.

Section 246(3) Referral

[33] Because I am satisfied there is a matter that should have been determined by the Board but was not, I refer that matter back to the Board for determination and suspend the current appeals until the Board makes that determination.

[34] I find the Board should determine, pursuant to section 96(2) of the Act, whether there was a significant change in the worker's medical condition that the Board had previously decided was compensable, or there had been a recurrence of the worker's injury, by at least the August 2014 MR arthrogram, which would allow the Board to reopen the worker's claim and consider additional compensation benefits, such as further wage loss and physiotherapy.

[35] With respect, in my view, the case manager, in May 2016, restricted her inquiry to only considering whether there had been a "new" left knee injury and did not fully consider the opinion of Board medical advisor Dr. Meetarbhan, that if any tear was present, it likely represented the natural progression of the worker's pre-existing degenerative condition in the left knee. The case manager was clearly aware, as set out in the June 1, 2016 decision letter, that a permanent aggravation of pre-existing degenerative changes in the anterior and posterior horn of the medial meniscus was compensable under the claim; particularly given the repeat arthroscopy in September 2013. Notwithstanding the worker's allegation that he sustained a "new" left knee tear on January 20, 2014, there was a sufficient basis on which the Board could have also considered whether there were sufficient grounds to reopen the worker's claim – with respect to not only further medical intervention, but also the additional compensation entitlements as requested by the worker's attending physician and by legal counsel (and the worker himself).

Reasons and Findings

[36] For the above-noted reasons, I suspend the current appeals and pursuant to section 246(3) of the Act, I refer a matter back to the Board for determination. I find the Board should determine whether there had been a significant change in the worker's medical condition that the Board had previously decided was compensable, or there had been a recurrence of the worker's injury, by at least the August 2014 MR arthrogram, such that the Board might reopen the claim for additional compensation benefits entitlement – wage loss and physiotherapy.

[37] I am also mindful that, retrospectively, the Board has the benefit of Dr. Lee's June 12, 2017 operative report. Intraoperatively, Dr. Lee referred to a "bit of tear" in the medial and posterior horn of the medial meniscus. This information may now provide correlation between scanning findings, as referred to by Dr. Meetarbhan in the May 29, 2016 clinical opinion memorandum.

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