WCAT Decision Number: WCAT-2004-00030-RB
WCAT Decision Date: **January 08, 2004**
Panel: Ralph D. McMillan, Vice Chair

Introduction

On August 29, 2001, a case manager at the Workers' Compensation Board (Board) set out a history of the worker's claim, noted no wage loss had been paid on the claim at all and the worker had continued to work for the accident employer until January 2001 when he was laid off. The case manager said the worker indicated he is now self-employed and, in this respect had not provided any information with respect to his self-employment earnings so there was no way to assess whether there was any wage loss entitlement on that basis. The case manager said if the worker were to provide further earnings information the Board would re-look at his entitlement to wage loss benefits. Additionally, the claims manager said evidence did not support the worker had been left with any residual permanent functional impairment (PFI) as a result of his December 15, 2000 compensable injury.

The case manager denied the worker's request for a further MRI investigation for which he had been referred, due to ongoing pain symptoms in his neck and upper back. The case manager said medical opinion was that an MRI or other treatment would be of no benefit at this point. The worker was considered to be fit for suitable employment, however, this decision was subject to further review if medical evidence were to be submitted by his caregivers.

Issue(s)

Whether the worker is entitled to wage loss benefits.
Whether ongoing medical investigations are a Board responsibility.
Whether the worker is entitled to be examined for PFI as a result of his December 15, 2000 compensable injury.

Jurisdiction

This appeal was filed with the Workers' Compensation Review Board (Review Board). On March 3, 2003, the Appeal Division and the Review Board were replaced by the Workers' Compensation Appeal Tribunal (WCAT). As this appeal had not been considered by a Review Board panel before that date, it has been decided as a WCAT appeal. (See the *Workers Compensation Amendment Act (No. 2), 2002*, section 38.)

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Background and Evidence

On December 15, 2000 the worker was struck with considerable force by ice and water which erupted from a burst pipe which he was working on. The worker's claim for injury was accepted by the Board on a health care basis only as he did not lose any time from work. As noted above, the day of injury was December 15, 2000 and the worker first reported to his doctor December 21, 2000. The doctor noted the worker had been blown 20 feet by a burst compressed air pipe. He presented with complaints of tingling in both hands and legs with pain in his left shoulder. The doctor diagnosed moderately severe contusions of the left elbow and both thighs, soft tissue injury to the neck and back and a muscular injury to the left shoulder. The doctor questioned a rotator cuff tear. He said the worker could not return to his normal employment, however, he was fit for modified duty.

The worker underwent radiological investigation on December 21, 2000 with respect to his cervical and lumbar spine as well as his left shoulder. Nothing was identified.

By January 4, 2001 the worker was complaining of pain in the left shoulder and tingling digits of the right hand. On examination the doctor found a full range of motion in the left shoulder with pain at extremes of internal rotation. There was minimal paresthesia in the mid and ring fingers. Hand grip was equal in both right and left. There was resolving medial bruising of the right thigh.

Radiological investigation done March 5, 2001 of the worker's lumbar spine identified Schmorls nodes along the margins of disc spaces from T10 to S1 inclusive. Lumbar discs were otherwise well maintained. Also identified was spina bifida occulta at S1 with some sclerotic change consistent with degenerative change in the L5-S1 facet joints. It was noted there had been no change since December 21, 2000.

By March 5, 2001 the worker's complaints were primarily on the right side. It was noted the right arm and leg remained troublesome with increased difficulty walking. There was right arm and right leg paresthesia with low back and shoulder pain. The right hand grip was decreased when compared with the left, the right arm colour was worse than the left arm and the right leg muscles were weaker than on the left. The doctor diagnosed a fine tremor right arm explosion injury with paresthesia, numbness right arm, right leg nerve traction injury, brachialis flexion right sciatic nerve.

On March 27, 2001 the worker attended neurologist Dr. D.E. Parton who recorded that the worker was thrown backwards hitting his right elbow on the floor. He noted the worker had back and shoulder discomfort since that incident centered around the right scapula. The right hand had become numb and weak. Dr. Parton noted the worker had landed on the elbow first but there had been no broken bones. The whole hand felt tingly and the worker described variable numbness in the right leg with some back

stiffness. He noted the worker was able to put in six hour days laying floors but had to favour the right arm. Dr. Parton felt the worker should have an MRI of his cervical and thoracic spine to rule out any injury there. He did not find any sign of radiculopathy in the legs.

On May 2, 2002 the worker underwent an MRI of his cervical spine and the four upper levels of the thoracic spine. Other than minimal bulging of the posterior longitudinal ligament at C3-4 and C4-5 the MRI was considered to be unremarkable of both the cervical and upper thoracic spine.

On May 23, 2001 the worker was examined by Board medical advisor, Dr. D. Hemmerich, who noted the worker had persistent posterior neck, upper and lower extremity symptoms following his work injury. Dr. Hemmerich opined the soft tissue discomfort about the lower posterior cervical spine was in keeping with soft tissue strain. Neurologic symptoms described in both upper and lower extremities did not fit any particular diagnosis. Dr. Hemmerich felt the pain would likely resolve over time and the worker should increase and maintain higher levels of activity in his daily routine. He did not feel there was any sign that increasing the activity levels would cause the worker further injury.

On the same day the worker met with Dr. Hemmerich, the worker and his wife met with the case manager. It was noted the worker had stopped work entirely as of May 4, 2001. A doctor's progress report for April 9, 2001 indicated the worker, for the first time, was not fit to do modified or part-time work.

Subsequent progress reports to September 28, 2001 indicated the worker was temporarily totally disabled (TTD) from employment. On September 28, 2001 the worker's attending physician again said the worker was fit for modified, sedentary work. This state of affairs appears to continue unchanged to November 13, 2001 at which time the worker's attending physician referred the worker back to neurologist Dr. Parton. Progress reports for December 2001 indicated the worker's right arm symptoms were getting worse.

The worker again saw Dr. Parton January 23, 2002 who noted the worker was able to manage his flooring company but was not able to do any physical work at all. He noted the worker had been sent to an aggressive physiotherapy program by the Board during the summer and during a course of neck traction had begun to experience severe pain in the neck going down the right arm, which had continued on after that point. He noted the worker was hard to examine because of his discomfort. Dr. Parton's impression was:

> His presentation could suggest a causalgia or reflex sympathetic dystrophy and I am not entirely certain that this is the case as we don't have any specific diagnostic test for it. I usually recommend Neurontin 400 tid to build up to 800 tid or qid over a week or two and see if might get

> a handle on it. It might also be reasonable to have him on an oral long lasting narcotic preparation to see if it gives him a bit more relief in the day. I also gather he has some ongoing battles with WCB, who have cut him off and no longer recognize his claim.
>
> I don't think there is any role for any further investigation such as a repeat MRI, etc. He seems convinced that he had a very terrible neck injury from this traction and perhaps you could enlighten me as to what went on then.
>
> I also wonder if there may not be a role for a stellate ganglion block for therapeutic and diagnostic purposes, but until the situation is a bit clearer I wouldn't recommend it right now.
>
> [reproduced as written]

On February 21, 2002 Board medical advisor Dr. D. Jarman examined the worker. Dr. Jarman was of the opinion the worker likely had a musculoligamentous injury with perhaps a neuropathic component. Dr. Jarman did not feel there was evidence of reflex sympathetic dystrophy but he approved the use of localized anaesthetic blocks. Dr. Jarman felt that if treatment aimed at improving the pain levels were unsuccessful the worker could be referred to a pain management program. This would not be to treat the pain itself but to help the worker learn methods for coping with pain, irritability and sleep disturbance. Dr. Jarman said that historically people with pain syndromes similar to the worker's experience gradual improvement over a prolonged period of time. Subsequently, on March 11, 2002 Dr. Jarman referred the worker to Dr. Berkman at the pain clinic for assessment.

The worker was seen by Dr. Berkman on April 25, 2002 who felt the worker had a type I complex regional pain syndrome (RSD). The worker was provided with a stellate ganglion block. The worker was reassessed by Dr. Berkman on May 3, 2002 who noted that following the original injection the worker had experienced some reaction problems. These had resolved, however, the block had produced no lasting change in the worker's symptoms. Following the first block the worker had some initial improvement and therefore a second block was provided. The worker had a negative reaction and the doctor felt therefore further blocks would not take place. It was determined he should be provided instead with an intravenous sympathetic block. This procedure took place May 24, 2002. When reviewed on June 3, 2002 the worker's condition was basically unchanged and a second intravenous block was performed.

The worker next saw Dr. Berkman on July 19, 2002 who recorded the worker as saying that following the second intravenous block there had been some partial relief (30 to 40 percent) of his pain for approximately two days. The doctor noted the worker had ongoing symptoms consistent with chronic pain syndrome. Dr. Berkman noted a treatment used by a doctor in Toronto in circumstances similar to the worker's which involved a sodium Amytal infusion as a therapeutic agent. Dr. Berkman said:

> I had a length discussion with [the worker] with regard to trying this as an alternative, since none of the procedures to date have given him any long term benefit. This may be due to altered processing of the pain signals in the brain, which are constantly maintaining his current pain state. The sodium Amytal is supposed to have a mechanism in suppressing the pain pathways centrally and various receptor sites and has been shown over the years to be effective. I discussed the risks of the procedure, including prolonged sleep post procedure and the potential for respiratory depression and prolonged drowsiness, the patient seemed satisfied with the discussion, and was keen to proceed.
>
> [reproduced as written]

The procedure was booked for one week post-examination due to the four hour recovery phase and limited bed space.

The proposed procedure took place as planned and initially, during the procedure, the worker reported that his pain had almost disappeared, however, when the worker awakened in the recovery room he informed the nurse there had been no change to his pain levels.

On July 21, 2003, on referral from Dr. Jarman, the worker had an MRI of his cervical spine with the following findings:

> At the C3-4 level, a small broad based right paramedial disc protrusion is noted measuring 2mm in maximal AP dimension. Despited (sic) its small size, the protrusion posteriorly indents the anterior aspect of the cervical cord at this level. The minimal diameter of the spinal cord is 10mm.
>
> At the C4-5 level, a right paramedial mild broad based disc protrusion is noted measuring approximately 3mm in maximal AP dimension. It abuts and posteriorly displaces the anterior aspect of the cervical cord. Minimal spinal cord dimension at this level is 10mm.
>
> At the C5-6 level, a mild generalized disc bulge is noted which effaces the anterior CSF space.
>
> At the C6-7 level, a mild disc bulge is noted, more prominent to the right of midline. There is effacement of the anterior CSF space abutting the right anterior aspect of the C6-7 cord. Minimal spinal cord dimension is 11mm.
>
> The intervertebral foramina appear widely patent.
>
> Signal intensity within the visualized cervical cord is normal.

> IMPRESSION: C3-4 and C4-5 right paramedial disc protrusions resulting in mild acquired spinal stenosis.
>
> [reproduced as written]

On August 1, 2003, the worker's attending physician, noting the results of the MRI referred the worker back to Dr. Parton.

The MRI was reviewed by Dr. Hemmerich whose opinion was that the acquired spinal stenosis identified on MRI would not be considered secondary to the work injury under the claim.

On December 18, 2003 an oral hearing was held to discuss the worker's appeal. The worker attended accompanied by his union representative. The employer was represented at the oral hearing.

At the outset of the oral hearing it was noted that subsequent to the decision letter appealed the worker provided the Board with some earnings information. On October 25, 2001 the Board sent the worker an appealable decision letter indicating the information submitted was unacceptable and explained to the worker what type of information was acceptable. The issue of whether the worker is entitled to wage loss benefits either under section 29 or 30 of the Act, therefore, remains an open issue. If and when the worker supplies the Board with acceptable proof of earnings, the Board will be able to determine his entitlement, if any.

The worker's entitlement to further investigation with respect to his ongoing problem, including an MRI, which was denied in the August 29, 2001 letter has become a moot issue in light of the fact that the Board, subsequent to the appealed decision letter, accepted the need for and authorized an MRI.

In light of the above, the issue remaining for this panel to address is whether the worker is entitled to be examined for permanent functional impairment (PFI) to determine whether he has been left with a residual impairment as a result of his December 15, 2000 compensable injury.

At the oral hearing the worker said that while he was attending Rehabilitation in Motion he was placed in an exercise program and was provided with treatment by way of "traction." The worker said at first the traction treatments went well, however, at one point the tester left the room and the machine continued to apply increasing traction, following which the worker's problems increased significantly. The worker said following the traction incident he returned to his attending physician and showed him the discolouration which had increased in his hands. He said there was pain and tingling on the right side of his head, right side of his face, down the right arm, down the right leg from his waist through his buttock. The worker said he also has problems with both bladder and rectal bleeding.

The worker said he had received nerve blocks in his hand, spine and neck, provided on three separate occasions by Dr. Berkman. These blocks were of no assistance.

The worker said for some time prior to the day of injury he had been working for the accident employer and had been laid off. Following his layoff he became self-employed and when he was called back to work from layoff he kept his business running. This was accomplished by the worker hiring other people. Subsequent to his December 15, 2000 compensable injury the worker's other business continued to operate with the worker only finding the jobs and doing the paperwork. Further, the worker supervised the people who did the actual work and the worker did only very minimal work physically. On questioning, the worker said the business, while still operational, had gone dormant from about December 2002. The worker said his doctors have seen his drooping eye and almost useless right hand. He said he continues to have a lot of pain and suffering.

The worker said the December 15, 2000 incident injured both sides of his body, worse on the right. Up to the time of the traction incident at the Rehabilitation in Motion the worker said his condition was beginning to resolve. After that, however, his right side just continued to worsen. On questioning the worker said his condition at present continues to worsen.

Reasons and Findings

Prior to the December 15, 2000 compensable injury there is no evidence to indicate the worker had any physiological problems or pre-existing conditions which were likely to have contributed to his subsequent ongoing complaints. The Board was well aware of the exacerbation/injury sustained by the worker while at the Rehabilitation in Motion program prior to the issuance of the decision letter under appeal. The first mention of this injury appears in a claim log memo dated August 15, 2001. An investigation was initiated by the Board and Board medical advisor Dr. Hemmerich said it was unlikely the proposed RSD diagnosis by Dr. Parton was related to the compensable injury but he agreed the traction at the rehabilitation program could have aggravated the soft tissue injury accepted under the claim. Dr. Hemmerich felt, however, the aggravation was more likely to be short than long-term. On March 14, 2002, Board medical advisor Dr. Jarman said the worker had been referred to an anaesthetist for nerve blocks. He also said it would be unlikely the worker would be successful at a return to work requiring repetitive use of the right arm or work requiring exposure to cold environments.

On August 11, 2003, Board medical advisor Dr. Hemmerich said he had reviewed the radiologist's report from a recent cervical MRI and compared it to the previous MRI report and findings on examination by both Dr. Jarman and himself. The second MRI report was noted to have shown a minor amount of acquired spinal stenosis. Dr. Hemmerich said it was unclear whether the MRI findings noted by the radiologist were

clinically significant. Acquired spinal stenosis, however, would not be considered secondary to the work injury under the claim.

When examined by Dr. Parton it appears the diagnosis of reflex sympathetic dystrophy was not confirmed.

The "acquired spinal stenosis" identified by radiological testing (MRI) has not (based on Dr. Hemmerich's opinion) been accepted as a Board responsibility. No decision letter has been provided to the worker in this regard.

The worker's evidence at the oral hearing is that prior to the traction incident at Rehabilitation in Motion, his injury appeared to be resolving. However, following that incident his condition has worsened and indeed the worker said it continues to worsen as time goes by. While Dr. Hemmerich accepted the traction injury was likely to have caused a temporary aggravation of the worker's soft tissue injury, time has proven him wrong. The worker continues to experience significant ongoing problems and on March 14, 2002 Board medical advisor Dr. Jarman felt the worker would be unsuccessful at returning to work requiring repetitive use of the right arm or work requiring exposure to cold environments. Based on the above, I find the worker has not recovered from his December 15, 2000 compensable injury and since we are now three years post-injury with no resolution in sight he is entitled to be examined for the purposes of determining the extent of any permanent functional impairment. The worker's appeal is allowed.

In summary, the worker's entitlement to wage loss benefits remains an open issue which requires him to provide the Board with acceptable documentation with respect to earnings. Once he has complied with this the Board can determine his entitlement to wage loss benefits under section 29 or 30 of the Act. The denial of medical treatment, specifically an MRI, is a moot issue since the Board subsequently approved and authorized that treatment.

In reading the claim file it appears the Board is not prepared to accept a radiologic finding of acquired spinal stenosis identified on MRI and further is not prepared to accept proposed treatment with sodium Amytal, however, no decision letter has been provided to the worker with respect to either of these two issues. The worker is entitled to have his condition assessed to determine whether it is at plateau and once plateau has been determined the worker is entitled to be examined for the purposes of permanent functional impairment.

Conclusion

The decision of the Board dated August 29, 2001 is varied to the extent set out above.

Ralph D. McMillan

Vice Chair

RDM/rbe

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