WCAT Decision Number: WCAT-2004-00036-RB
WCAT Decision Date: **January 08, 2004**
Panel: David A. Cox, Vice Chair

Introduction

The worker has appealed the January 31, 2002 decision of an officer of the Workers' Compensation Board which terminated her wage loss and health care benefits on January 25, 2002. She was informed there was insufficient objective medical evidence to support further disability and that her continued employment would not exposure her to risk factors.

Issue(s)

Was the worker entitled to temporary wage loss and health care benefits beyond January 25, 2002?

Jurisdiction

This appeal was filed with the Workers' Compensation Review Board (Review Board). On March 3, 2003, the Appeal Division and 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.)

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

Background and Evidence

On May 29, 2001 the worker was employed as a bank teller. She made application to the Board on June 7, 2001 for a right shoulder injury. The July 12, 2001 claim log memo of a case manager recorded that the worker's employment required her to stand at a counter which was too high. In the result, the worker had to perform her teller functions with her arm/shoulder elevated to approximately 70 to 80 degrees. This was evident for all of her job functions except for the tasks that required the use of a cash drawer. The memo reported that the worker had noticed a gradual onset of her shoulder symptoms in the fall of 2001 and had initiated massage therapy. An

ergonomic assessment had been completed in January 2001 by an occupational therapist who had also noticed that the height of the desk top and the computer set up was not appropriate. The worker had increased symptoms and attended her physician in May 2001 and also started physiotherapy treatment the first week of June 2001.

In correspondence to the worker dated July 12, 2001, the case manager advised the worker that effective on May 29, 2001 her claim had been accepted for a right shoulder rotator cuff tendonitis. This decision letter noted that, despite recent change in the workstation in mid-May, the overall counter top height had not been altered at the worker's site of employment. The case manager had been advised by a manager of the accident employer that the branch would soon be relocated and that the height of the counter top would be addressed at that time. In the meantime, the worker was advised to consider increasing the height of her walking surface with an anti-fatigue mat. She was informed that her physiotherapy treatments up to eight weeks would be authorised by the Board.

The progress report of the attending physician, based on treatment of the worker September 28, 2001, reported that a stress mat was to be introduced at the worker's job site in order to raise her chair. The physician stated that once this was in place, the worker could begin a graduated return to work with the first two weeks at two hours per day and the second week at four hours per day. Physiotherapy was to continue over the course of those four weeks. The physician stated the worker would then increase her hours to six for two weeks with no physiotherapy and then to full days.

A progress report based on treatment of the worker November 13, 2001, noted that the worker's shoulder had improved and plateaued. The physician noted that there had been partial improvement in the worker's workstation but that the worker still had to work with her arm elevated at her counter and presently worked only four hours per day. The physician noted that the treating physiotherapist had not been satisfied with the worker's level of improvement and felt that the worker would benefit from an MRI.

An MRI of the worker's right shoulder was undertaken December 11, 2001 and the claim log memo of a Board medical advisor dated December 14, 2001, stated that the MRI had revealed tendonopathy or a partial tear of the right supraspinatus tendon.

The December 18, 2001 claim log memo of a nurse advisor set out the opinion that further physiotherapy was not recommended for the treatment of the worker and that pain management techniques as well as a home-based exercise program were needed in order for the worker to progress with her graduated return to work.

The January 10, 2002 progress report of the attending physician noted the worker was at work, four hours per day. It was also noted that there had been a further workplace assessment. Further modifications were needed to the worker's workstation. The attending physician felt the worker needed to continue with physiotherapy treatment.

A Board medical advisor, in a claim log memo dated January 17, 2002, reported that a site visit at the bank had been undertaken. The physician noted, after observation of the workstation, that although the front desk height was higher, it did not, in the Board medical advisor's opinion, pose an undue ergonomic risk upon the right shoulder. The medical advisor stated the opinion that there was no contraindication for the worker to return to full duties immediately. The medical advisor noted that the work duties did not involve repetitive activities of the right shoulder in greater than 60 degrees of abduction or 60 degrees flexion nor did they involve force or right shoulder movements in awkward postures.

The progress report of the attending physician, based on treatment of the worker January 18, 2002, noted no improvement in the worker's symptoms and that the worker could not get beyond four hours per day at work. The physician noted that the workstation had still not been altered and that the worker needed to continue with physiotherapy treatment. The physician recommended that the worker continue at her graduated return to work at four hours with a follow up in two weeks.

The January 31, 2002 claim log memo of the case manager reviewed the Board medical advisor's opinion and stated that additional benefits would not be extended to the worker as there were no current risk factors in her workstation. The worker was informed that the counter top height did not represent a risk factor for injury but merely a "comfort or perceived comfort issue". The worker was also advised that the employer had ordered an automatic stamp and that the worker would not be required to use her hand or arm at all, other than writing or counting money. She was advised that she could write on her computer workstation platform which was lower than the counter top.

The Board then issued the January 31, 2002 decision from which the worker has appealed.

The progress report of the attending physician, based on treatment of the worker February 1, 2002, documented that the worker continued to be sore at the end of her four hour workday and that her workplace had not underwent major modification. The attending physician requested that the Board arrange an orthopaedic specialist referral and recommended that the worker continue at her graduated return to work at the present level. The physician stated the worker could not go above four hours per day.

In a progress report based on treatment of the worker February 5, 2002, the attending physician stated that the worker's shoulder was better as she had performed less stamping at work and in the result, the worker was to attempt a five hour day the following week and then a six hour day the week after. The physician estimated the worker could resume full duties on February 25, 2002.

A telephone memo dated March 7, 2002 recorded that the case manager had spoken with the attending physician who had requested an orthopaedic referral. When asked if this was in response to the MRI that had shown a tear, which was not accepted under claim, the physician had replied that the understanding of the MRI was that it was either a tendonopathy or a tear and that if it were a tendonopathy, it might require decompression.

The physician reported that the worker had returned to full hours after her claim had been concluded by the Board and was not doing well.

The case manager stated that while there were no extreme risk factors evident, the worker's claim had been accepted based on the worker's statement that she had to write a lot on the front counter which was not at an ideal height. The case manager stated the worker however, had not been required to lift her arm above 60 degrees which was the general requirement for the worker's type of injury.

In correspondence to the Board dated March 19, 2002 the attending physician set out that the main consideration was whether the worker had any pathology based on her repetitive injuries at work in a rather non-ergonomic setting. The doctor stated that the MRI clearly showed either a partial tear or tendonopathy of the rotator cuff. The physician repeated that an orthopaedic surgeon's assessment as to whether or not a decompression procedure would be helpful was necessary.

A July 2, 2002 report of an orthopaedic surgeon provided the impression that the worker had a rotator cuff tendonopathy of her right shoulder and that surgical options had been discussed. The specialist also reported that a steroid injection had been undertaken and that the worker no longer had pain with resisted external rotation and abduction but still had pain with forward elevation. The specialist stated that if after six weeks, the worker still had discomfort, she could return for review and it would be decided whether a surgical acromioplasty and rotator cuff exploration was to be undertaken.

The November 5, 2002 report of an orthopaedic surgeon set out the impression that the worker had a rotator cuff tendonopathy of the right shoulder. The physician stated that the worker had underwent extensive conservative treatment and that the last remaining option was surgical intervention.

The orthopaedic surgeon noted:

> …It has been four months since I last reviewed her. She has ongoing shoulder discomfort. She had an injection in June and then was off for about six weeks didn't have a lot of shoulder discomfort during this period of time. She went back to work in August for two weeks and then had some increased discomfort. She was off for two weeks at the end of August and then has been back full time since. Her pain is constant now…

[reproduced as written]

In correspondence received by WCAT on September 22, 2003, the worker submitted that, after her benefits had been discontinued on January 25, 2002, she had continued exposure to risk factors in her workplace. As well, there was medical evidence of her injury. The worker stated that since the case manager's July 12, 2001 decision letter, approximately 80 percent of her workload still had to be completed on a work top that was at the same height. The worker stated that the case manager had contradicted herself in the January 31, 2002 correspondence which concluded the worker's benefits. The worker submitted that since her work surface had not changed in height, how could the case manager in July state that there were risk factors sufficient enough to allow her claim and then in January say that there were not any. The worker also noted that the automatic stamping machine had not arrived. The worker stated that she found it difficult to work a five hour day and that after four hours her shoulder was extremely sore. The worker stated her workstation had not been improved and that in her opinion, her claim should remain open pending the evaluation of an orthopaedic surgeon.

Reasons and Findings

The initial acceptance of the worker's claim for a right shoulder rotator cuff tendonitis was premised by the view of the case manager that specific risk factors were present in almost all of the worker's job functions. However, upon receipt of the Board medical advisor's opinion, the case manager explained that the claim had been accepted; based

> …on the worker's statement that she had to write a lot on the front counter which wasn't at an ideal height for her. I assumed that there may have been some postural problems regarding her feeling that she had to "lift" her shoulder while writing. She wasn't lifting her right arm above 60 degrees, etc. which is the general requirement for this type of injury.
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> [reproduced as written]

The decision to conclude the worker's entitlement to temporary partial disability wage loss benefits relied on a Board medical advisor's opinion that the worker's employment had not exposed her to any undue ergonomic risk upon her right shoulder. The Board medical advisor made no specific reference to the available medical evidence as supplied by the attending physician in the form of progress reports.

The reasoning presented by the case manager to conclude wage loss benefits did not, in my opinion, address the reasonableness of the worker's inability to return to full duties. On similar medical findings to those presented to the attending physician proximate to the conclusion of wage loss benefits on January 25, 2002, the case manager was prepared to support a graduated return to work. The influence of the Board medical advisor's opinion contradicted that of the attending physician who reported there had been no improvement in the worker's symptoms in mid-January 2002 and that the worker had been limited by pain and spasm.

Wage loss benefits pursuant to sections 29 and 30 of the *Workers Compensation Act* (Act) as set out at the time of the case manager's decision, were that these benefits were payable, "only as so long as the disability lasts". The Board medical advisor's opinion alone, that there were no ergonomic shoulder stressors in the workplace, did not recognise that the worker's claim had been accepted and a graduated return to work process initiated.

Paragraph #97.35 of the *Rehabilitation Services and Claims Manual*, *Volume 1* (RSCM) provides that where a treating physician has expressed an opinion that a claimant is disabled from employment by reason of a compensable disability the adjudication of the claim may rely upon the overall existing medical evidence from a physician who has examined the worker or other substantial evidence on the file in order to reach a conclusion contrary to that opinion.

I find there is insufficient supportive medical evidence that the graduated return to work had proven successful in aiding the worker in a return to her pre-injury status. The attending physician had provided clear indication that full time status had not been reached and also that the worker required further physiotherapy treatment and a referral to an orthopaedic surgeon. The Board medical advisor's opinion was not accompanied by any observations or clinical analysis why a return to work to full duty was not contraindicated. I therefore prefer the opinion of the attending physician that the worker had not reached a functional capacity for full duties as a teller on the date the graduated return to work was concluded. The attending physician did clear the worker to resume full duties on February 25, 2002 (progress report February 5, 2002). I find the worker is entitled to section 30 temporary partial wage loss benefits to this date.

The claim file contains reference to the worker's absence from employment due to her diagnosed tendonopathy after the orthopaedic surgeon's consultation in July 2002 and a return to work in mid-August 2002. The orthopaedic surgeon's consultation report also documented the worker's inability to work for a short time frame near the end of August.

I recommend the Board consider if these and/or any other absences from employment after February 25, 2002 entitled the worker to a reopening of her injury claim. I draw the Board's attention to the consultation reports of the orthopaedic surgeon with regard to the worker's proposed shoulder surgery. Noting the orthopaedic surgeon's request, the Board should advise whether this surgery is authorised under the injury claim.

Conclusion

The Board's January 31, 2002 decision is varied. I find the worker entitled to section 30 wage loss benefits up to February 25, 2002. I recommend that the Board investigate and determine whether the worker is entitled to a claims reopening for further time loss from employment and to consider authorisation of the surgery proposed by the treating orthopaedic specialist.

If the worker has incurred any costs for the March 19, 2002 report of the attending physician or the orthopaedic surgeon's consultation report of November 5, 2002, she is entitled to be reimbursed up to the amount of the Board's tariff agreement with the British Columbia Medical Association.

David A. Cox
Vice Chair

DAC/cmm

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