WCAT Decision Number: WCAT-2004-00066-RB
WCAT Decision Date: **January 09, 2004**
Panel: David A. Cox, Vice Chair

Introduction

The worker appeals from the October 25, 2001 decision of an officer of the Workers' Compensation Board (Board) which informed him that his recent left elbow complaints for which he had received medical attention in October 2001 were unlikely to be related to his June 17, 1986 injury claim. The case manager disclosed to the worker that there was a lack of continuity of medical treatment; no mention of ongoing problems to the employer combined with the late development of his problems. The case manager reiterated the opinion of a Board medical advisor who had advised that it was unlikely that the worker's recent left elbow problems were related to his 1986 injury claim.

Issue(s)

Was the worker's left elbow condition in October 2001 related to his left elbow injury claim of June 17, 1986? If so, was the worker entitled to a reopening of the June 17, 1986 injury claim?

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).

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Background and Evidence

On June 17, 1986 the worker, then a sawmill employee, was straightening a log with a picaroon when he slipped and fell backwards, striking his left elbow on a steel floor. The physician's first report diagnosed an olecranon bursitis. Subsequent treatment included draining of fluid from the elbow. A left elbow radiograph undertaken on June 28, 1986 showed a history of injury with no evidence of a fracture.

A Board medical advisor in a claim log memo to file dated July 10, 1986, stated the bursitis appeared to be due to the blow the worker had suffered on June 17, 1986.

On June 17, 1986 the worker reported that he had further injured his elbow while pulling cable. The Board medical advisor in a claim log memo dated November 20, 1986 set out the opinion that the olecranon bursitis had been present when the worker had re-injured his elbow and that the new injury had merely aggravated the bursitis due to the original injury.

In a hand written memo to file dated November 28, 1986 it was noted that the second incident would be accepted under the injury claim.

A diagnostic imaging service report based on multiple views of the worker's left elbow taken October 2, 2001, noted a history of trauma with no acute fracture identified. Olecranon spurring was identified with mild spurring in other areas of the elbow.

The progress report of the attending physician based on treatment of the worker October 2, 2001, noted the worker was to be referred to an orthopaedic surgeon.

The October 9, 2001 report of the orthopaedic surgeon divulged that after the worker's injury in 1986, his elbow seemed to have settled but over the last few years the worker had developed elbow symptoms. The surgeon was of the opinion that the patient's symptoms were coming from an olecranon spur and a thickening of the bursa. The surgeon recommended that the bursa and the spur be excised.

The worker completed a reopening questionnaire and returned it to the Board on October 12, 2001. In that questionnaire the worker recorded that his left elbow had bothered him since November 1986 and had progressively worsened. He stated he had been able to perform all phases of his work despite his worsening elbow condition. He stated he had not sought medical treatment since November 7, 1986 and had not made a habit of complaining to his co-workers or his employer concerning the condition of his left elbow. Furthermore, he stated that nothing unusual had happened to aggravate his condition and that prior to October 2001 he felt he had been able to live with his elbow. Due to his worsening problems he had finally reached a point that he needed medical attention. The worker recorded that his only time loss was to attend an appointment with the orthopaedic specialist.

A Board medical advisor in a hand written claim log memo dated October 24, 2001, set out the opinion that an olecranon bursitis which had occurred 15 years previously was of minimal likely relation to an elbow problem in the year 2001. The Board medical advisor set out the opinion that the olecranon spurring might well be a congenital condition with an unlikely relationship to the compensable injury of 1986.

The October 25, 2001 decision from which the worker has appealed was then issued.

The treating orthopaedic surgeon in a consultation report dated February 28, 2002 responded to the worker's request for information on his left elbow. The orthopaedic surgeon stated that it was "very unlikely" that the surgeon could tell at surgery whether the left elbow condition had been caused by an injury in 1986. The surgeon stated that it was possible that the recent problem was associated to that injury. However, the specialist was not able to be more definite.

A submission dated April 19, 2002 was received from the worker's union in support of his appeal. The union representative noted that the worker underwent surgery on his elbow March 13, 2002 and characterised the need for that surgery as due to a flare-up of the worker's 1986 injury. The representative referred to the orthopaedic surgeon's opinion and added that the worker's physician in 1986 had informed the worker that he might have future problems with his elbow. However, the representative stated there was nothing in writing to confirm that opinion. Nonetheless, based on the orthopaedic surgeon's letter, the representative felt that there was at least an even possibility that the worker's left elbow problems were related to his injury in 1986 and should be considered under paragraph item #97.10 of the *Rehabilitation Services and Claims Manual*, *Volume 1* (RSCM).

Reasons and Findings

Policy items #107.00 and #107.10 of the RSCM provides that in order to consider a claims reopening there must be evidence that an initial injury had causative significance in relation to the symptoms reported at the time of the reopening request. Where there has been a recurrence of the original compensable injury symptoms with no intervening cause, a reopening may be considered.

In the case before me, in November 2001 the worker requested a reopening of his 1986 left elbow claim from which he had suffered no time loss. There are a number of criteria that need to be satisfied in order to establish a causative link between the worker's need for medical attention in 2001 and a diagnosed olecranon bursitis in 1986. If an association is to be evident, I would expect a continuity of medical complaints and treatment over the intervening time frame. The worker reported to the orthopaedic surgeon that his elbow had initial settled down and that he had went on only to develop increased symptoms approximately 15 years after injury. Despite the worker's evidence that his condition had gradually progressed in severity, he made no report to the Board, his employer, physician or co-workers in order to corroborate ongoing symptoms in

relation to the 1986 injury. The worker also denied any intervening event, compensable or non-compensable, to account for the progression of his symptoms.

The worker's representative referenced policy item #97.00 of the RSCM. This policy provides that there is no burden of proof on the claimant. The policy further states that some basic evidence must be submitted by a worker to establish a proper claim. There must be more evidence than hindsight in order to conclude that a claim has been fairly established.

The orthopaedic surgeon's opinion on the likelihood of a relationship to the original injury claim was not definitive. The Board medical advisor's opinion was that a causal relationship was unlikely. I do not consider the lack of certainty in either of these opinions to favour the position of the worker. The case manager has adequately recorded the lack of supportive evidence in the reasoned October 25, 2001 decision letter. In combination with that reasoning, I find the Board medical advisor's opinion compelling. Paragraph #97.00 of the RSCM sets out that the correct approach to adjudication is to examine evidence and conclude whether it is sufficiently complete and reliable upon which to arrive at a sound conclusion. If, on weighing the available evidence, there is a preponderance in favour of one view over the other, that is the conclusion that must be reached.

This is not a case where the weighing of evidence leads to a conclusion that the disputed possibilities are evenly balanced. The whole of the evidence leads to a conclusion in support of the case manager's decision. In accordance with policy item #97.00, I find the fundamental facts needed to establish a reopening are not present.

Conclusion

For the foregoing reasons the Board's October 25, 2001 decision is confirmed. No costs are allowed.

David A. Cox
Vice Chair

DAC/cmm