WCAT Decision Number: WCAT-2004-00091-RB
WCAT Decision Date: **January 12, 2004**
Panel: David A. Cox, Vice Chair

Introduction

The worker appeals from four separate decisions of officers of the Workers' Compensation Board (Board). The first, dated October 19, 2001 concluded the worker's temporary wage loss benefits at the date of her discharge from a work conditioning program on October 17, 2001. The worker was informed that at that date the Board considered she was no longer disabled.

Correspondence to the worker from a case manager dated December 27, 2001 informed her that prior decisions made on claims of September 18 and October 19, 2001 would not be changed. The worker was informed that under the October 19, 2001 decision no new medical information had been received to indicate the worker was not fit to return to work as recommended.

The case manager also reviewed a request to use a longer period of earnings in order to set the worker's wage rate. Upon review, the worker was informed that her one-year earnings prior to injury best represented her actual loss of earnings by reason of the injury with regard to future earnings.

In correspondence to the worker dated August 20, 2002 a case manager informed her that a carpal tunnel syndrome would not be accepted under her injury claim and that the case manager would not authorize any further proposed treatment of the worker's neck.

September 12, 2002 correspondence basically reiterated that, on the basis of a Board medical advisor's opinion, there would be no authorization for treatment to the worker's neck or a specialist's appointment. In the result, the August 20, 2002 decision would not be changed.

Issue(s)

Was the worker fit to return to work at the date of discharge from the work conditioning program?

Did the worker have entitlement to temporary total disability benefits beyond October 17, 2001?

Were the worker's earnings in the one-year prior to injury the best representation of her long-term earnings wage rate?

Was the Board provided significant new information from which to change the October 19, 2001 decision?

Was the worker's diagnosed carpal tunnel syndrome acceptable under her injury claim?

Did the worker have entitlement to further treatment to her neck in the form of a percutaneous facet rhizotomy and authorization to seek further specialist's consultations?

Jurisdiction

These appeals were 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 these appeals had not been considered by a Review Board panel before that date, they have been decided as WCAT appeals. (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 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 and law arising or required to be determined in an appeal before it (section 254).

This is an appeal by way of rehearing, rather than a hearing *de novo* or an appeal on the record. WCAT has jurisdiction to consider new evidence, and to substitute its own decision for the decision under appeal.

Background and Evidence

On July 23, 2001 the worker was employed as a chambermaid. While in the course of her employment sorting laundry, she was struck on her head and neck by a heavy bundle of laundry containing sheets and wet towels. The laundry had been thrown from the floor above her.

The worker attended emergency services at a hospital complaining of neck pain. The physician's progress report based on treatment of the worker July 25, 2001 reported that the worker had increased neck pain, numbness of both hands and tingling in her left hand. The physician diagnosed a neck strain and estimated the worker would miss 14 to 20 days of work.

A medical imaging report dated July 26, 2001 set out that x-rays of the cervical spine showed normal facet joints with no bone injury. Degenerative changes were also noted.

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The August 10, 2001 memo of a client services representative noted that the worker's claim would be accepted for a left and right neck strain which had occurred on July 23, 2001.

A physiotherapist report dated August 20, 2001 reported the worker had decreased range of motion in her neck and was not capable of performing full duties due to a "severe" injury. The physiotherapist commented that slow progress had been made due to severe neck pain and that initially the physiotherapist had been unable to massage or mobilize the patient due to pain and headache.

The worker was assessed at a work conditioning program on August 28, 2001. A discharge summary report of that date recorded that the worker was not ready to participate in the program and needed to continue her therapy and work on cervical flexion.

Subsequently, the worker was admitted to a work conditioning program on September 12, 2001. The intake assessment report of that program recorded that she had made progress with subjective reports of pain reduced and improved mobility of the cervical spine.

A medical imaging report dated September 12, 2001 set out the findings of an MRI of the worker's cervical spine as mild disc bulges present at C3-4 as well as C4-5 and C5-6.

A physician's progress report, based on treatment of the worker on September 24, 2001, noted no improvement in the worker's condition and that the work-hardening program had worsened her condition. The worker reported that both hands were numb and the physician questioned a nerve impingement.

The intermediate report of the work conditioning program dated October 2, 2001 noted that although the worker had made slow but steady progress she still had headache and neck pain.

A claim log memo dated October 16, 2001 contained a work conditioning program update which noted that the worker still complained of headache. The program supervisor felt that she demonstrated the ability to perform her pre-injury employment. It was noted that the program representative had spoken with the worker's physician who had been in agreement but had suggested that the worker not return to work until

she had seen a specialist. It was noted that there were no hard neurological signs. The memo further stated that the worker had been contacted and advised that the opinion of the therapist would be accepted over that of the attending physician and that the worker's wage loss would be concluded.

The October 18, 2001 discharge summary report of the work conditioning program set out that the worker had reported no improvement in her neck pain during the work conditioning program and also complained of constant pins and needles in both hands. Lifting and carrying, the worker reported, aggravated her condition and she felt she was not capable of a return to work.

The report provided that the worker remained guarded in her cervical mobility which was close to full, with pain at the end range of motions. In the physiotherapist's opinion the worker had progressed moderately well in terms of mobility and tolerance to activities. Overall, the therapist noted that the worker remained limited by pain and that she was still recovering from an upper cervical flexion injury which would continue to cause her pain for a couple of months. The therapist recommended that the worker attempt a return to work since her work was part time.

The October 19, 2001 decision from which the worker has appealed was then issued.

A claim log memo dated October 23, 2001 set out that a family member of the worker had reported that the worker had been out of country for a month and one-half due to an accident of a family member. It was noted that the worker had been employed by the same company for 10 to 12 years and a request to consider three-year earnings was forwarded.

The October 31, 2001 report of a neurosurgeon set out the impression that the worker had radicular pain, mainly along the C5-6 nerve root on the left side. In addition to that the neurosurgeon reported, the worker had myofacial pain in the cervical region. In the neurosurgeon's opinion, the worker had not responded to conservative treatment and recommended an MRI scan of the cervical spine.

A team meeting medical review memo dated November 27, 2001 set out that although it was estimated by the work conditioning program that the worker was fit to return to work, the neurosurgeon had reported objective findings of radiculopathy and an MRI was pending. The report stated the opinion that in view of the worker's pain behaviour, there would have to be unequivocal MRI findings to justify surgical treatment. The memo set out that upon release from the work conditioning program it was recommended that the worker return to work and that she had "declined to do so".

A telephone memo dated November 28, 2001 under the heading 'Employer Contact' recorded that the case manager had asked the employer to provide an explanation why

the worker's earnings were lower in the last year than in the previous three to five years. The employer had explained that in the last six years there had been an economic downturn and all workers had taken cuts. For instance, the employer's representative explained, the worker formally worked in laundry and rooms and now only did laundry and was not needed every day. The employer could not say whether the business was likely to improve and stated that the one year previous was more likely to represent the future.

A further telephone memo dated November 28, 2001 reported that the case manager had reviewed the worker's claim with the worker's daughter. The memo stated that work conditioning program recommendations had been reviewed as well as team meeting notes which indicated that, while the claim had been accepted for a neck strain, the neurosurgeon had requested an MRI based on degenerative changes in the worker's neck. The case manager noted that the Board would refer the worker to an MRI to see if there was a claims-related injury, but there was no indication the worker could not return to work.

The wage rate issue was also reviewed and it was explained that it would not be appropriate to use three or five-year earnings prior to injury.

In a follow-up report dated December 20, 2001, the neurosurgeon noted the worker continued to have neck pain and numbness in her hand, worse on the left than the right.

The December 27, 2001 decision from which the worker has appealed was then issued.

The neurosurgeon, in a February 18, 2002 report, noted that the MRI scan indicated the worker had a symptomatic disc problem at C4-5. The neurosurgeon stated that the patient's neck pain may or may not have been related to the disc bulges, but most likely were muscle injuries from the accident. Secondly, the neurosurgeon stated that the left hand problem could be a carpal tunnel syndrome. The specialist recommended a consultation with a neurologist with regard to the carpal tunnel and recommended conservative treatment for the neck. The worker had been assured, the neurosurgeon stated, that her pain would improve without surgery.

The consultation report of a neurologist dated May 21, 2002 set out the clinical impression that the worker had non-specific soft tissue neck pain with no evidence of cervical radiculopathy. The worker's condition could be managed conservatively and the neurologist stated that based on electrophysiological study findings the intermittent bilateral hand numbness was related to a carpal tunnel syndrome. This was seen as a relatively minor complaint which could be treated conservatively.

The neurosurgeon, in a consultation report dated May 31, 2002, noted the worker still complained of significant neck pain, difficulty with sleeping, sitting for long periods and restricted neck motion.

The neurosurgeon recommended a percutaneous facet rhizotomy although the procedure worked in only 50 percent of patients. The neurosurgeon also noted that the carpal tunnel syndrome although mild, continued to cause the worker persistent nocturnal paresthesia and pain on activity.

The August 20, 2002 decision from which the worker has appealed was then issued.

The August 28, 2002 memo of a Board medical advisor provided that an MRI had shown three-level degenerative disc disease with no lesion specifically attributable to the claim incident to account for the worker's symptoms. Therefore, in the Board medical advisor's opinion, it was not relevant to the current issues and the diagnosis on claim should not be changed.

With regard to the facet rhizotomy, the Board medical advisor stated there was little chance of effectiveness in a setting of degenerative disc disease and stated there was no good clinical indication that the facet joint was the source of the worker's pain. Also, it was a procedure that was rarely performed in the province and had risks attached. The Board medical advisor therefore stated it would not be recommended or approved under claim.

The September 12, 2002 decision from which the worker has appealed was then issued.

A February 3, 2003 report of the neurosurgeon set out that a cervical facet rhizotomy had been performed December 20, 2003 and that the worker still had pain and was not able to return to work.

With her notice of appeal, the worker furnished a package of documentation from her claim file.

The worker remarked that she had been employed for 17 years with the accident employer and had no complaints of head, neck or back pain prior to her accident. Cervical spine x-rays had proven there was an abnormality in her cervical region.

The worker did not agree that there was no evidence of a permanent functional impairment and stated her injury had proven not to be a simple neck sprain.

The worker stated that she had not refused to return to work but continued to have pain and felt she was not able to perform her job tasks. Under her doctor's instruction she had not returned to work.

The worker also pointed out that the work conditioning program had not corroborated she was capable of full-time employment. In fact, her physician had recommended that she not return to work and that she see a specialist. The worker stated she disagreed with the opinion that her therapist in the work conditioning program was more knowledgeable about her neck condition than her family doctor and stated she continued to have neck pain, decreased range of motion, numbness and tingling in both hands.

In her opinion, the discharge summary report was full of discrepancies and that she was not able to complete functional tasks in relation to her work duties. She remarked that a usual shift at her place of employment was from four to eight hours. She was not a part-time worker and reiterated that she had worked for 17 years and had accumulated top seniority. She had performed whatever amount of work was available every day. She stated that her hours of work were dependant up on the season.

The worker reiterated that the work conditioning program had not helped her and that she continued to be in pain at discharge and did not have a full range of motion. She stated that her main complaint continued to be neck pain and not headaches.

It was reported that the worker did not have a full range of motion in her neck and had not been able to drive since her accident because she could not move her neck freely. She was unable to perform her pre-injury employment due to constant pain.

With regard to the wage rate set on claim, it was submitted that the worker had been off work in December 2000 for approximately four to seven weeks with an illness. The worker disagreed that her one-year prior earnings represented her future loss in that the industry was obviously busier during the July to September months and set out that the worker's four-year past earnings had been furnished to the Board.

An oral hearing was held December 1, 2003. The worker attended and was represented by a worker's' adviser. Also appearing as a witness was the worker's daughter. The appeal proceedings were aided by the interpretation of an interpreter from the Punjabi to the English language.

At the hearing the worker furnished a signed statement documenting her ongoing neck complaints as well as a list of her job tasks as a laundry person. A hand-drawn document was also furnished to describe the geographical set-up of the injury worksite. These documents were accepted as exhibit #2.

The workers' adviser furnished the September 30, 2003 report of the treating orthopaedic surgeon, furnished for the benefit of another worker's claim, regarding the percutaneous facet rhizotomy procedure. The request for opinion to the specialist dated September 30, 2003 from the workers' adviser and the neurosurgeon's response

dated October 28, 2003 was furnished. The neurosurgeon briefly described the procedure and stated it was not a surgery but rather a percutaneous procedure, performed under general anaesthetic. The document stated that there was likelihood greater than 50 percent that the procedure would alleviate chronic pain. The neurosurgeon did not believe that a rhizotomy in a chronic patient would be effective enough for the patient to recover and return to work. However, the physician did not consider it to be a high risk procedure and in the physician's experience, there were good results from acute pain but that a rhizotomy might be required once every two to three years.

The workers' adviser also furnished a handwritten letter to the attending physician requesting comments to a series of questions. This was accepted as exhibit #4 with the understanding that the physician's response would be delivered within three weeks and would form part of the exhibit. The December 1, 2003 report of the attending physician set out the opinion that the level of cervical disc degeneration found at x-ray was not unusual for the worker's age. The attending physician stated that it was more likely than not that the compensable incident had caused her chronic pain and had aggravated the worker's pre-existing asymptomatic cervical degenerative disc disease. The doctor stated that the worker's pain was disabling and that even a small amount of lifting was incapacitating.

On behalf of the worker, the workers' adviser stated that the worker was not fit for a return to work on October 17, 2001 and in fact now exhibited residual symptoms from the compensable injury.

The adviser submitted that the use of one-year average earnings prior to the date of injury was not a best representation of the worker's long-term earnings loss. The adviser stated that a shorter period of time should have been used in order to encompass the busier times of the year when the worker's hours would have been longer.

The adviser also stated that the carpal tunnel syndrome was ongoing and was temporally related to the compensable injury.

The adviser asked that the percutaneous facet rhizotomy be accepted as a Board responsibility and that the worker be referred to Disability Awards on the basis of a continuity of ongoing residual symptoms. The adviser also asked for a recommendation that vocational rehabilitation intervene in order to aid the worker in a return to employment.

The worker's daughter, in answer to the advisers' questions, stated that prior to her compensable injury her mother was able to carry on work and daily living activities pain free. She stated her mother was able to drive her car back and forth to work and enjoyed her work as a chambermaid and laundry person. She described that her

mother, prior to the injury was able to travel, garden and attend her temple on a regular basis as well as put in volunteer hours. Post-injury, her mother had not returned to work, had constant neck pain with all activities and had to rely on medications for pain relief. The daughter stated that her mother was not able to sit at the temple more than 30 minutes and no longer drove her car because of the fact she could not safely move her neck.

The worker briefly described her July 23, 2001 injury after a bundle of laundry, thrown from another floor 15 to 20 feet up, had struck her on the back of her head. She stated she had no neck pain right away but by the next day had pain in the middle and both sides of her neck. She also stated that two to three days after her injury, she had numbness and tingling in her hands, worse on the right.

The worker stated that treatment in the work conditioning program had worsened her condition. She described that over the six to seven weeks of the work conditioning program, even riding a stationary bike proved painful. Although she was able to fold towels for 10 to 15 minutes in the program, the more she did of this activity the worse her neck pain became. In her opinion, she had not been able to return to work at either four hours or eight hours.

The worker described her duties in the laundry room as contained in exhibit #2. She also described that in order to move dry linen from the laundry room to the second floor, she would have to use a dolly. This required her to fill the dolly with dry, clean linen and then push its full weight upwards. She then climbed a set of stairs and reached down through an opening in the floor and pulled up on the dolly by its handle. Sometimes this required her to grab the dolly with two hands. She considered that the approximate weight of the dolly would have been 30 pounds. The worker also explained that this task was completed many times over the course of her shift as she kept up to the washers and dryers. She stated that once she had pulled the clean laundry up with the use of the dolly, she placed the laundry on shelves on the second floor. She stated that from January through June she averaged four hours per shift, Monday through Friday. She stated that between July and October she worked seven to eight hours per day as it was the busiest time of the year. From November to December she would then average four hours. She described herself as the most senior person at the motel. In January 2000 she was moved from her position as chambermaid and at that point did laundry exclusively.

The worker stated that when discharged from the work conditioning program her neck pain was to a point that she could not even do things at home. Activities like reaching and moving her neck increased her pain and she had headaches with too much activity. She also stated that her hands bothered her all the time and that her physician had told her not to return to work. After surgery in December 2002, she stated she had pain relief for approximately two weeks but then her pain returned to the same level. She

stated the specialist had informed her that the right nerve hand not been hit and another rhizotomy was necessary. The worker stated she was awaiting an appointment with a pain clinic and had attempted other treatments such as acupuncture, chiropractic and massage. These modalities brought her short-term relief but her neck pain and headaches had not resolved. She also stated that her hands had a "sleeping" sensation and that she sometimes had swelling in her left hand.

The worker explained that, aside from a high blood pressure problem, she had no prior neck or headache problems over the 17 years with the accident employer. She stated that she had worked a five-day schedule since January 2000 in the laundry room and had only missed work in December 2000 for four to seven weeks because of her high blood pressure. She stated that the trip to England referred to on the file had occurred in 1998.

The workers' adviser referred to exhibit #3 and described that a facet rhizotomy was a non-invasive procedure and not of high risk. Its use of solely for pain and as such should be accepted by the Board.

The workers' adviser stated that the worker had shown a continuity of symptoms since her injury and that there was a basic inconsistency in the case manager's decision and the reports from the work conditioning program. The adviser stated it was evident from these reports that the worker's pain level never changed and that she was not capable of a full range of motion. He stated that the two specialists and the attending physician who had examined the worker did not corroborate the findings of the work conditioning program clinicians. The adviser stated the worker had not demonstrated an ability to return to work at eight hours and even though her hours fluctuated in the low season, the fact that she could not return to eight hours of employment was never investigated by the Board.

The adviser stated the worker's complaints were consistent and that she was limited by her neck pain. He pointed out that the October 31, 2002 report of the neurosurgeon, documented a 50 percent range of motion that was never referred to by the case manager. The worker had also been told by the attending physician to stay off work until the completion of an MRI scan.

The adviser pointed to the November 27, 2001 team meeting claim log memo which he stated, admitted there was objective evidence of a C5-6 radiculopathy.

The work conditioning program, the adviser stated, had only cleared the worker for a limited return to work.

With regard to the wage rate, the adviser stated that the worker's T4 earnings were consistently in the $8,000 to $10,000 range and that the Board had used earnings in a low time of year rather than optimizing her earnings in the high season. In the result,

the adviser stated, use of the full year did not best represent the earnings loss of the worker. He stated that a shorter period of earnings which would have encompassed the higher earnings was more representative.

The adviser stated that, on the basis of the evidence, there was indication that the worker had not fully recovered from her compensable injury and had been left with a permanent functional impairment. Although the worker had undergone further investigation and treatment, these treatments had been unsuccessful and in the result, a referral to Disability Awards was necessary to examine the amount of the permanent residual complaints.

The adviser stated that the worker faced significant limitations and restrictions to a return to work as no light work was available in her pre-injury employment. Therefore, a referral to Vocational Rehabilitation Services was necessary.

Findings and Reasons

October 19, 2001 Decision

The discharge summary report of the work conditioning program, in my opinion, was misinterpreted by the case manager. The physiotherapist clearly reported the worker was limited by pain and was still in recovery from her cervical injury. The therapist estimated the worker's pain would continue for a couple of months and basically recommended she "try" a return to part-time work. The attending physician did not recommend a return to work until "only" after a specialist's appointment. That appointment on October 3, 2001 resulted in the impression of a neurosurgeon that the worker had radicular pain. The specialist recommended an MRI which was covered by the Board on an investigative basis. The specialist's findings were classified as "objective" in a November 27, 2001 team meeting memo. This evidence supports that the worker was not physically capable of a return to full employment as a laundry person. The work-conditioning program discharge did not indicate the worker had demonstrated the capabilities to full work and the prognosis of the treating neurosurgeon suggested an objective basis for the worker's continued neck pain.

Section 29(1) of the *Workers Compensation Act* (Act) provides that payment for temporary total disability will continue only so long as the disability lasts. There is sufficient medical evidence to support a continuation of temporary benefits beyond October 17, 2001. A neurological examination had not confirmed that the worker had recovered from the effects of the compensable injury and pathology had been suggested to account for the worker's ongoing complaints of pain. In fact, in a report dated February 18, 2002, post-MRI, the neurosurgeon opined that the worker's neck pain was related to either a C4-5 disc bulge or, "a muscle injury from the accident".

However, by the date of the MRI's completion, (December 9, 2001) the medical evidence is best represented by the comments of the worker's attending physician that there had been no significant change in the worker's symptoms or examination. A neurophysiological consultation report had led to the opinion that there was no evidence of nerve root compression or cervical radiculopathy but non-specific soft tissue neck pain.

The worker's condition, with the hindsight of her oral evidence, in fact, did not substantially change even after a rhizotomy procedure in December 2003. Also, the worker reported that chiropractic, massage and acupuncture treatment had not improved her condition. I would therefore find that as of December 9, 2001, the date of the MRI scan, the worker's compensable condition was no longer temporary but had plateaued. She is therefore entitled to section 29 wage loss benefits and health care benefits from October 17, 2001 to December 9, 2001 inclusive.

Paragraph #34.10 of the *Rehabilitation Services and Claims Manual, Volume 1* (RSCM) contains a meaning of temporary total disability. The policy sets out that a temporary physical impairment is one which is likely to improve or become worse and is therefore not stable. Policy sets out that ongoing change is a natural feature of human physiology and that impairments resulting from an injury commonly deteriorate or improve over a period of years. An impairment, however, is not considered temporary simply because it is possible that, as the worker becomes older, the condition may change of the worker may have to undergo further treatment. It only remains temporary when such a change can reasonably be foreseen in the immediate future.

Paragraph #34.50 of the RSCM provides that wage loss benefits payable for temporary total disability will be terminated when the worker's physical impairment resulting from the injury ceases to be temporary total, becomes partial, disappears entirely or stabilizes.

Paragraph #34.54 of the RSCM provides that a compensable condition is considered stabilized where there is little potential for improvement.

The medical evidence has established a continuity of symptoms from the date of the compensable injury with a pathology confirmed by the neurosurgeon as related to the injury claim. The evidence leads me to conclude that the worker had not fully recovered from the effects of the compensable injury claim. There is no history, prior to the compensable injury, of any disability or condition related to the worker's neck condition. Although radiological investigations have shown degenerative disc disease with no evidence of nerve root compression, the worker continues with neck symptoms identified as non-specific soft tissue neck pain.

Paragraph #96.20 of the RSCM provides guidelines in order to ensure consistent referrals of all cases where there is a potential permanent disability. The policy states

that where a criteria is met, the Board is required to refer the claim file to Disability Awards. The three criteria set for evaluation of a potential permanent disability include the case where a worker indicates there is a permanent disability as a result of the compensable injury or states that there is an inability to return to employment as a consequence of the injury.

Furthermore, the policy states that if there is any doubt about the existence of a permanent disability, the claim is referred to Disability Awards Department for a final consideration.

In this claim, the worker's oral evidence meets the criteria set out in that policy. She has not returned to her pre-injury employment and in the result, the file should be referred to Disability Awards Department in order to make a final determination with regard to entitlement to a permanent partial disability award based on the worker's continued complaints of pain.

The worker is entitled to temporary total disability wage loss and health care benefits from October 17, 2001 to December 9, 2001 inclusive. She is also entitled to a referral to Disability Awards to determine the extent of her residual neck complaints.

December 27, 2001 Decision

The issue of whether the neurosurgeon's consultation report constituted significant new evidence from which to alter the October 19, 2001 decision is moot as I have found the worker's injury claim should not have been concluded on October 17, 2001. The remaining issue arising from this decision concerns the setting of the long-term wage rate on claim.

The Board's policy, specifically paragraph #67.20 of the RSCM, provides that in the determination of a long-term earnings loss after eight weeks of wage loss benefits, a review is carried out to determine the best representation of an earnings loss by reason of an injury. The policy provides that normally, earnings in the one-year period prior to the date of injury are used to reflect the worker's long-term wage loss. There are instances when the three-month earnings figure prior to the injury may be used. This is generally limited to situations where there is a relatively fixed change in the worker's earning pattern which is deemed likely to continue into the future. The Board may also use the three-year earnings prior to the injury. These situations are limited to cases where there are extenuating circumstances in the one-year period prior to the injury and where the one-year period would be incompatible with a normal historical earnings pattern. The policy states that this could be a result of economic downturns that produced anomalies or irregularities in the earnings pattern in the one-year prior to the

injury. The policy also sets out that when exceptional circumstances occur the Board can decide to use the five-year earnings prior to the injury. The use of the five-year period however, has limited application and would apply only when the use of the three-year period would produce an inappropriate reflection of the worker's normal employment history.

In the case before me the Board chose the one-year earnings period prior to injury as a best reflection of the worker's future earnings pattern. The worker, a long-term employee of 17 years prior to the compensable injury, provided oral evidence that since January 2000 she had worked a five day workweek and that her hours of work averaged from four to eight dependent upon the season. The employer's evidence, obtained by the case manager, was that due to an economic downturn, the worker could not expect an improvement in those hours. The initial wage rate was based on the average of the worker's three-months earnings due to her varied hours of work.

A long-term consideration of a wage rate for wage loss benefits must consider what the wage rate would have been if not for the compensable injury. To take into account, as the worker's adviser suggested, only the peak hours of the worker's busy season, would not reflect her consistent historical work pattern which included less hours in slow periods. The worker had been steadily employed for 17 years. Her evidence was that there had been no significant change in her work hours since she had been moved to strictly laundry work in January 2000. A downturn in employment hours was present at the point of her injury and was expected to continue into the future. The worker was given the benefit of her higher earnings during the first eight weeks of her injury claim. To extend these earnings in the long term would not be, in my opinion, a snap shot of her future earnings if she had not been injured. There is no substantive evidence to suggest that these higher earnings would have continued for the remainder of her employment year. There is therefore no extenuating circumstance from which to conclude that a shorter or longer period of earnings would be more representative. The one-year earnings period prior to injury is compatible with the worker's historical earnings pattern and I find it the best representation of the long-term earnings rate.

For this reason, I find that the Board correctly set the worker's long-term wage rate.

August 20, 2002/September 12, 2002 Decisions

These decisions denied the worker's carpal tunnel syndrome symptoms in relation to the injury claim and also denied authorization for percutaneous facet rhizotomy, a procedure proposed by the attending neurosurgeon.

Carpal tunnel syndrome is recognized by the Board by regulation as an occupational disease. Specific policy with reference to carpal tunnel syndrome is set out in the RSCM and describes a carpal tunnel syndrome as a condition caused by compression of the median nerve at the wrist. Paragraph #27.32 of the RSCM provides that where a

worker occupationally performs frequent, repetitive and forceful movements of the hand/wrist that are reasonably capable of stressing the tissues of the appendage affected by the carpal tunnel syndrome, and in the absence of evidence suggesting a non-occupational cause, a strong likelihood of work causation exists.

Any adjudication of a carpal tunnel syndrome considers a lengthy list of occupational risk factors set out in policy as well as non-occupational causes. The Board's decision to deny the worker's bilateral carpal tunnel syndrome considered its relation to the July 23, 2001 injury claim accepted for a neck injury. There is no evidence that a traumatically-induced bilateral wrist injury arose from the accepted injury mechanism despite the worker's evidence of a temporal relationship with the appearance of carpal tunnel syndrome symptoms two to three days after the compensable injury.

In order to establish a clear relationship it must be shown that the compensable injury mechanism had causative significance in the appearance of the diagnosed "mild" bilateral carpal tunnel syndrome. In other words, the carpal tunnel syndrome must be seen as a consequence of the compensable neck injury. Policy paragraph #22.00 of the RSCM sets out that not all consequences of work injuries are compensable. The policy states that once it has been established that in injury has arisen out of and in the course of employment, a question arises as to what consequences of that injury are compensable. The minimum requirement before one event can be considered as the consequence of another is that it would not have happened but for the other.

The policy further states that the matter must be looked from a common sense point of view and it should be considered whether the previous injury was a significant cause of the later injury.

Under the circumstances of this claim, there is insufficient evidence from which to reasonably associate the neck injury and the carpal tunnel syndrome symptoms. The neurologist at first, surmised that the worker's hand/wrist symptoms might have a radicular cervical genesis, however, there has been no suggestion by any of the medical practitioners that a carpal tunnel syndrome was caused by the compensable injury mechanism. Common sense dictates that a reasonable conclusion, on the weight of the evidence, is that there is no support for this supposition. I find there is insufficient evidence to conclude that the carpal tunnel syndrome arose from the July 23, 2001 compensable injury. The worker has the discretion to pursue with the Board, whether her overall work activities were of causative significance in the inception of her bilateral carpal tunnel syndrome symptoms.

With regard to the acceptance of the rhizotomy treatment recommended by the treating neurosurgeon, I uphold the Board's decision not to authorize it.

Section 21(1) of the Act provides that the Board may furnish or provide for the injured worker any medical, surgical, or other care or treatment that it may consider reasonably necessary at the time of injury and thereafter during the disability to cure and relieve from the effects of the injury or alleviate those effects. The Board also has the discretion to adopt rules and regulations with respect to the furnishment of health care to injured workers.

Section 21(6) of the Act provides that health care furnished or provided must at all times be subject to the direction, supervision and control of the Board. All questions as to the necessity, character and sufficiency of health care to be furnished shall be determined by the Board.

Chapter 10 of the RSCM contains published policy for the provision of health care benefits. The rationale for the Board's supervision is set out at paragraph #78.10 and states that the main purpose of control of treatment by the Board is to ensure that treatment is not overlooked, and that treatment choices are not overlooked. The policy sets out that the Board uses it control over treatment to promote recovery, and to exclude choices by patients or doctors that would delay recovery, or create an unwarranted risk of further injury. The control of treatment by the Board, the policy states, is not intended to exclude patient choices. If there are reasonable choices of treatment, or reasonable differences of opinion among the medical profession with regard to the preferable treatment, or choices to be made that depend on personal preferences, the matter should be recorded as one of patient choice.

The Board medical advisor's reasons not to authorize the facet rhizotomy are contained at the claim log memo (August 28, 2002). The workers' adviser has provided a consultation document of the neurosurgeon to explain the use of the procedure in the case of a back injury (exhibit #3). I accept that for the purpose of weighing evidence, that it is an anecdotal document. There is no specific evidence to suggest that the neurosurgeon's opinion would also be directed to the worker's neck claim. I do not find the worker's choice of treatment in this case constitutes a reasonably necessary, suitable treatment. While there may be arguments for and against the use of the procedure, the proof, so to speak, is in the pudding. The facet rhizotomy provided the worker with no pain relief and I accept the Board medical advisor's opinion that it had little chance of effectiveness. In the result, I do not find that it was medically necessary and therefore uphold the Board's decision not to authorize the treatment.

For the foregoing reasons I find the worker's carpal tunnel syndrome is not related to the injury claim and that the Board properly denied authorization for the facet rhizotomy.

Conclusion

In summary the October 19, 2001 decision is varied. I find the worker is entitled to further wage loss benefits beyond October 17, 2001. I also find that the worker is entitled to a referral to Disability Awards to determine the extent of any permanent residual complaints from the compensable injury.

The worker is also entitled to the costs of the attending physician's December 1, 2003 report in accordance with the Board's existing tariff agreement with the British Columbia Medical Association.

The December 27, 2001 decision is confirmed. I find the Board properly set the worker's long-term wage rate on her average earnings in the year prior to injury.

The August 20, 2002 and September 12, 2002 decisions are also confirmed. I find that the carpal tunnel syndrome was not related to the worker's injury claim and that the Board reasonably denied the acceptance of the facet rhizotomy procedure.

David A. Cox
Vice Chair

DAC/hf/hba