WCAT Decision Number: WCAT-2004-00098-AD
WCAT Decision Date: **January 12, 2004**
Panel: Sonja Hadley, Vice Chair

Introduction

In a decision letter dated October 17, 2000, a Workers' Compensation Board (Board) case manager noted that the worker had compensable neck surgery, and subsequently reported neurological complaints related to poor balance, an ataxic gait and low back complaints. The case manager declined to accept these latter as yet to be diagnosed symptoms as Board responsibility, as he found they did not result from the upper back-cervical injuries and surgery accepted under the claim. The case manager concluded that the physical impairment resulting from the surgery and part of the depression the worker was experiencing were acceptable under the claim. He noted, however, that the depression was multi faceted and did not result solely from the worker's work injury and subsequent surgery. The worker's file was to be referred to the Board's Disability Awards Department.

In a second decision letter of the same date, the case manager advised the worker that as only part of his depression was accepted as a Board responsibility, the cost of his Paxil medication will be accepted while the worker was participating in his vocational rehabilitation. The case manager further stated that Darvon would be accepted as a Board responsibility for a one month period from the date of that decision letter.

The worker appealed those two decisions to the Workers' Compensation Review Board (Review Board). In amended findings dated February 26, 2003, the Review Board denied the worker's appeal. The Review Board panel had requested a further assessment by a neurologist, which was provided by Dr. Beckman. He supported the view that the worker has a genuine neurologic problem but he could not relate it to the worker's compensable surgery. The Review Board panel preferred the opinion of the specialist, Dr. Beckman, over that of the worker's physician, Dr. Quandt. With respect to Board responsibility for Paxil and Darvon, the Review Board found that the Board accepted responsibility for Paxil to treat the worker's depression which was in part related to his injury. Darvon was to treat the worker's pain symptoms, also felt to be injury-related. The psychologist who initially felt the worker's depression was a result of the injury and disability subsequently revised his opinion and concluded that the worker's depression is related to his physical problems. The Review Board concluded that the worker's ongoing physical problems are related to non-compensable neurological problems. On this basis, the Review Board found he will not be entitled to the cost of medication for treating those problems. Although not stated directly, the underlying conclusion to this finding is that the worker's depression is not compensable.

The worker has appealed the Review Board findings.

Issue(s)

The issues on this appeal are: (1) are the worker's yet to be diagnosed neurological symptoms, related to balance problems, ataxic gait and low back complaints, compensable? (2) did the Board correctly limit its responsibility for the costs of Paxil and Darvon? (3) is the worker's depression related, in part or in whole, to his compensable injury?

Jurisdiction

This appeal was filed with the Appeal Division. 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 an Appeal Division panel before that date, it has been decided as a WCAT appeal (See the *Workers Compensation Amendment Act (No. 2), 2002,* section 39).

Background and Evidence

The worker, then a 37 year old panel saw operator, suffered a compensable injury on May 27, 1997. He developed pain in the upper mid back, right shoulder, arm and hand, with tingling into the fingers. On that date, the attending physician diagnosed a strain of the right arm.

The worker's symptoms progressed and continued. A CT scan of November 27, 1997 showed a large central and left posterolateral disc prolapse at C6/7 with compression of the cervical cord. There was also a large posterior osteophyte at C7/T1 with impinging of the bone spur upon the cervical cord on the left side. An MRI of January 16, 1998 showed left posterolateral protrusions of the C6-7 and C7-T1 discs, larger at the former level. The Board accepted the claim for a permanent aggravation of a pre-existing degenerative problem between C-6 and T-1, which ultimately required surgery on October 29, 1998. Wage loss benefits were paid from June 30, 1997 to October 15, 2000, followed by rehabilitation allowances.

The worker was examined and assessed by Dr. Hu, orthopaedic surgeon, on April 8, 1998. In his report of that date, he noted some right lower extremity weakness grade 4+ out of 5, particularly at the dorsiflexor and plantar flexors of the foot. The remainder of the motor examination was found to be unremarkable. He considered that cervical surgery may be an option.

In a consultation report of May 14, 1998, Dr. Padilla, neurosurgeon, found on examination that standing up, the worker's Romberg's test was mildly positive and he could not consistently heel – toe walk. He had evidence of a mild truncal ataxia that Dr. Padilla said may be due to Demerol, or an underlying neurological condition. Dr. Padilla found it very hard to believe that the worker's disc prolapses were the cause of his ongoing problems. He thought the worker should have at least a CT scan of his

head with contrast to exclude the possibility of interhemispheric lesion causing his problems. A CT scan of the head, dated June 17, 1998, was reported as normal.

In a progress report of August 10, 1998, Dr. Quandt, attending physician, documented that the worker had two weeks of increasing problems with moving his left toes. Objectively, the worker's left foot toe movements were reduced significantly.

On October 29, 1998 the worker had surgery – anterior cervical corpectomy of C7 with bone graft and plating of C6 to T1. On follow up on March 23, 1999, Dr. Hu wrote that the worker had been having some numbness in the right leg, which was present pre-operatively, as well as some numbness in the left leg.

The worker was referred to a Medical Rehabilitation Program (MRP). In an intake assessment report of July 21, 1999, Dr. Cheyne documented the worker felt the surgery had been helpful and that he said he was able to "walk without a list now". He was admitted into the program. However, Dr. Cheyne observed that the worker described in detail "a whole variety of symptoms that are difficult to explain including leg symptoms, imbalance, loss of proprioception, etc". In a progress report of July 30, 1999, Dr. Quandt reported that the worker's symptoms were "all worse after intense physio week…". Objectively, it was noted the worker walked with shuffling short steps and "'flailing' lower legs". The worker was referred to Dr. Novak, neurologist. In the MRP discharge summary report, Dr. Cheyne stated that the worker now had "worrisome neurologic findings suggestive of motor-neuron disease" and said he would call Dr. Quandt and ask that he see the worker and arrange for an urgent neurologic consultation.

In a consultation report of September 3, 1999, Dr. Novak documented the worker's main complaint to be pain in the back of his neck and upper thoracic spine without radiation. Second, he complained of weakness in his arms, especially with elevation, easy fatigueability and clumsiness (weakness) of hand movement. Third, his walking was unsteady and he had difficulty going short distances, which he attributed to weakness in his legs. The right leg wanted to shake when fatigued. Fourth, he had bilateral sacral and buttock pain and headaches. Fifth, he had intermittent numbness involving both feet. On examination, Dr. Novak found the worker's gait to be somewhat wide - based and hesitant bilaterally. His gait ataxia was brought out more clearly when he attempted to walk on his heels or toes. In the sitting position, he had a very fine forward nodding head tremor and at times, there was a suggestion of very mild low amplitude truncal titubation (a staggering gait with shaking of the trunk and head). He had marked difficulty balancing. Dr. Novak stated under "Impression":

> This patient has a complicated neurologic picture which is clearly worse since his cervical spine surgery. I am most impressed with the weakness in his upper extremities and hip girdle muscle weakness, which is in excess of simply being poorly conditioned. His ataxia is very definite and could in part be explained on the basis of his weakness although a more

> central abnormality will have to be ruled out by CT scanning as was originally recommended by Dr. Padilla. A primary myopathy is also suspect here. The fact that he has retained reflexes would speak against a primary motor neuropathy. Inclusion body myositis and myasthenia gravis are also to be considered. He has no definite cortico-spinal tract findings and a significant cord lesion has already been ruled out.

Dr. Novak asked for a CT enhanced brain scan and a detailed reassessment by Dr. Laidlaw, looking for evidence of a primary myopathy.

Dr. Laidlaw saw the worker and reported on October 26, 1999 that when he reviewed the worker in 1997, he had moved rather awkwardly and unusually. It was difficult to evaluate his power and coordination but he felt the reflexes were within normal range. On examination, Dr. Laidlaw noted the worker moved very awkwardly, having a wide based gait which seemed somewhat ataxic, but he had a high stepping type of gait as well. Dr. Laidlaw felt that the power was actually quite good throughout the arms and legs, and said one encountered "a very intermittent effort at times". Nerve conduction studies were undertaken by Dr. Laidlaw. He interpreted these to show no clear myopathic features and the neuropathic features mentioned would normally be considered to be very soft ones. He could not find any evidence of an underlying myopathy or any progressive neuropathic features. He felt the worker's clinical picture had "certainly changed considerably" and that he had a very abnormal gait; he said that he was "not sure that I can explain it at all".

Under memo #27 dated December 9, 1999, Dr. Schilling, Board medical advisor, documented his discussion with Dr. Novak with respect to the latter's consultation report of September 3, 1999. Dr. Schilling summarized that it appeared that the multiple symptoms the worker displayed were a mixture of symptoms due to the compensable injuries, as well as symptoms due to a yet to be diagnosed neurological condition which Dr. Novak would continue to investigate.

In a consultation report dated December 11, 1999, Dr. Novak noted that the EMG and nerve conduction studies were entirely normal and that the main finding was that of an abnormal unsteady gait. Dr. Novak observed that prior to his cervical spine surgery, the worker was assessed by Drs. Padilla and LeFevre and that "interestingly Dr. Padilla described some ataxia of stance and gait in his report, recommending a CT brain scan." Dr. Novak's neurological examination again revealed a definite moderate imbalance in the worker's stance and gait, worse with attempted walking on his heels or toes. No clear-cut sensory abnormalities were noted although the worker had some subjective numbness in his toes bilaterally. Dr. Novak's impression was that the worker had a non-specific, but clearly demonstrable, gait disorder which seemed to have been present prior to his surgery. He did not feel the worker had any clear-cut signs of spinal cord dysfunction. His gait ataxia was still unexplained but clearly represented his main disability. Dr. Novak felt that with a normal CT enhanced brain scan in June 1998, it

was unlikely that MRI scanning of the brain would be helpful. He recommended a hospital rehabilitation program, rather than a work hardening program.

In a letter dated January 18, 2000, addressed to a physiotherapist, Dr. Novak noted the worker's gait imbalance and said "it is possible that he may have suffered some cord injury at the time of his cervical spine surgery".

Dr. Schilling requested that Dr. Postma, a Board medical examiner with the Medical Rehabilitation Program, interview and examine the worker and provide advice with respect to current diagnosis, any further treatment options, and possibly work re-entry issues. In an initial medical assessment dated February 23, 2000, Dr. Postma noted a written list of 50 symptoms provided by the worker. Dr. Postma reported that he arranged for the worker to have an MRI of the brain as well as the cervical spine and this was carried out on February 22. He reviewed the MRI films of the skull and brain and saw no evidence of specific pathology. He said he briefly spoke with a neuroradiologist who told him she could find no evidence to suggest features of multiple sclerosis and that the brain images were in keeping with a normal study considering the worker's age. Dr. Postma said his examination revealed no evidence of significant pathology. Dr. Postma's final diagnoses included that the worker had an abnormal gait with unknown etiology, likely of non-organic origin; features of "total body pain and discomfort" in keeping with a significant somatoform disorder and no organic abnormalities or deficits. He said this would indicate that a degree of emotional distress is experienced as physical symptoms. There was no clinical evidence of motor or nerve function deficits; and a degree of disability conviction as part of the somatoform disorder.

The case manager then referred the worker for a psychological assessment in order to address whether the "diagnosis of Somatoform Disorder was confirmed" and, if so, the treatment plans/options. In a Psychological Assessment dated June 7, 2000, Dr. Dorward, Board psychologist, provided a response to the two referral questions. With respect to the first question, Dr. Dorward said there is no such diagnosis as "Somatoform Disorder", which term is used to describe a class of disorders. He said one of the somatoform disorders is somatization disorder, to which Dr. Postma may in fact have been referring. However, Dr. Dorward said the worker did not meet the criteria for this disorder as the onset must be prior to age 30. One of the criteria for a disorder called "Undifferentiated Somatoform Disorder" is that there are physical complaints that are not accounted for by a medical condition. Dr. Dorward noted that the worker would meet the criteria for this disorder if there was medical certainty that his symptoms were not better accounted for by a medical condition. However, since there was a conflict of medical opinion on that question, Dr. Dorward believed it was not for a psychologist to resolve medical disputes. He went on to state:

> Furthermore, I am extremely reluctant to offer a psychological diagnosis for physical symptoms (i.e. make a diagnosis of the Somatoform type). Psychology and psychiatry have long been used to provide psychological

> explanations for patient complaints of physical symptoms that medicine was unable to find physical pathology for. I can recall being taught in my own training that stomach ulcers were caused/exacerbated by repressed (or excessive hostility). We now know that bacteria are the culprits. In short, and as some researchers have noted, the Somatoform Disorder is a diagnostic category that all patients who stump medicine could be tossed into.
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> Thus, I would not confirm the diagnosis of "Somatoform Disorder". Nor would I diagnose a psychological disorder of a similar type. Nevertheless, I do appreciate that some of the symptoms reported by [the worker] are very unique and perplexing. . .

Dr. Dorward provided the following diagnoses:

Axis I -	Major Depressive Disorder (in full Remission, being treated via maintenance Paxil). Etiology is likely attributable to injury and disability. Personality Traits and Coping Style affecting medical condition. [The worker] is very pre-occupied with physical symptoms and has very little realistic future orientation. He is very passive concerning his situation and has limited psychological insight into himself.
Axis II -	Deferred
Axis III -	Numerous physical complaints including pain and physical limitations of unknown specific etiology.
Axis IV -	Occupational Problems
Axis V -	90

With respect to the second referral question, Dr. Dorward responded that as there was no diagnosis of Somatoform Disorder, he would not recommend treatment. However, he recommended the worker continue his use of Paxil as it appeared to successfully treat his depression.

In a claim log entry dated August 24, 2000, Dr. Atkins, Board medical advisor, reviewed the worker's medications. He noted the worker was currently on Paxil for maintenance of effective therapy of depression, which condition had not been accepted on the claim. He was also using 2 – 8 Tylenol #3 per day and occasional Demerol. Dr. Atkins thought it reasonable to pay for no more than 60 Tylenol #3 per month, if requested, but it would not be reasonable to fund the other mentioned medications.

In a claim log entry of October 17, 2000, a Board officer accepted part of the worker's depression. He said the depression was multi-faceted and not solely from the impairment resulting from the accepted surgery. His yet to be diagnosed non-compensable neurological symptoms contributed to his psychological functioning.

He said the Paxil for depression can be accepted, but only as long as the worker was actively engaged in vocational rehabilitation. He reasoned that once the worker completed his involvement in that regard and hopefully successfully returned to suitable employment, then his depression should be viewed as more related to his neurological symptoms.

In a letter dated November 3, 2000, Dr. Quandt, the worker's attending physician, stated that after surgery, the worker did continue to have multiple problems as noted in his report of July 13, 1999. At that time, however, Dr. Quandt had not noticed any upper motor neuron signs. However, in his next report of July 30, 1999, Dr. Quandt noted that the worker's symptoms "were all worse after intense physio . . . and, furthermore, on my examination, I noticed that the patient was walking with shuffling short steps and that he was, what I called, flailing his lower legs". Dr. Quandt said that subsequently, it became very obvious that the worker had suffered a peri-operative upper motor neuron injury. (I note that "perioperative" is defined by Dorland's Medical Dictionary as "pertaining to the period extending from the time of hospitalization for surgery to the time of discharge".) He said it was both his own and Dr. Novak's impression that the worker's upper motor neuron injury was either caused by the operation itself or by rigorous intense physiotherapy following the surgery.

In a consultation report of May 31, 2001, Dr. Laidlaw noted that he first saw the worker in November, 1997 and at that time he moved very awkwardly and very unusually. On examination, the worker walked with a very wide-based gait, walking rather quickly and being able to turn corners without any trepidation or loss of balance. There was no evidence of high stepped gait. Power was normal throughout the arms and legs, as was tone and coordination to alternating movements. His finger/nose pointing was intermittently abnormal. There was no clonus and no evidence of a positive Bibinski. Dr. Laidlaw said he generally had a "difficult time in summing up this man's problems". He thought to be complete, the worker should probably have evoked potentials done of the spinal cord and brain, as well as a myelogram of the neck. He said he had "a hard time putting together the whole picture here" and perhaps a second neurologic opinion might be useful.

Dr. Atkins, Board medical advisor, reviewed Dr. Laidlaw's report under a claim log entry dated August 21, 2001. With respect to Dr. Laidlaw's query whether the MRI report could be reliably interpreted in the presence of cervical spine hardware, Dr. Atkins said he had previously personally reviewed that report and he did not recall that the interpreting radiologist mentioned that as a concern. Therefore, Dr. Atkins did not think that further imaging of the worker's cervical spine would be indicated.

In a claim log entry dated August 21, 2001, Dr. Dorward, Board psychologist, reviewed recent file material as well as his earlier assessment report of June 7, 2000. He noted that in his earlier report, he had diagnosed a Major Depressive Disorder in Full Remission from successful treatment with medication. He had also indicated that the likely etiology of the depression was the injury and disability. He subsequently read on

the claim file that the worker's various and unexplained (to date) neurological symptoms have not been accepted under the claim. Therefore, Dr. Dorward revised his earlier statement that the injury was the likely cause of the worker's depression. Instead, his opinion was that the worker's physical problems are the likely cause of his depression – and that the most psychologically disabling physical symptoms are those that are not claim related. Thus, any additional psychological distress associated with the worker's non-compensable physical symptoms would also be non-compensable. Dr. Dorward was not surprised that the worker experiences distress during the vocational rehabilitation process.

The worker was examined for PFI purposes by Dr. Smith, Board medical advisor, on June 6, 2002. Under the "Present Complaints" heading of his PFI evaluation report, Dr. Smith stated that the worker's gait has been abnormal since a few months after the initial injury, but seemingly was much worse after his surgery. He now used a forearm crutch in one of his hands, to help his sense of stability. He took Paxil for depression, and his mood was much better since going on this drug. For pain control, he used Tylenol #3, or Darvon. He only rarely required the latter.

In his accompanying memo to the CADA, Dr. Smith stated in part:

> The worker presented in a pleasant manner, and cooperated fully throughout the interview and examination process. However, he presented with a myriad of detailed symptoms affecting both upper and lower extremities, and seemed highly symptom-focused. The symptoms were also described in an unusual fashion, and in a manner which seemed to point to no specific underlying pathology. Like other examiners before me, I had considerable difficulty sorting out [the worker's] symptoms, and relating them to the known underlying pathology. Indeed, the vast majority of his complaints, especially those relating to the lower extremities, could not reasonably be related to any of the known pathology in his neck. . .
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> Having said this, at no time did I get the impression that [the worker] was demonstrating significant pain behaviour, nor exaggeration of any of the clinical findings. He appeared to be giving good effort throughout, and had no complaints during the examination process. . .
>
> Of some concern is the fact that he has hyperreflexia perhaps more on the right than the left lower extremities, that he had sustained ankle clonus on the right only, and that his Babinski response was possibly weakly (sic) positive on the right. His gait was not typical of any known neurological condition that I have encountered, but the combination of findings would suggest that further investigation may well be justified. However, I should point out that whatever these further tests may be, given the investigations already on file, I could not reasonably relate the need for these

> investigations to the condition accepted under this claim. None of these findings would normally be expected to result from his two-level cervical spine surgery, nor would there appear to be any organic basis for linking his current findings and complaints to any of his compensable conditions.

The Review Board noted that the worker appeared to have some undefined neurological disorder. The panel asked for the worker to be referred to an appropriate specialist to determine if he has a neurological condition and, if so, whether it was likely a sequela of his surgery or an unrelated neurological problem that had developed. In response, Dr. Beckman, neurologist, provided an independent medical-legal report dated August 26, 2002, after interviewing and examining the worker and reviewing the medical records. In that report, Dr. Beckman documented the worker's belief that his balance difficulty began some time around April of 1999 when he was in rehabilitation and that his balance had remained unchanged since that time, although it will fluctuate. He had pain in his upper and middle back but the low back did not seem to be problematic. On examination, Dr. Beckman did not see evidence of pain behaviour. His motor exam revealed normal power and tone; no spasticity was noted. There was no clonus and no Hoffman reflex. He appeared to have some pendular reflexes when doing his knee jerks. There tended to be an intermittent titubation of his head noted. Coordination revealed some mild abnormalities of finger/nose and rapid alternating movement. His heel/shin testing was also not normal and he walked with a wide based gait. There was some difficulty with attempted heel to toe testing. Sensory exam was normal except for perhaps a slight reduction in vibration in the left toe.

Dr. Beckman noted the worker's belief that his coordination problems started in the spring of 1999 when he was getting some therapy. However, he also noted reports from Dr. Padilla that prior to surgery there was some incoordination present although Dr. Padilla wondered whether it was because of the three Demerol the worker had taken. Subsequent to this, the worker's balance has been poor. Dr. Beckman concluded:

> His objective neurologic examination today reveals evidence of what appears to be some mild cerebellar signs with some difficulty with finger/nose, heel/shin and problems with his gait although I must admit that the gait is slightly atypical for pure cerebellar gait but sometimes can be seen. He did not have any significant eye movement disorder although I did wonder about some hypometric saccades and he did have pendular reflexes which are often seen in cerebellar disorder. I clearly do not find anything to suggest that he has cortical spinal tract involvement as would be caused by spinal cord injury from his operation. Clearly there was no evidence of clonus or increased tone. He had superficial abdominal reflexes present. There was no Hoffman reflex.

> He has had imaging of his head. There is no evidence to suggest multiple sclerosis or cerebellar atrophy. This was done in 2000. It is quite clear from reviewing this gentleman's medical information that his current neurologic abnormalities are not caused by the work related injury of May of 1997. The question here is what is the diagnosis? I believe that this gentleman does have a primary neurologic abnormality rather than this being simply a somatoform disorder although the lack of clinical progression would be a bit atypical for this. However having said that it would be worthwhile having him have a lumbar puncture to see if there is any evidence of inflammatory disease within the CSF and look for oligoclonal banding and perhaps repeating an MRI scan of head. As mentioned there is no evidence that he has a spinal cord lesion. This gentleman was cooperative with the examination today and I did not see any magnification of pain behaviour today. Clearly this patient will need to be followed from a neurologic point of view for the possibilities of either demyelinating disease versus a neurodegenerative disorder.

In a letter dated November 8, 2002, addressed to the Review Board, Dr. Quandt stated that when he got to know the worker sometime after his accident, the worker walked, talked and moved normally except for his head position. However, several weeks after the surgery following extensive and probably excessively vigorous physical therapy, the worker developed upper motor neuron signs, including a positive Babinski reflex and clonus. These symptoms have subsided since then and sometimes disappeared all together. Dr. Quandt said it was his conviction that the worker's cervical lower motor neurons and the cervical extensions of upper motor neurons were stressed severely enough by the peri operative events and or by the post operative excessively vigorous physiotherapy to leave permanent functional impairment without showing structural damage.

Submissions and New Evidence

A submission was made to WCAT dated September 28, 2003 on behalf of the worker. Attached to the submission were two new medical reports. The first medical report is a consultation report by Dr. Calne, of Pacific Parkinson's Research Centre, Vancouver Hospital, dated July 17, 2003. On examination, Dr. Calne found no wasting or involuntary movements in the worker's limbs. Tone was normal. Power was generally reduced. When testing strength, there was "a rather inconsistent and tremulous response with quite marked shunting of effort". Coordination was normal. The tendon reflexes were normal and both plantar responses were flexor. Touch, pinprick, vibration and joint position sense were normal. The worker could stand and walk without assistance but his gait was slow and unsteady. Nevertheless, he could walk a few steps heel to toe. Dr. Calne summarized:

> I understand that concerns have been raised as to whether he has a neurodegenerative disorder, and I really could not find any evidence of this. I am afraid that I cannot suggest any laboratory investigations or x-rays that are likely to help. With a very obvious shunting of effort, when testing muscle power, it did occur to me that a psychiatric opinion would be useful. I know that [the worker] has seen a psychologist, but it seems that he has not seen a psychiatrist recently.

The second medical report is that of Dr. Roberts, from a medical centre in Washington state, dated September 11, 2003. The history he had was that in about May or June 1999 during a physical therapy session, the worker suddenly developed increased weakness of the legs, left greater than right with numbness and tingling radiating into the legs. All of the symptoms have persisted and the worker now has intermittent numbness radiating down the arms and into the legs, probably aggravated by motion of the neck. There is also difficulty walking with poor balance and the worker was using a forearm crutch. There had been partial impotence. On examination, Dr. Roberts found that the worker's reflexes were 3+ with nonsustained clonus at both knees and ankles. Babinski and Hoffman signs were not detected. With respect to coordination, finger-nose-finger was accurate, but heel-knee-shin was slightly dysmetric bilaterally. The worker had moderate reduction of vibratory sensation on the feet bilaterally as well as mild to moderate reduction of proprioception at the level of the toes. Gait was unusual with short, wide steps and a steppage quality. Romberg sign was positive. Dr. Roberts' impression was:

> This gentleman appears to have a cervical myelopathy which I presume is related to mechanical compression of the spinal cord from the C6-7 disk herniation that developed in 5/97 after his accident. His spinal cord has now been decompressed and there does not seem to be a source of ongoing injury although I think there is a small chance of potential ongoing injury due to cervical instability. A flexion/extension x-ray series of the neck would be helpful to rule this out. Otherwise, I am afraid he is going to have to cope with a certain level of disability. He would likely benefit from some form of chronic pain management program. He would also likely benefit from ongoing physical therapy.

A submission dated September 28, 2003 was made on behalf of the worker. It is submitted that the worker is not necessarily relating his neurological complaints to the surgery performed on October 29, 1998. Rather, the worker relies on Dr. Quandt's opinion that his neurological complaints are secondary to peri-operative events. The worker argues that in accordance with Section 99 of the Act, a decision favourable to him is required.

It is noted that, as early as July 1997, as discussed in Memo #2, the worker informed the claims adjudicator that he was experiencing difficulty walking. It is further noted, however, that Dr. Beckman, based on his discussion with the worker, was of the

impression that the worker's difficulty with balance did not commence until approximately April 1999, some two years following the work injury and five months after surgery and that such an impression would certainly influence Dr. Beckman's opinion regarding the causal relationship between the injury and the worker's neurological complaints.

It is further noted that Dr. Beckman advised that no cord abnormality was noted on the MRI, but that it is apparent that Dr. Beckman did not have the opportunity to review the CT scan of November 27, 1997 which predated the MRI of January 16, 1998. The CT scan identified a large central and left posterolateral disc prolapse compressing the cervical cord as well as a bony spur impinging upon the cervical cord on the left side. It is noted that Dr. Laidlaw, on November 4, 1997, reported that the worker moved awkwardly and unusually, thus providing further evidence that the worker's neurological complaints had manifested much earlier than April, 1999 and even before surgery. Further evidence cited in support of this proposition is Dr. Padilla's finding of mild truncal ataxia on July 15, 1998, which it is submitted was related to a neurological condition as opposed to the effects of Demerol. It is stated that it is apparent from Dr. Padilla's report that he did not have the benefit of the November, 1997 CT scan as he stated that the MRI of January 1998 demonstrated no evidence of spinal cord compromise.

To this time, the worker's neurological complaints can not be explained on the basis of a brain disorder, including cerebellar atrophy or multiple sclerosis, which in fact Dr. Beckman ruled out. Investigations in regard to the possibility of a demyelinating disease or a neurodegenerative disorder as suggested by Dr. Beckman have also proved negative. Dr. Laidlaw ruled out a primary myopathy. It is submitted that Dr. Novak's statement, in his December 11, 1999 report, that there were no "clear-cut signs of spinal cord dysfunction" left open the possibility that spinal cord dysfunction had not been entirely excluded. In this regard, reference is made to Dr. Novak's statement of January 18, 2000 in which he said it was possible the worker may have suffered some cord injury at the time of his cervical spine surgery.

The worker argues that there may have been cord injury relating to his cervical disc protrusions, noting the findings of the November 27, 1997 CT scan which, it is submitted, provides direct evidence of injury to the cervical spinal cord. The worker submits that it is most plausible that, even though the cervical spine was decompressed at surgery, damage to the cord had already occurred, accountable for his neurological complaints. He argues this is a more tangible explanation as opposed to the possibility of a myopathic, neuropathic or myelopathic disease process which escapes diagnosis. Further, the timing of the onset of the worker's pronounced neurological complaints shortly into a physiotherapy program, when to that time, satisfactory progress from surgery appears to have been made, suggests that post-operative therapy is also suspect.

It is noted that both February 22, 2000 MRI studies of the head and cervical spine were normal, with the latter demonstrating satisfactory post-surgical features at the C6-7 and C7-T1 levels. However, it is pointed out that Dr. Laidlaw, on May 31, 2001, advised that the fact the worker has a plate in his neck makes a MRI and a CT scan very difficult to interpret. Therefore, it is submitted, any defect of the spinal cord at these levels secondary to trauma would be difficult to decipher.

It is submitted that the potential causes of the worker's neurological complaints can be summarized as follows: (1) a disease process either myopathic, neuropathic or myelopathic in nature (2) traumatic cervical myelopathy related to either the work injury and the resultant compression of the spinal cord as identified on the CT scan of November 27, 1997, the surgery, the post-surgical therapy or some combination of all three or (3) a psychological condition. It is apparent Dr. Beckman believes the cause may be found under the first category. Dr. Quandt, noting that the worker's disability and physical presentation evident today have manifested since the work injury in May 1997, in association with the absence of an relevant medical history prior to May 1997, and the lack of a non-compensable diagnosis, is convinced that the worker's disability in all respects must be viewed as arising out of and in the course of his employment. It is stated that Dr. Calne has subsequently ruled out a neurodegenerative disorder, as suggested by Dr. Beckman. Reference is made to the opinion of Dr. Roberts that the worker appears to have a cervical myelopathy which he presumes is related to the mechanical compression of the spinal cord from his C6-7 disc herniation.

In conclusion, it is submitted that the worker's neurological complaints may be myelopathic in nature; a myelopathic condition may be secondary to trauma or disease. There is direct evidence of compression to the cervical spinal cord secondary to trauma. In this regard, the extent of the injury was not diagnosed for some six months during which time the worker did complain of trouble walking and was described to exhibit awkward and unusual movement. Over these six months, the worker continued with regular employment for about one month and underwent occupational therapy aimed at treating a simple strain. After surgery, the worker seemed to be improving; however shortly into a program of therapy, his recovery took a downturn and since then, his neurological complaints have essentially remained constant, not suggestive of a progressive disease. Although alternative explanations separate and apart from the worker's compensable injury have been advanced, investigations including two brain scans, nerve conduction studies and multiple neurological consultations have failed to identify a myopathic, neuropathic or myelopathic disease process. Although it is recognized there is doubt and conflicting opinions concerning the cause of the worker's neurological complaints, it is submitted the possibilities must be considered at the very least to be evenly balanced that the worker's complaints are related to his compensable neck injury. Therefore, in accordance with Section 99 of the Act, a decision favourable to the worker is required.

The worker submits that should he receive a favourable decision with regard to the compensability of his neurological complaints, then it would naturally follow that his depression and Paxil prescriptions would be compensable. Nevertheless, it is argued that when depression was first diagnosed in August, 1997, and at the time Dr. Quandt prescribed Paxil for his depression in July 1999, the worker's neurological complaints were neither pronounced nor sustained, which clearly incriminates his compensable cervical injury and associated pain symptoms, his major surgery, the duration of his disability related to his compensable injury, and his altered lifestyle as a result of his injury as the factors causative of depression. In short, as his depression was established as early as August 1997, and as he does have a compensable residual disability, he argues that on balance, his compensable injury must be viewed as being of causative significance. Again, Section 99 of the Act is relied upon.

It is further submitted that the case manager's unilateral adjudication and termination of Darvon on or about November 17, 2000 is contrary to Board policy set out in #77.30 of the *Rehabilitation Services and Claims Manual* (RSCM). It is submitted that the worker is therefore entitled to the continued use of Darvon at Dr. Quandt's discretion until such time as this matter is adjudicated in accordance with policy. Furthermore, it is noted that as the medical advisor authorized the indefinite use of the narcotic agent Tylenol #3 (memo of August 24, 2000), any decision concerning alternative narcotic medication would certainly necessitate medical guidance.

The worker requests reimbursement of his costs incurred in seeking the medical opinion from Dr. Roberts in accordance with the fee schedule.

Law and Policy

Item #77.30 of the RSCM provides that where an adjudicator or payment clerk continues to receive accounts for narcotic analgesics, hypnotic-sedatives and tranquilizers beyond the eight-week limit, the worker's claim file will be referred by the adjudicator to a Board medical advisor. Darvon is given as an example of a narcotic analgesic. The Board medical advisor will contact the attending physician by phone where possible, outline the details of this policy, and discuss any special or extenuating circumstances. The Board medical advisor will also discuss the use of acceptable therapeutic alternatives. If necessary, an extension beyond eight weeks may be recommended by the Board medical advisor following this discussion.

Item #97.10 of the RSCM provides, in part:

> Complaints are sometimes received at the Board that a worker has not been given the benefit of the doubt. Usually, these complaints relate to a situation in which the claimant has a disability, but the issue is whether it is one arising out of or in the course of employment. The essence of the complaint is often that if there is some possibility that the injury arose out of the employment, the worker should be given the benefit of the doubt.

> For the Board to take that view, however, would be inconsistent with the terms of the Act. Where it appears from the evidence that two conclusions are possible, but that one is more likely than the other, the Board must decide the matter in accordance with that possibility that is more likely.
>
> Under the terms of Section 99, the Board is required to decide an issue in accordance with the possibility which is favourable to the worker where it appears that "the disputed possibilities are evenly balanced". This applies only where there is evidence of roughly equal weight for and against the claim. It does not come into play where the evidence indicates that one possibility is more likely than the other.
>
> While an absence of positive data does not necessarily mean that a condition is not related to a person's employment, it may mean that there is a lack of evidence that any such relationship exists. The Board, as a quasi-judicial body, must make its decisions according to the evidence or lack of evidence received, not in accordance with speculations unsupported by evidence. . .

Reasons and Findings

It is submitted on this appeal that the worker is not necessarily relating his neurological complaints to the surgery of October 29, 1998 but that he relies on Dr. Quandt's opinion that his neurological complaints are secondary to "peri-operative events". However, it is also argued on behalf of the worker that his neurological complaints had manifested before surgery, as early as July, 1997. The findings of the November 27, 1997 CT scan are said to provide direct evidence of injury to the cervical spinal cord which, it is stated, accounts for the worker's neurological complaints. Although the February 22, 2000 MRI of the cervical spine showed satisfactory post-surgical features at the C6-7 and C7-T1 levels, reliance is placed on Dr. Laidlaw's May 31, 2001 statement that the plate in the worker's neck makes an MRI scan very difficult to interpret. Further the timing of the onset of the worker's pronounced neurological complaints shortly into a physiotherapy program suggests that post-operative therapy is also suspect.

There have been a number of medical opinions with respect to the role of the worker's spinal cord in his ongoing neurological complaints, and specifically, the role of the compensable surgery and the compensable injury. In this regard, although Dr. Novak said, in his report of December 11, 1999, that there were no clear cut signs of spinal cord dysfunction, on January 18, 2000 he wrote that the worker may "possibly" have suffered some cord injury at the time of his surgery. Dr. Laidlaw said he had a "hard time putting together the whole picture" and suggested a second neurologic opinion. Dr. Quandt is of the opinion that the worker suffered a peri-operative upper motor neuron injury caused by surgery or rigorous intense physiotherapy following surgery. On the other hand, Dr. Smith was of the opinion that the vast majority of the worker's symptoms (especially the lower limbs) could not be reasonably related to any of the

known pathology in the neck or to the surgery. Dr. Beckman said he saw nothing to suggest cortical spinal tract involvement as would be caused by a spinal cord injury from surgery and suggested there was evidence of what appears to be some mild cerebellar signs for which he suggested further tests. There is no evidence that these further tests were undertaken. However, Dr. Calne has given the opinion that he could find no evidence of a neurodegenerative disorder and suggested a psychiatric opinion would be useful because of what he described as "a very obvious shunting of effort, when testing muscle power". No psychiatric opinion has been provided. Dr. Roberts, although noting that the February, 2000 MRI revealed a complete fusion between C6, C7 and T1 without evidence of spinal cord compression or neural foraminal stenosis at any level, gave his impression that the worker "appears" to have a cervical myelopathy which he "presumed" is related to mechanical compression of the spinal cord from the C6-7 disc herniation that developed in May 1997 after his accident.

I have carefully considered all of the evidence, especially the numerous investigative tests, specialist examinations, consultations, and opinions. In the end, I find the weight of the evidence does not provide a sufficient foundation to conclude with confidence that there is a likelihood that the worker's compensable injury, spinal surgery, the rigors of post-operative physiotherapy or some combination thereof have had causative significance in the worker's yet to be diagnosed neurological symptoms (poor balance, ataxic gait and low back complaints). Rather, the weight of the evidence leads me to a conclusion that although this is a possibility, it is not likely. I find further that the disputed possibilities are not roughly evenly balanced or weighted and so neither Section 99 of the former provisions of the Act, nor Section 250(4) of the current provisions, apply.

I understand the worker's difficulty in accepting the possibility of a psychological basis for some of his complaints. However, I note Dr. Calne's recommendation that the worker be referred to a psychiatrist. I further note that Dr. Dorward stated that the worker would meet the criteria for "Undifferentiated Somatoform Disorder" if there was "medical certainty that his symptoms were not better accounted for by a medical condition". In this case, there is no such "medical certainty". However, the DSM-IV provides as one of the diagnostic criteria for 300.81 Undifferentiated Somatoform Disorder that "after appropriate investigation, the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication)". In my view, there is a difference between "medical certainty" that the worker's symptoms are not better accounted for by a medical condition and an acceptance that the symptoms cannot be "fully explained" by a known general medical condition. I find that the latter description applies to the circumstances of this case. I have considered the above discrepancy with respect to DSM-IV criteria, my finding that the worker's non-compensable neurological symptoms cannot be "fully explained" by a known general medical condition, as well as Dr. Calne's recommendation. On this basis, I refer the question of whether the worker meets the diagnostic criteria for Undifferentiated Somatoform Disorder, or any other psychological condition, and, if so, whether the compensable injury had causative significance in its development, back to

the Board for further investigation and determination. I note there has been no decision letter to the worker on this issue.

The next question relates to the Board's limiting its responsibility for the costs of Paxil and Darvon. I agree with the worker's submission that the termination of Darvon on or about November 1, 2000 did not comply with item #77.30 of the RSCM. The worker has been awarded a pension of 6% of total for his two level cervical fusion. There has been no consideration given as to whether Darvon is reasonably required, and, if so, for how long, for the symptoms related to that compensable disability. In that respect, I disagree with the Review Board finding that the worker's ongoing physical problems are related to non-compensable neurological problems. Although I agree that many of the worker's physical problems are related to what has been considered to be non-compensable neurological problems, it is also the case that some of the worker's physical problems are related to his compensable injury and surgery, as acknowledged by the Board in awarding the worker a pension. In the decision under appeal, the case manager offered no reasoning as to why Darvon would be accepted as a Board responsibility for only a one month period. The case manager did advise the worker in that letter to speak to his family physician about alternate non-addictive pain medication. In his claim log of the same date, the case manager wrote that he had asked a nurse advisor to contact the attending physician and discuss the appropriateness of continuing narcotic medication. However, there is no evidence that either a nurse advisor or a medical advisor contacted the attending physician in this regard. I find, therefore, that the case manager erred in limiting Board responsibility for Darvon for a one month period, without the appropriate medical advice and consultation, consistent with policy item #77.30. I direct that the Board adjudicate its responsibility for Darvon, consistent with policy item #77.30.

The next question relates to the case manager's decision to accept the cost for Paxil only while the worker was participating in his vocational rehabilitation. Again, there is no reasoning as to why Paxil will only be accepted for this limited period of time, beyond the case manager's statement that he was only accepting part of the worker's depression. Whether Paxil was reasonably required for a longer period of time as treatment for the compensable part of the worker's depression was not addressed by the case manager. The Review Board found that as the worker's depression was related to his physical problems, which were in turn related to non-compensable neurological problems, the worker was not entitled to the cost of medication for treating those problems. However, Dr. Dorward's revised opinion, given August 21, 2001, was that the worker's physical problems are the likely cause of his depression and that the most psychologically disabling physical symptoms are those that are not claim-related; thus, any <u>additional</u> psychological distress associated with the worker's non-compensable physical symptoms would also be non-compensable. This opinion supports the case manager's decision to accept part of the worker's depression; however, it does not support the Review Board finding that the worker's depression is related <u>solely</u> to non-compensable physical problems.

I accept Dr. Dorward's opinion of August 21, 2001 as it relates to the cause of the worker's depression and find the Board correctly interpreted that opinion in concluding that the depression was related, in part, to the compensable injury. I find that the worker required Paxil for the compensable part of his depression beyond the limited time accepted by the Board. I find that the worker is entitled to the ongoing costs of Paxil until it is determined that Paxil is no longer required to treat his compensable depression.

Conclusion

I deny the worker's appeal on the issue of whether his yet to be diagnosed neurological symptoms related to balance problems, ataxic gait and low back complaints are compensable. I confirm the Review Board findings of December 10, 2002.

I refer the question of whether the worker meets the diagnostic criteria for Undifferentiated Somatoform Disorder, or any other psychological condition, and if so, whether the compensable injury had causative significance in its development, to the Board for further investigation and determination.

I allow the worker's appeal on the issue of whether the Board correctly limited its responsibility for the costs of Paxil and Darvon. I direct that the Board adjudicate its responsibility for Darvon, consistent with item #77.30 of the RSCM. I find that the worker is entitled to the ongoing costs of Paxil until it is determined that Paxil is no longer required to treat his compensable depression. I vary the Review Board findings of December 10, 2002.

I allow the worker's appeal on the issue of whether the worker's depression is related in whole, or in part, to his compensable injury. I vary the Review Board findings of December 10, 2002.

If there were costs incurred in obtaining a medical opinion from Dr. Roberts, dated September 11, 2003, those costs should be reimbursed, in accordance with the Board's fee schedule.

Sonja Hadley
Vice Chair

SH:cd/gw

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