WCAT Decision Number: WCAT-2004-00113
WCAT Decision Date: **January 13, 2004**
Panel: Julie A. Brassington, Vice Chair

Introduction

The worker was employed as a transit operator. In 2001, the worker was 48 years old; she began working for the employer in 1992. On October 17, 2001, the worker was injured when the bus she was driving suddenly and unexpectedly stopped. She submitted an application for compensation to the Workers' Compensation Board (Board) and her claim was initially accepted for bilateral forearm strains and bilateral hand strains.

On March 24, 2003 the Board officer advised the worker that wage loss benefits were to conclude as of March 30, 2003; that she did not have a psychological condition and that neck and right shoulder injuries had not been accepted as part of the claim. The worker requested a review of the letter and sought reinstatement of her wage loss benefits, acceptance of her neck and right shoulder symptoms under the claim and the provision of psychological treatment and further medical treatment.

In *Review Reference Decision #1749*, dated September 5, 2003, a Board review officer advised the worker that the evidence supported that the worker's compensable injuries were a significant cause of her right-sided neck and shoulder symptoms that commenced in December 2002. The review officer found that at the time these symptoms developed, the worker had not recovered from her compensable injuries of bilateral wrist strains and bilateral forearm strains. The review officer found that the worker's bilateral wrist strains and bilateral forearm strains resolved by March 30, 2003. The review officer also found that the worker did not sustain a psychological condition. The worker appeals these decisions.

Issue(s)

As provided by item #314.30 of the Workers' Compensation Appeal Tribunal's (WCAT) *Manual of Rules, Practices and Procedures*, WCAT will generally restrict its decision to the issues raised in the appellant's notice of appeal and submissions. The worker raised the following issues in this appeal:

- The first issue under appeal is whether the worker's bilateral wrist and bilateral forearm strains had resolved by March 30, 2003.

- The second issue under appeal is whether the worker sustained a psychological condition as a result of the October 17, 2001 injury?

Jurisdiction

This appeal was filed with the WCAT under section 239(1) of the *Workers Compensation Act* (Act). The worker appeals the September 5, 2003 decision of the Review Division.

Evidence

I have reviewed the evidence in the claim file, submissions made by the worker and her representative in support of her position, the Act in effect at the time of the events here in question, and applicable Board policy as set out in the *Rehabilitation Services and Claims Manual, Volume 2* (RSCM). The employer, although aware of this appeal, has not made a submission. The employer did make a prior submission to the Review Division. Interested parties have received full disclosure of the claim file. The medical and claim history will not be repeated in detail here except as relevant to the current appeal.

The worker was in receipt of benefits from the Board until March 30, 2002. She then went on sick leave through her company long term benefits plan until May 18, 2003. She returned to work on May 19, 2003.

On January 23/24, 2003 the worker was assessed at an occupational rehabilitation program. The Discharge summary report indicated that it was unlikely that the worker could tolerate the amount of functional activity required of her in an occupational rehabilitation program. The barriers to participating in the program were identified as:

- Reduced pain free range of motion of the wrists bilaterally.
- Reduced strength of the wrist and forearm musculature bilaterally.
- Decreased tolerance for all upper extremity activities.
- Decreased general conditioning.

The program recommended that the worker receive further activation in the form of a graded therapeutic exercise program for a period of four to five weeks. If she was able to have some success in a graded exercise program, and improve her tolerance to movement involving the upper extremities and wrists, she would be a more suitable candidate for an occupational rehabilitation program at that time. The report ended with a recommendation that the worker might be a possible candidate for a pain program should she not be able to make further gains in an active physiotherapy program.

On March 3, 2003 the worker was assessed by a Board psychologist. The psychologist found that the results of the Multi-Dimensional Pain Inventory suggested that the worker had made a rather successful accommodation to persisting pain and did not suggest that

the worker had psychological factors making great impact on her pain presentation. The Millon Behavioural Health Inventory results suggested that when people with the worker's pattern have a persistent pain condition, the probability is that they will respond well to traditional outpatient treatment. The psychologist opined that the worker did not appear to be suffering from any form of depressive disorder, nor was there indication of psychological factors impacting on pain, its severity, exacerbation, maintenance nor onset. From a psychological perspective, the psychologist concluded that the worker would not be limited or restricted in returning to work.

On March 14, 2003 the worker was examined by Dr. K., a rehabilitation specialist. He indicated that the clinical evaluation suggested that the worker had a wrist sprain and that a good recovery had occurred. He noted a deconditioning of the hand muscles. Dr. K. reported the worker sustained a cervical injury resulting in soft tissue injury and there was objective evidence of involvement of the musculature in the neck and across the shoulder. He felt the shoulder joint was intact. Dr. K. recommended that treatment intervention be that on active release technique to try and improve the muscle, reduce the tone and reduce tissue tautness, and that this be followed by a regular conditioning program. He arranged an EMG study to exclude the possibility of a peripheral nerve injury. The studies came back negative.

On April 14, 2003 the worker's physician reported that the worker was in an extremely agitated, frustrated, depressed and confused state. The worker had tumours in both forearms which the physician felt were difficult to distinguish between fibroid nodules and lipoma. He noted that he discussed the tumours with Dr. K., who indicated that if he could easily get at one to remove it, would be diagnostic of compartment type syndrome. The physician stated that he was convinced that the worker's pain was secondary to soft tissue problems and whether this was compartment syndrome or not was irrelevant. He stated that clinically the worker was not capable of working. She required significant and prolonged counselling.

On May 13, 2003 the worker was again examined by Dr. K. He noted the worker had chronic pain with the intensity of pain varying. Throbbing pain occurred within one and a half hours of driving a bus. By the end of the shift the worker reported that she felt as though her arm was swollen, her elbow throbbed and she had sharp shooting pains in her hand intermittently. He noted that the worker felt she was forced back to work due to finances, and that she felt her work injury had not resolved and the pain issues continued to limit her function significantly. He also noted that she was back on Effexor at that time. Dr. K. stated that due to the chronic pain which was present and the worker's poor tolerance to function, he recommended that consideration for psychological support be given. He stated that the worker would be a candidate for a chronic pain program followed by a work readiness and graduated return to work program.

On May 14, 2003 Dr. B., a chiropractor, noted that the worker remained physically disabled. He felt that for financial reasons the worker had been forced back to work, endangering her welfare. He indicated that he personally supervised her return to work that had required a period of retraining. He noted this was followed by part-time work and that the worker was at that time working full duties four hours a day. He stated she could only drive with her left hand, as her right hand was too painful, swollen and weak. He noted that she had a fracture in her capitate (wrist bone). He stated that the signs and symptoms of her diagnosed bilateral forearm compartment syndrome still existed. He reported that the worker had been referred to him on March 12, 2003 for active release technique treatment of her continuing myofascial pain syndromes in the right trapezuis and levator scapule muscles. He noted that the worker's right neck/trapezuis injuries were directly related to her inability to utilize her ipsilateral arm/hand due to discomfort. He stated the treatments began immediately. However, he noted that the gains with the prescribed therapy regressed with the worker's return to work. He stated that at that time the worker was suffering from wrist, forearm, right neck and right trapezuis pain with occupational duties and activities of daily life.

The employer made a submission to the Review Board on July 9, 2003 indicating that the worker had applied for long term disability benefits through the company benefit program. This was originally denied and the worker approached the employer to request an immediate return to work. Given the duration of the worker's absence and the extent of her injuries, the employer's benefits adviser recommended two days of refresher training, followed by a very graduated return to work. The worker however, requested an immediate return to full duties, due to the financial pressures caused by the lack of Board or LTD benefits.

As a result, the employer proposed a more abbreviated return to regular duties which included both regular driving duties and an assignment to do "change-offs". The worker's chiropractor approved a fairly aggressive option of a graduated return to work schedule. The employer expressed their concern as the chiropractor's letter indicated the worker was in no way ready to return to work. The employer reported that the worker returned to work on May 2, 2003, resuming regular full-time duties to May 20, 2003. On May 29, following consideration of additional information, the worker's long term disability plan allowed coverage from the time the worker's benefits were terminated by the Board until her return to work.

The employer reported that on June 5, 2003 the worker again booked off due to disability related to her right arm and applied to reopen her long term disability claim. The long term disability claim was reopened and the worker again commenced a graduated return to work program. She resumed full-time duties on June 30, 2003.

The July 25, 2003 medical records of the worker's physician note that the worker was getting approximately five and one-half hours driving time per shift. She was experiencing difficulty with one specific type of vehicle and had been assigned to the spare board. He

noted that by the end of the shift the worker was tired. She was on Effexor 150 milligrams per day and appeared mentally better; less depressed. The worker was tender along the left forearm to elbow with good hand grip. The right forearm and wrist were sensitive with good hand grip noted. The physician reported it was tender with spasms across the right trapezuis. There was good range of motion in the neck. The worker was given a note indicating she was not to drive the vehicle, she was having problems with.

In support of the worker's position that her bilateral wrist and bilateral forearm strains had not resolved by March 30, 2003, her representative submitted a medical report dated September 8, 2003 from Dr. K. and a letter from Dr. H., the worker's family physician dated September 18, 2003.

Dr. H., the worker's physician, wrote that the worker continued to be at work driving the bus. He stated she could cope with a four hour shift, but if the shift is longer or is she returned for a split shift, the pains were significantly increased. He reported that the disability is in the right hand, forearms, elbows, neck and upper back. He noted numbness with a burning pain. Examination demonstrated muscle spasm and tenderness in all areas and palpation created an increased sensitivity. He noted that the increased pain increased the worker's fatigue. Dr. H. stated mentally the worker was ready to return to work, but physically, she was not ready due to the level of her pain. He indicated that in order for the worker to remain on the job she required therapy from time to time. He stated that there is no question that all of the worker's disability was the result of the injuries while driving the bus on October 17, 2001.

Dr. K. examined the worker on September 8, 2003. He noted that the worker is right hand dominant. Examination of the cervical spine showed full range of motion with pain through the end range of movement. Tenderness was noted in the soft tissues across the shoulder region with slight increased tone. Cervical spinal movements showed mild tightness to the left side, but no limitation in range. Flexion was 70 degrees, extension 65 degrees and lateral rotation 45 degrees bilaterally.

On examination, Dr. K. found the worker's shoulder girdle range of movement to be full. There was no evidence of clicking in the shoulder region or evidence of an impingement sign. The worker's arms showed no evidence of effusion, soft tissue swelling or instability surrounding the joints. Pronation and supination were full with grade 5 power bilaterally.

Dr. K. stated the worker continued to be symptomatic with chronic myofascial pain, which was interfering with her functional abilities. She was anxious with some psychological factors secondary to the chronic pain for which she required the use of Effexor. He noted that due to financial circumstances the worker returned to an accommodated position. In addition, on occasion, she has paid other employees to carry out some of her shifts. She suffered increased pain, soreness and stiffness following her work activities and has had to take the occasional day off.

Dr. K.'s diagnosis was wrist and forearm sprain, cervical sprain, chronic myofascial pain involving both upper extremities, shoulders and neck, anxiety with altered mood, and mood disorder.

Dr. K. opined that with the lack of resolution of the worker's symptoms particularly that of pain, which had not responded to therapeutic intervention, had brought her to a point where she had plateaued and has been able to return to work in a compromised situation. He indicated complete resolution of the worker's symptoms was unlikely and it was his opinion that the worker would benefit from a chronic pain program to best cope with her ongoing condition. Further, he recommended a functional capacity evaluation to determine the worker's limitations within the work environment.

Reasons and Findings

Issue 1

The issue under appeal is whether the worker's bilateral wrist and bilateral forearm strains had resolved by March 30, 2003.

Policy item #33.00 of the RSCM states that wage loss benefits are payable where an injury or disease resulting from a person's employment causes a period of temporary disability from work. Section 29(1) of the Act provides that payments for temporary total disability will continue only so long as the disability lasts. This means benefits payable under this section will be terminated when the worker's physical impairment resulting from the injury ceases to be "temporary total", i.e. becomes partial, disappears entirely, or stabilizes. If the impairment remains temporary but is only partial, there may be entitlement to temporary partial disability benefits under section 30(1) of the Act.

The best evidence of continued disability is medical reports certifying ongoing temporary disability related to the condition accepted under the claim. The medical evidence provided by the worker's own attending physician, Dr. H., and the rehabilitation specialist, Dr. K., indicate that the worker continued to be disabled until September 18, 2003 and only returned to work due to the financial pressures she found herself under.

In the September 8, 2003 medical legal report Dr. K.'s diagnosed wrist and forearm sprain, cervical sprain, chronic myofascial pain involving both upper extremities, shoulders and neck, anxiety with altered mood, and mood disorder. Dr. K. opined that the worker was at a point where she had plateaued and had been able to return to work, albeit in a compromised situation.

Dr. H. in his September 18, 2003 letter stated the worker could cope with a four hour shift, but if the shift is longer or she is returned for a split shift, the pain level was significantly increased. He reported that the disability was in the right hand, forearms, elbows, neck and upper back. He noted numbness with a burning pain.

I find the medical evidence is compelling and indicates that the worker's bilateral wrist and bilateral forearm strains had not resolved by March 30, 2003. I find that there is medical evidence to support that the worker's bilateral wrist and bilateral forearm strains continued to be a problem until the plateau date of September 8, 2003 as indicated by Dr. K., the rehabilitation specialist. I find that the worker is entitled to sections 29 and 30 benefits from the time the Board terminated such benefits until September 8, 2003 and return the file to the Board to determine benefits past that date.

Issue 2

The second issue under appeal is whether the worker sustained a psychological condition as a result of the October 17, 2001 injury?

The Board's policy regarding psychological injury is set out in item #22.33 of the RSCM. Psychological problems arising from a physical or psychological injury are acceptable as compensable consequences of the injury. However, there must be evidence that the worker is psychologically disabled. It cannot be assumed that such a disability exists simply because the worker has unexplained subjective complaints or is having difficulty in psychologically or emotionally adjusting to any physical limitations resulting form the injury.

The Board psychologist assessed the worker on March 3, 2003 and as a result of testing and interviewing, the worker was of the opinion that the worker was not suffering from a psychological condition. Although the worker's physician and the specialist both note that the worker was depressed and on medication, I prefer the evidence of the Board psychologist over them. The Board psychologist examined the worker, and using the accepted standard measurement tools to determine the existence of psychological disability, found there was none.

Based on the evidence before me, I find that the worker does not have a compensable psychological disability. Having found this, I would be remiss if I did not note that both the specialist and the worker's physician note that the worker is suffering from chronic disabling pain. The Board has not made a decision on the matter of chronic pain. I recommend the worker discuss this matter with the Board officer.

Conclusion

With regard to the issue of whether the worker's bilateral wrist and bilateral forearm strains had resolved by March 30, 2003, I find they had not. I grant the worker's appeal, for the reasons set out above. *Review Reference #1749* is varied and I find that there is medical evidence to support that the worker's bilateral wrist and bilateral forearm strains continued to be a problem until the plateau date of September 8, 2003 as indicated by Dr. K., the rehabilitation specialist. I find that the worker is entitled to section 29 and 30 benefits from the time the Board terminated such benefits until September 8, 2003 and return the file to the Board to determine benefits past that date.

With regard to the issue of whether the worker sustained a psychological condition as a result of the October 17, 2001 injury, I find that she did not. This part of the appeal is denied and *Review Reference #1749* is confirmed in regards to this matter.

I have not addressed the matter of the worker's right-sided neck and shoulder symptoms as the review officer granted the worker's appeal and found that the evidence supporting the worker's compensable injuries were a significant cause of her right-sided neck and shoulder symptoms that commenced in December 2002. The worker did not appeal this decision to the Appeal Tribunal. Had she, I would have concurred with the review officer's decision.

The worker is entitled to such expenses of this appeal as she can establish pursuant to section 9.42(b) of the *Workers Compensation Amendment Act (#2) 2002* - Bill 63, including reimbursement to her union for the cost of Dr. H. and Dr. K.'s opinions.

Julie A. Brassington
Vice Chair

JAB/hba

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