WCAT Decision Number: WCAT-2004-00135
WCAT Decision Date: **January 13, 2004**
Panel: Susan L. Polsky Shamash, Vice Chair

Introduction

The worker, a home support worker, claimed compensation for a January 22, 2001 low back injury. The Workers' Compensation Board (Board) accepted her claim for compensation and paid her wage loss and health care benefits from January 30 to April 8, 2001. The worker later claimed compensation for a second low back injury which occurred on March 13, 2002. That claim was also accepted and the worker was paid wage loss and health care benefits from March 14 to April 1, 2002.

On October 1, 2002 the worker experienced a significant exacerbation of her low back pain following treatment for a dental emergency. In a November 27, 2002 letter a case manager denied reopening of the worker's claim on the basis that her original injury was muscular back pain and she now had a disc prolapse. The worker now appeals from a decision of the Review Division dated July 24, 2003 that denied her appeal.

The worker requested an oral hearing. I am satisfied that this appeal can be determined on the basis of the claim file and the submission of the worker's representative without the necessity of an oral hearing. The issue is primarily a medical one. The worker's representative has provided an October 28, 2003 written submission as well as October 22, 2003 comments from the worker to this panel.

The employer is no longer active. The successor employer did not participate in this appeal although advised of its right to do so.

Issue(s)

The issue to be resolved on this appeal is whether the worker's October 2002 low back symptoms are related, in some significant sense, to either or both of her previous compensable low back injuries.

Jurisdiction

This appeal is brought under section 239(1) of the *Workers Compensation Act* (Act) which permits appeals from Review Division findings to the Workers' Compensation Appeal Tribunal (WCAT).

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

The worker, now 50 years of age, provides care to the sick, elderly and terminally ill in their homes.

In her February 12, 2001 application for compensation, the worker said that on January 22, 2001, while bed-bathing a client, she held her lower back in an overstretched position until it gave out. She rested for a while and then decided to continue working because her clients depend on her. When she was relaxing at home that evening her back went into very painful spasms. She could not get out of bed for a few days. She said that she had had some muscular problems in her back in the past but they were never like this.

The worker reported her injury to her employer the following day and sought medical attention from Dr. I. Schokking, her family physician. His first report is for a February 2, 2001 visit. In his clinic note for that date he recorded that she had a 10-year history of low back pain exacerbated by work since falling down stairs at work. She had never made any formal claims in the past because her employer had convinced her not to apply. She had two exacerbations each year that she treated with anti-inflammatories and one to two weeks' rest. During the previous year she had had six such flare ups. She had not sought medical attention from Dr. Schokking despite worsening pain with each episode. The worker said that on this occasion she had moderate spasms that came and went. She had low back pain with no radiation and no bowel or bladder symptoms. Dr. Schokking said that an x-ray showed anterior osteophyte at L3-4 and 50 percent disc narrowing at L5-S1. He diagnosed an exacerbation of chronic low back pain, prescribed anti-inflammatories and physiotherapy, and estimated that the worker would be off work for 14 to 21 days because there were no light duties available at her work place.

Dr. Schokking's next report is for February 22, 2001. The worker still had low back pain without radiation. He said that a lumbar CT scan showed minimal left L4-5 disc bulging with minimal osteoarthritis. Dr. Schokking diagnosed improving muscular back pain and advised the worker to continue gradual activation. He said that she may ultimately require work conditioning to prevent her recurrent back pain.

On March 8, 2001 the worker told the case manager that her back was considerably better although she continued to have some twinges and jabs as well as stiffness. She

began a graduated return to work in lieu of a work conditioning program on March 14,2001, progressing to full duties on April 9, 2001. The worker apparently continued to be followed by Dr. Schokking but he did not send any further reports to the claim file. Her wage loss benefits were concluded on April 8, 2001.

On March 13, 2002 the worker slipped on ice and fell onto her buttocks. In her application for compensation the worker said that she felt immediate sharp pain in her mid back and pain in her lower back and buttocks. She also pulled a muscle in her neck when she was trying to get up. Shortly thereafter she began to feel stiffness and pain in her lower back.

The worker sought medical attention from Dr. K. Joss, a colleague of Dr. Schokking's, on March 14, 2002. She diagnosed a lower back strain with spasm and considered the worker disabled from working. The worker was treated with rest, heat, gentle stretching, massage and physiotherapy. Dr. Joss said that by April 8, 2002 the worker's back had returned to her baseline degree of stiffness and she was pain free. She was fit to return to work by April 2, 2002 but did not return until April 8, 2002 following a week's vacation. The Board accepted her claim for a strain to the lumbo-sacral region with spasm and paid her wage loss and health care benefits from March 14 to April 1, 2002 inclusive.

Nothing further was received on either claim file until an October 13, 2002 admission history for the worker from Prince George Regional Hospital completed by Dr. Schokking. He diagnosed her as suffering from acute left L5 sciatica. He also diagnosed early cauda equina syndrome because she had decreased rectal tone and urinary retention. Dr. Schokking recorded that the worker had a two-week history of progressive back pain radiating down her left leg with no acute injury. He had initially advised her to rest at home but she continued to be active and was ultimately hospitalized for analgesic treatment. Dr. Schokking also said she had a history of depression. He considered that she had obsessive compulsive disorder with control being her main issue causing her to have difficultlies with any illness or problem she could not control. That was why she had difficulty resting and dealing with her back pain.

The worker was discharged from hospital on October 16, 2002. In the discharge summary Dr. Schokking said that an urgent CT scan showed that the worker had a large left-sided and central disc space herniation at L4-5 with disc space narrowing at this level and vacuum phenomenon. The disc affected the lateral recess of L5, consistent with her clinical findings. Dr. Schokking also said that the worker had a history of two previous WCB claims for L5 disc herniations. He noted that she had a consultation with Dr. Daly, orthopaedic surgeon.

In his October 16, 2002 consultation report Dr. Daly said that the worker told him that following her January 2001 injury her pain resolved with physiotherapy. She had been doing fairly well at work although she took the odd day off to rest her back whenever it became sore. Although Dr. Daly felt that the recent CT scan was a little worse than the

previous in terms of the size of the disc, he considered that her presentation was confusing. She seemed to have symptoms of acute radiculopathy that the CT scan supported at face value. However, those changes had been present for the last year and a half and there were no new features to account for her current symptoms, especially the cauda equina syndrome. He found her rectal tone to be satisfactory and considered that her bladder problem was probably more related to medication. He did not think her's was an emergency situation but recommended a surgical evaluation.

On October 28, 2002, the Board sent the worker a reopening questionnaire. In answering it she said that her back had bothered her from time to time since she returned to work in April 2001 but not to the same extent as it did now. She had avoided heavy lifting or transfers at work whenever possible and took time to rest. She did not report her problems or seek medical attention because she thought it was part of her condition. She had a dental emergency on October 1, 2002 which required her to be in the chair for more than an hour. She felt discomfort while lying down and when she got up she was very stiff. She went home and lay down and felt enormous back pain that subsided after several minutes. Since then she had pain in the left side of her back and down into her left leg. She saw her doctor on October 2, 2002 and was given pain medication. She went to physiotherapy the following day. By the following week she had tingling in her left foot and could not move her toes. On October 13, 2002 she got up to get something, her disc herniated and she was taken to hospital immediately.

In a progress report of October 22, 2002 Dr. Schokking said that Dr. Daly thought the worker's most recent CT scan was only minimally worse than the one taken 18 months previously. She had improved and was able to sit for brief periods with virtual resolution in the leg numbness and no bowel or bladder symptoms. By November 8, 2002 her symptoms had improved somewhat. However, she could not stand or sit for more than 30 minutes and was not able to return to work.

The case manager requested a medical opinion regarding the relationship between the worker's current back problem and her January 22, 2001 compensable injury. In a November 26, 2002 memo, Dr. N. Byrne, medical advisor, noted that there was no evidence of radiculopathy following that injury either on examination or on CT scan. The worker returned to work and had back pain on and off but no radicular complaints until October 2002. Dr. Byrne noted that there was an L4-5 disc prolapse apparent on the February 2001 CT scan but there was no reason to associate that to the work incident which was minor and unlikely to result in a disc prolapse. He thought that her recent symptoms were a natural progression of it. On the basis of this opinion the case manager denied reopening of the claim.

In support of her appeal to the Review Division the worker's representative provided a February 26, 2003 letter from Dr. Schokking. He said that he has been her physician since 1996. She had a ten-year history of intermittent back pain with lifting. He said that on October 10, 2003 the worker described worsening of her back symptoms for three months which markedly worsened after sitting in the dentist chair. She had an

L4-5 disc herniation that was the same level that showed on her February 2001 CT scan. He considered it likely that this was a worsening of the previously proven herniation that had been intermittently symptomatic over ten years. She probably had had an intermittently herniating disc over the years. He was not aware of any activity she did which might bring on the herniation other than lifting in her job. Although sitting for two hours in a dentist chair might exacerbate it, it should not cause a disc herniation. In Dr. Schokking's opinion the chance was significantly less than 50 percent that the worker's condition would have become disabling in October 2002 in the absence of her prior injuries. He believed that lifting patients as a home care aid would exacerbate an intermittently herniating disc and would therefore accelerate her symptoms.

The worker underwent surgery for removal of the left L4-5 disc on February 17, 2003 which was performed by Dr. J.R. Padilla, neurosurgeon.

On June 2, 2003 the review officer requested Dr. Schokking's records of the worker's low back treatment over the previous five years. This was not received before the review officer issued his decision.

I have had the benefit of reviewing Dr. Schooking's records. These included his chart notes recording the February 2 and 22, 2001 and March 14 and October 22, 2002 appointments already documented on the claim file. In addition, Dr. Schokking or one of his associates saw the worker on January 30, February 9, March 5 and 26 and September 21, 2001, March 20 and 28, April 8, and October 1, 11, 13 and 30, 2002 and several times thereafter.

These confirm that, although the worker had some dull radiation into both buttocks on January 30, 2001, this resolved and she had no further radiation of her symptoms. On March 26, 2001 Dr. Schokking advised the worker to undertake a fairly extensive exercise program to improve her back problem because she probably had a disc lesion. The September 21, 2001 visit was with respect to neck and upper back complaints. The September 28, 2001 visit was for shortness of breath caused by a panic attack. The worker wondered whether the shortness of breath sensation was related to her back problem. The March and April 2002 visits were with respect to the 2002 compensable fall. She did not see Dr. Schokking again until after the dental chair incident.

The two CT scans Dr. Daly compared were also forwarded to the claim file. That of February 9, 2001 showed a moderate midline disc bulge at the L4-5 level, slightly more prevalent in the left paracentral region with mild circumferential disc bulging resulting in relatively mild compromise of the thecal sac and appearing to involve the traversing left nerve root at this level. The October 14, 2001 scan showed a large left-sided and central disc space herniation at L4-5 along with disc space narrowing at this level. The vacuum phenomenon previously mentioned was also noted. The thecal sac was displaced posteriorly and to the right. The left L5 nerve root was likely affected in the lateral recess of L5.

Submissions

The worker's representative relied upon her May 23, 2003 submission to the Review Division in which she reviewed the information on the 2001 claim file and argued that the worker's evidence regarding her ongoing low back condition ought to be accepted. She submitted that but for the worker's previous compensable low back injuries as well as her ongoing duties at work which required her to bend, lift and twist, she likely would not have had the significant problem which developed in October 2002. There was evidence of a disc herniation in February 2001 that was only minimally worse 18 months later. The very serious symptoms the worker developed in October 2002 could not be related to something so insignificant as sitting in a dentist's chair.

In response to the Review Division decision in her October 28, 2003 submission the worker's representative argued that the only problem the worker had with her back prior to January 2001 was muscular/soft tissue. It previously resolved within days but she never really recovered from January 2001 injury. Her symptoms worsened depending on her activity. The worker is certain that that this is when her disc problems began. Her type of work puts her at high risk for this type of injury. She believes that she was misdiagnosed in January 2001 and that is why she did not come into see her doctor again before October 2002.

The worker and her representative took issue with some of Dr. Schokking.'s statements in his February 26, 2003 opinion. Although she had intermittent back problems over the previous ten years, they were not disc problems. Dr. Schokking appeared to assume they all related to her fall down the stairs ten years previously. However, prior to January 22, 2001 she did not miss any significant time from work due to low back symptoms. There was no x-ray or other evidence of a disc problem. The representative submitted that this disc was injured in that incident and the incident in the dental chair only brought it to light. She argued that it is inappropriate to rely on the fact that these claims were accepted as soft tissue injuries when the diagnosis ultimately turned out to be wrong. She submitted that this was a progressively deteriorating compensable condition that became a manifest disability in October 2002 and the worker is entitled to have her claim reopened.

Law and Policy

Section 5(1) of the *Workers Compensation Act* (Act) provides for payment of compensation where a worker suffers a personal injury arising out of and in the course of her employment.

Item #22.00 of the *Rehabilitation Services and Claims Manual, Volume 1* (RSCM) provides that a claim will not be reopened just because a later injury would not have occurred but for the original injury. The matter must be examined from a common sense point of view and what needs to be considered is whether the previous injury was a significant cause of the later injury.

Item #22.20 of the RSCM provides that where a worker has a compensable condition that was rendered disabling by an aggravating incident outside of work, the claim is not reopened just because the incident would not have been significant if the condition had not existed. Rather, it is considered that the non-work incident caused the disability.

Item #15.10 of the RSCM provides that where a worker has a deteriorating condition that is at a critical point where it is likely to become a manifest disability regardless of the work situation, anything may cause it to become disabling. The fact that something at work caused the ultimate disability is only coincidental. The worker would not have escaped the disability regardless of the work activity and the deteriorating condition is therefore considered to have been the cause.

Item #97.32 of the RSCM provides that a statement of a worker about her own condition is evidence insofar as it relates to matters within her own knowledge.

Reasons and Findings

The Review Division denied the worker's appeal on the basis that her 2001 claim was accepted for a soft tissue injury to the low back with no neurological findings despite the findings of the CT scan. The worker had a long history of intermittent back problems which were increasing in severity and the herniation was likely present prior to the January 22, 2001 incident and not caused by it. Given this, combined with the normal neurological findings, the review officer could not conclude that this claim caused a disc injury. He also noted the diagnosis of low back sprain with muscle spasm in the spring of 2002 following the worker's March 2002 fall. The review officer found support for his conclusion in the Board medical advisor's opinion. He therefore found that the worker's symptoms in October 2002 were not a compensable consequence of her January 22, 2001 injury at work but were more related to the October, 2002 emergency dental treatment.

I agree with the Review Division's decision. I am not satisfied that the worker's disabling L4-5 disc herniation in October 2002 is related to either or both of her January 2001 and March 2002 compensable low back injuries.

Although the worker feels very strongly that the January 22, 2001 incident at work is the cause of her herniation, the medical evidence does not support her. This is not the type of statement policy contemplates. The worker's opinion on the cause of her condition is not sufficient. While her representative is very critical of the information contained in Dr. Schokking's opinion, the worker herself is the source of Dr. Schokking's information. She related her prior back problems to her fall down the stairs ten years previously; she advised him of her ongoing exacerbations and their increasing severity, as well as the length of time she took from work to recover from them.

There is no medical evidence of radicular involvement at or near the time of either of the worker's January 22, 2001 or March 13, 2002 compensable low back injuries.

The representative's submissions that either this disc herniation was caused by the January 22, 2001 incident, or is a compensable consequence of it, or that that incident initiated a deteriorating condition that ultimately became manifest in October 2002 are not supported by a medical opinion. At best, Dr. Schokking relates the October 2002 herniation to a pre-existing herniation that has been intermittently symptomatic over ten years related to lifting at work. Dr. Schokking also states that the worker has had chronic back pain intermittently since her January 22, 2001 but admits that this is no different than her picture prior to that injury. He goes so far as to postulate that the herniation in October 2002 is related to her work because of the lifting that she does.

The worker's claims are not for generalized lifting as a care aid over time. Rather they are for two specific incidents, neither of which resulted in any evidence of radicular involvement. Dr. Schokking considers that the October 2002 herniation would not have occurred if she had not had the prior injuries but does not explain how such soft-tissue injuries could have lead to a herniation. As the review officer noted, Dr. Schokking appears to believe that those claims were accepted for injuries to the disc.

I am not satisfied that either or both of the worker's January 22, 2001 or March 2002 injuries were a "significant cause" of the worker's L4-5 disc herniation for which she underwent surgery in February 2003. I come to this conclusion on the basis of the objective medical findings following both injuries which showed soft tissue injuries only and no radicular involvement. I do not accept the submission that these were misdiagnosed. There is no medical support for this contention. Given the soft tissue nature of these injuries combined with the fact that the worker returned to work after the January 2001 injury in less than three months and did not return to see her doctor with low back complaints until she fell in March 2002 and not again until October 2002, I find that the worker's problem in October 2002 is not related to either or both of her previous compensable injuries. I also come to this conclusion because there is no medical opinion that adequately explains a relationship and there is a medical advisor's opinion to the contrary. I am persuaded by Dr. Byrne's opinion and rely upon it. The worker is therefore not entitled to reopening of either claim.

The worker's representative requested reimbursement of the expense of obtaining Dr. Schokking's February 26, 2003 medical opinion that was submitted to the Review Division. Section 7 of the *Workers Compensation Act Appeal Regulation* only provides me with the authority to award expenses associated with obtaining or producing evidence submitted to the appeal tribunal. Dr. Schokking's report was already on the claim file and not obtained in support of the further appeal to this tribunal. I therefore have no authority to grant this request.

Conclusion

I deny the worker's appeal and confirm the Review Division's decision.

Susan L. Polsky Shamash
Vice Chair

SLPS/dcw

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