WCAT Decision Number: WCAT-2004-00157-RB
WCAT Decision Date: **January 14, 2004**
Panel: Lois Williams, Vice Chair

Introduction

The worker, a community health nurse, suffered a neck strain and right epicondylitis condition in January 2000. The Workers' Compensation Board (Board) accepted her claim for benefits. The Board noted that the worker had pre-existing problems in her neck and elbow and granted the employer relief of costs on the claim effective April 18, 2000. The worker completed a graduated return to work on July 14, 2000, but went off work again in September 2000.

In a letter dated December 19, 2000, a Board case manager declined to reopen the worker's claim. The case manager noted the worker's pre-existing problems and a Board medical advisor's opinion that there was no evidence of a "pathophysiological process" to explain the worker's persistent subjective complaints of cervical pain. The case manager said that she questioned why the claim had been accepted, but she did not readjudicate that acceptance. She said that the cervical strain and elbow tendonitis appeared to have responded well to therapy and rehabilitation, as the worker was found fit to return to work with no limitations on July 14, 2000 and stopped therapy early on July 27, 2000. The case manager's decision was that the worker's current condition was not related to the injury accepted under the claim. The worker appeals this decision.

Issue(s)

Was the worker's pain and disability in September 2000 related to the neck strain and right lateral epicondylitis condition accepted by the Board as being caused by the work injury in January 2000?

Jurisdiction

This appeal was filed with the Workers' Compensation Review Board (Review Board). On March 3, 2003, the Appeal Division and the Review Board were replaced by the Workers' Compensation Appeal Tribunal (WCAT). As this appeal had not been considered by a Review Board panel before that date, it has been decided as a WCAT appeal. (See the Workers Compensation Amendment Act (No. 2), 2002, section 38.)

Background and Evidence

According to the worker, on January 15, 2000 she and another nurse were in a client's home, doing a complex dressing change that took one hour to complete. The worker had to do a lot of bending and stretching to remove multiple dressings/bandages from the client's neck and chest area. She then assisted the client into a low seat in the bathtub and poured several one-litre containers of water over the client to remove remaining dressings. She supported the client's upper body with her right arm while the client leaned back so she could remove underarm dressings. She assisted the client back to the bedroom and applied new dressings, wrapping the bandaging around the neck and chest area. This again involved much bending and stretching, especially of right arm.

The worker reported that the next day she assisted another client's daughter to lower the client's bed and together they performed an underarm lift, with the worker using her right arm.

On February 28, 2000 the worker signed an application for compensation, stating that she had been diagnosed with a cervical injury and right arm tendonitis. The worker said that she had previous discomfort in both areas and had been receiving chiropractic care to the neck. She attributed her prior difficulties to work activities of carrying a heavy (approximately 25 lbs.) bag of supplies on her shoulder, and to driving a car that was not equipped with power steering. She said her prior elbow pain was worse a few times in December 1999 when she applied tensor stockings to client's legs following dressing changes. Although she felt her prior problems were also work-related, she said that the work activities of January 15 and 16, 2000 exacerbated her conditions.

On February 15, 2000 the worker's doctor faxed a first report of treatment that day to the Board, stating that the worker had first been seen January 17, 2000. The doctor recorded the worker's statement that pain developed in her neck and right elbow while doing a complex dressing and supporting a patient's upper body weight on consecutive days. The doctor said the worker had prior very slight discomfort on and off in her right elbow and neck, but "nothing like this". The doctor said that x-rays showed C5-6 degeneration in the neck.

The Board's case manager contacted the worker's doctor's office on March 15, 2000 and recorded that the medical office assistant informed her that the worker had been seen on January 17, 2000 with elbow pain related to a dressing change, and that there was a February 8, 2000 chart note regarding injuries. On March 15, 2000 the doctor faxed the Board his January 17, 2000 chart note which queried tennis elbow with the apparent comment that the worker did not know the cause of it.

The case manager contacted the worker's physiotherapist on March 16, 2000 and recorded that the therapist informed her that the worker had been assessed on January 27, 2000 for her elbow and there had been obvious swelling, and tenderness to touch. The therapist said the worker was being treated by a chiropractor for her neck

and the therapist did not assess that area. The worker had told the therapist that she had done a very difficult dressing over the weekend. The therapist said the worker had demonstrated the body motions and postures required to do the dressing change and it was evident to the therapist that the worker had a traumatic tendonitis in the elbow, sprained ligament and strained cervical and trapezius muscles. The therapist said that she does not like to fill out "WCB" paperwork and both she and the worker's doctor felt the worker would recover quickly. In hindsight, this was incorrect and the therapist told the case manager she "takes full responsibility for any problems this has caused".

The case manager did not record her rationale for accepting the claim, but issued a March 24, 2000 decision telling the worker that her "claim for injury to your cervical and trapizius [sic] area and right elbow on January 15, 2000 has been accepted".

On March 7, 2000 physical medicine specialist Dr. MacKean said the worker's injuries were most consistent with muscular tightness and spasm in the neck and upper back region, and there were no features to suggest disc herniation, thoracic outlet syndrome or reflex sympathetic dystrophy. The worker also had resolving signs of mild tendonitis and muscular discomfort in the right lateral elbow and forearm region.

On March 16, 2000 neurosurgeon Dr. Joaquin said the worker's neurological examination was normal and that there was no evidence of a herniated disc. To reassure the worker, he ordered an MRI. The March 19, 2000 MRI of the cervical spine showed a tiny central posterior focal disc herniation at C5-6, with no mass effect on the cord and with no nerve root abnormality.

The worker started an occupational rehabilitation program Apri1 10, 2000 and was cleared by the program and her doctor to start a graduated return to work on June 12, 2000. Although the occupational therapist noted at a meeting on June 2, 2000 that the worker had a decreased ability to perform patient care tasks involving sustained bending, and patient lifts and transfers, she did not find that worker was restricted from attempting as many of her work duties as possible. The worker was being provided with a vehicle with power-assisted steering. She had bought a pull-along carrying case for her supplies, rather than use a shoulder bag. A three-week graduated return to work was arranged, with ongoing evaluations as needed. The worker was to "buddy" with another nurse and gradually take on more tasks.

The worker complained of increased pain in the evenings after work, and on June 21, 2000 her doctor altered the return to work schedule to allow for more time before the hours were increased. On July 5, 2000, the doctor noted the worker was improving slowly, but that she was exhausted with the current return to work schedule. She was unable to function after work and found that her appointments for treatment were overwhelming and she could not get time for counselling. The doctor said that tension was palpable in the neck and shoulders, but there was a nontender [full] range of motion of the neck. He expected the worker to be fully returned to work by July 14, 2000.

On her July 14, 2000 discharge from the occupational rehabilitation program that had monitored her graduated return to work, the worker said she had worked the last two days at full hours and full duties and felt these shifts had gone well. She did not feel "perfect" but was managing well. The program therapist recommended that the worker continue with an exercise program and also with physiotherapy, as required, for four weeks to ensure a durable return to work.

On September 5, 2000 the worker's doctor reported that the worker had been back to full work for five to six weeks, with some vacation time off in August. The worker reported having a difficult time, with moderate pain at the end of her shifts. She felt overwhelmed with pain and exhaustion at the end of the previous week, and had severe pain on September 12, 2000, for which Tylenol #3 was of no help. On examination the doctor found mild tenderness of the cervical area, right greater than left, and also mild trapezius tenderness. The worker was disabled.

The Board's case manager asked a Board medical adviser if the worker's current symptoms were related to her injury and whether the worker's symptoms were resulting from the degenerative changes. On September 13, 2000, Board medical advisor Dr. Martin said, following review of the claim, that he was not aware of any specific injury the worker would have suffered from doing the complex dressing change on January 15, 2000 or lifting the next day, except for possible tendonitis in the right elbow and general weakness from the elbow down. In response to the questions asked, Dr. Martin said:

> 1. It would appear that she has persistent complaints of pain in her neck with no obvious source and/or etiology identified. I cannot answer your question as to whether they have been directly related to an accepted injury because it is not clear to me that there has been any injury identified other than activities. These do not constitute injury. They have all involved controlled body movement.
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> 2. I am not aware of any identifiable degenerative change that one could medically apply her current symptomatology to. As stated earlier she does have a subtle central posterior disc herniation at C5-6 which is of no clinical significance and it has no correlation to symptomatology. Her symptoms therefore cannot be related with any degree of certainty to these non-specific findings.

Dr. Martin said that it was an administrative decision in that if the case manager had accepted that there had been an injury and the symptoms related to the injury were of neck pain of unspecific origin, it would follow that the worker's current symptoms were likely related. He could not give the case manager any medical evidence to support that, as there had been no pathophysiological process identified.

The case manager denied a reopening of the claim.

The worker's doctor wrote the Board on September 14, 2000, stating that most of the worker's exacerbation occurs near the end of a full shift, and leaves her with severe pain in the evening that continues through the night, leaving no time for full recovery before the next shift. The doctor said, in part:

> I recommend that her claim be reopened, and that she have further time off work to recover from this recent exacerbation. Following that, I believe that [the worker] may be capable of performing her duties adequately on a part-time basis. She has absolutely no desire to be off work completely, but we feel the return to full-time has been too intensive and led to the above result.

The doctor authorized the worker to return to work half-time on October 2, 2000, working a full shift, but not daily. However, the worker had a further and severe exacerbation of pain that day and did not work after that. She had also developed mouth pain which a specialist felt was related to referred pain from the trapezius and sternocleidomastoid muscles. On November 8, 2000, Dr. MacKean said the worker had chronic muscular pain involving the right side of the neck, right scapular region and right lateral elbow region. She seemed to be improving. Dr. MacKean felt the worker should stay off work and work on an exercise program. Dr. MacKean did not think that planned injections at a pain clinic would be helpful.

On January 8, 2001 Dr. MacKean noted that the worker had no relief from an epidural injection into her cervical spine by Dr. Bowers in December, but had felt slightly decreased pain from trigger point injections the week before. Dr. Bower had also prescribed morphine for the worker. Dr. MacKean noted that the worker had some other major stressors in her life at that time. She suggested that the worker take an additional six months off work, follow up with Dr. Bowers regarding further trigger point injections, continue morphine, and her regular exercise program. On May 3, 2001 Dr. MacKean noted the worker continued to take morphine and felt unable to return to work. Dr. MacKean recommended the worker take a longer time away from work "to work on her rehabilitation and also to hopefully get her stress level under better control".

On February 1, 2001 Dr. Bowers reported the worker had done well with her trigger point injections. The worker told him her pain had been reduced by about 50 percent. However she continued to take morphine and was having a lot of stress as her mother was dying in hospice.

On February 17, 2002 the worker's doctor wrote to the worker's union representative, stating that his records did not disclose the worker having neck problems before January 15, 2000. He said that the question regarding causation was a difficult one as most physicians would feel the probability was less than 50 percent of an average nurse straining her trapezius and cervical musculature during a dressing change, and then be

disabled many months later. The doctor said that perhaps the worker had poor upper body conditioning, when she was trying to position the heavy patient for a dressing change. He understood that she developed mild pain following the first application, followed by increasing pain with subsequent dressing changes. He said the worker presented to him one month following the onset. It was the doctor's opinion that the worker's "cervical and trapezius symptoms were consistent with the situation that occurred January 15/16th onward". He said the worker was an honest patient with no previous neck injuries and there was no other cause known.

The worker's doctor said what was more difficult was the explanation for the longevity of the worker's symptoms. He said that, in general, appropriate rehabilitation programs do have good success rates, but this worker never fully recovered. He also noted the worker had experienced some mood trouble related to her injury, and the emotional issues were heightened by some significant events in her personal life. The doctor said the worker continued to currently be disabled from her injuries of January 15/16, 2000.

On April 8, 2002, the worker's chiropractor wrote to the worker's union representative, stating that he began treating the worker on November 4, 1999 for tension in the suboccipital region and related headache that the worker related to muscular tension form a stressful family situation that had been ongoing for the previous five months. She had received previous unspecified care for this without much success. The chiropractor identified abnormal suboccipital tension and tenderness in the left paracervical muscles down to the base of the neck. The worker reported 50 percent relief after three treatments. She returned to treatment on January 25, 2000 for recurrence of the initial problem and also right elbow pain, consistent with lateral epicondylitis. The chiropractor limited his treatment to the cervical area after the first visit, treating the worker a total of three times, and recalls that the worker felt her elbow lesion was disabling, a view he did not share. She was not pleased with his advice that she should be able to work. She did not return to treatment. The chiropractor said he was not aware of any disability from neck symptoms prior to April 16, 2000 and when the worker saw him on January 25, 2000 she did not say how long she had been off work.

In a February 25, 2002 report to the worker's union representative, Dr. MacKean said she believed that the worker's work activities of January 15, and 16, 2000 were causative in terms of the development of the subsequent problems with neck and upper back pain with muscular tightness and spasm. Dr. MacKean could not say whether or not the work activities were more than 50 percent responsible, but she did believe that they were causative in contributing to the ongoing problems that the worker had been having since then. Dr. MacKean said that when she first assessed the worker on March 7, 2000, the worker had reported no previous history of similar problems, and had said the problems started at work with dressing changes, transferring patients, bathing and other personal care activities. Dr. MacKean said that in her January 6, 2001 report she had noted the worker had other major stressors in her life. Dr. MacKean could not recall specifically what those stressors were, but she believed

they were family related stresses. In Dr. MacKean's opinion, significant stress can make any medical condition more noticeable and musculoskeletal problems and chronic muscular pain problems are often made worse if the person is under a lot of stress.

At the oral hearing held on October 14, 2003, the worker said that she had been experiencing some minor symptoms a few months before January 2000, which she described as tension in the neck and tension headaches. She said she was under stress at work, and colleagues at work who had similar symptoms encouraged her to see the chiropractor. She thinks that the three chiropractic treatments she received then made some difference but it was short-lived. Regarding the chiropractor's information that she had told him that she had previously had some professional treatment, the worker denied this. Regarding the chiropractor's information that the worker had related her symptoms to a stressful family situation, the worker said that her father had been diagnosed with Alzheimer's since the summer of 1999, and his condition had been deteriorating.

The worker described the work activities doing the complex dressing change and supporting the client in January 2000, and said that her neck and arm felt much stiffer and more painful afterwards. She said she did not recognize the magnitude of her problems until later. When she saw her doctor the first time, she did not specifically relate her elbow symptoms to the work activities, but she realized over the next week or two what had happened, and told him what had happened at a later date.

The worker said that she asked her doctor if it should be WCB, but she guesses that he had a problem with a claim being accepted. He said that it would be stressful for her but if she felt strongly about it, he would help her out. When her claim was accepted and she was referred to the rehabilitation program she saw a psychologist one time when she wanted to talk about pain control. She said that her family stress had been reduced as her father was in a nursing home by that time. Regarding information that she was a single mother with a 12 year old daughter, who had a fair amount of stress at that time, the worker said that the stress was not with her daughter. She said it was due to her pain issues. She found it hard to care for her daughter, but her daughter was very good about it, and was a straight "A" student. Regarding stress related to her mother, the worker said that in the summer of 2000, her mother had a health problem. The diagnosis turned out to be diverticulosis, but the worker had been worried that it was something more sinister. The worker said that, unfortunately, by the fall, her mother's health deteriorated drastically and she was diagnosed on December 29 with inoperable cancer, probably of the pancreas. The cancer was so far advanced there was no treatment, and she died within six weeks of the diagnosis.

The worker said that she had started to take counselling through the short term assessment unit at the local mental health center in February 2000, and that the counselling continued periodically for about a year. She tried a few anti-depressant medications but had terrible side effects.

The worker said that the graduated return to work program commencing in June 2000 was forced upon her. At first, she was working very reduced hours, shadowing another nurse, and not carrying materials. She had power-assisted steering in the car. She said that she was always still in pain and the pain was worse at the end of the shift. She said she was very tired, but tried to continue. When she was cleared to return to full-time work in mid-July, she used vacation time to stretch out her time off work. For example, she took vacation from July 24 – 27, July 31 – August 6, August 14 and 15, August 26 – September 3. When asked why she had not continued with the physiotherapy that had been approved for a further four weeks in July, she said that she did go three times. She then said that by the time she got the approval for physiotherapy she had already set up her own rehabilitation at a recreation center, involving 35 sessions with a kinesiologist over six months.

The worker said she stopped work early on September 11 due to terrible pain and complete exhaustion. She tried to return on October 2, 2000 but could not continue. She said that she had so many medical appointments that had gone on and on that emotionally she needed a break. She was still getting counselling in September 2000 when she left work. She said that in February 2001, she recontacted the counselor for bereavement counselling after her mother died. She saw the counselor a few times but did not use up the 12 sessions allowed.

The worker said that the injections from Dr. Bowers helped to some degree, taking the edge of her acute intense pain. She felt that the treatment, along with the long-acting morphine medication had a combined benefit. She also benefited from a referral to Dr. Ong-Lam at St. Paul's Hospital, who diagnosed her with chronic myofascial pain syndrome and treated her with botox injections. She had three series of these injections, starting in December 2002, and within six weeks started to feel better. She returned to work part-time 23 hours per week in April 2003 but does not do much hands-on patient care. She provides service to Patients at Home/Care for the Day, providing supervision, making referrals to outside agencies, monitoring vital signs, and coordinating care with the patient's physicians.

The worker said she is still under Dr. Ong-Lam's care, and is still on morphine.

Submission

The worker's representative submits that the case manager attempted to re-adjudicate the initial acceptance of the claim when she denied the reopening. She did not follow the process to do that and the claim remains accepted by the Board. The worker's representative submitted that as the claim is an acceptable one, the case manager should have accepted the Board medical advisor's opinion that the ongoing symptoms were related to the injury. The worker's representative also relied on the worker's doctor's opinion that the worker did not recover from her work injury and again became disabled when she attempted to return to work. The representative submits that the worker did not recover, but used her vacation time to stretch out her graduated return to

work as she attempted to cope with her ongoing pain. The worker also attended massage and physiotherapy treatments, and her rehabilitation program at the recreation center, all in attempts to relieve her pain so she could continue at work. The worker's representative submits that the injury that disabled the worker again in September 2000 was the January 2000 injury, and the worker's claim should have been reopened.

Findings and Reasons

Section 5(1) of the *Workers Compensation Act* (Act) states that compensation is payable where a worker suffers a personal injury arising out of and in the course of employment. Section 29 of the Act states that compensation is payable for temporary disability, so long as the disability lasts.

Board policy at item #106.20 of the *Rehabilitation Services and Claims Manual* (RSCM) states that an application for reopening of a claim is one that does not question the validity of any previous decision but requests that further compensation be paid on the basis that the claimant's circumstances have changed since the decision was made. An example of this is where there has been a total recovery and wage-loss payments have been terminated, but subsequently there has been a recurrence of the disability.

Policy item #107.00 of the RSCM states that an application to have a previous decision of the Board reopened will be treated as a new matter for adjudication.

In this case, the worker had been found fit to attempt a graduated return to work. By July 14, 2000 she was found fit to attempt a return to full work duties, with the doctor and the Board's therapist both acknowledging that the worker had some vacation time to use, and with the recommendation that she continue with therapy for her ongoing symptoms. The evidence is that the worker had ongoing symptoms and had ongoing difficulties directly related to the symptoms for which her claim had been accepted. She attempted to work through these with the assistance of therapy and with her rehabilitation program. However, she soon became exhausted and by September 2000 she was again disabled.

The case manager, in denying a reopening of the worker's claim, questioned the initial acceptance of the claim. However, she did not ask for permission to readjudicate that decision, and the acceptance of the claim stands. I find that the worker was disabled from work in September 2000 and was still disabled when she attempted to return to work in October 2000. I find that the evidence supports a finding that she was disabled by the symptoms accepted under her claim. This was not so much a recurrence of her accepted condition, but a continuation of it, that had again caused disability. I find that the worker was entitled to a reopening of her claim. The Board is to determine the quantum of benefits that flow from this decision.

Conclusion

I vary the Board's December 19, 2000 decision. I allow the worker's appeal and find that she was temporarily disabled by her accepted January 2000 injury in September 2000, such that her claim should have been reopened. The Board is to determine the quantum of benefits that flows from this decision.

I authorize reimbursement for the costs of Dr. MacMillan's February 17, 2002 report, Dr. Curran's April 8, 2002 report, and Dr. MacKean's February 25, 2002, to be paid in accordance with the Board's schedule of fees. There were no other direct appeal costs.

Lois Williams
Vice Chair

LW/mli

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