WCAT Decision Number: WCAT-2004-00162-RB
WCAT Decision Date: **January 14, 2004**
Panel: Lynn M. Wilfert, Vice Chair

Introduction

The worker, a registered nurse, had a claim accepted for injuries to her left arm and shoulder which occurred while removing a bed and patient out of a room on November 22, 1999. She has appealed three decisions with respect to this claim.

The first decision set out in a letter of November 22, 2000 from a Board case manager terminated the worker's wage loss benefits effective December 10, 2000. It was at that point the worker would have been discharged from an occupational rehabilitation program as fit to return to work. The case manager noted that the worker had a right shoulder disability which was not accepted under the current claim nor was it considered related to her previous claim.

The case manager reviewed further medical information provided and concluded that it did not provide a basis to reinstate the worker's benefits. The worker was told in a letter of March 30, 2001 which she has appealed.

The case manager reviewed a rheumatological consultation and in a decision set out in a letter of May 30, 2001 upheld the earlier decisions to terminate wage loss benefits and deny acceptance of the worker's neck and right shoulder symptoms. He also denied acceptance of any myofascial pain under the worker's claim and concluded there was no permanent functional impairment and no basis to refer the file to disability awards. The worker appealed that decision.

Issue(s)

- Are the worker's right shoulder and neck symptoms related to her November 1999 injury or any of her other claims?
- Had the worker recovered from her compensable injury by December 10, 2000?
- Is the worker's myofascial pain related to her November 1999 injury?
- Does the worker have a permanent functional impairment?

Jurisdiction

These appeals were filed with the Review Board. On March 3, 2003, the Appeal Division and the Review Board were replaced by the Workers' Compensation Appeal Tribunal (WCAT). As these appeals had not been considered by a Review Board panel

before that date, they have been decided as a WCAT appeal. (See the *Workers Compensation Amendment Act (No. 2), 2002,* Section 38).

Relevant Information

The worker has a history of shoulder claims commencing in 1984 when she injured her right shoulder moving a bed-side locker. She had persistent right neck and shoulder pain which was variously diagnosed as tendonitis, thoracic outlet syndrome and fibromyalgia. The claim was re-opened on several occasions and she eventually returned to work on a full time basis in 1987.

The worker had a further injury in November 1989 when she strained her right shoulder and trapezius while pressing down on a patient's legs to release his muscle spasms. She returned to work under this claim in April of 1990.

In October of 1992 she had a right trapezius and cervical strain while transferring a patient. She returned to work on full duties in February of 1994.

On November 22, 1999 the worker was moving a patient and his bed out of a room and while manoeuvring the bed developed pain in her left shoulder and elbow. Her claim was accepted for injuries to her left arm and shoulder including left epicondylitis. The worker commenced a work conditioning program in December 1999 and at the time of her discharge on January 25, 2000 she still had pain in her left elbow and shoulder. She was referred for an occupational rehabilitation program prior to a graduated supernumerary return to work. When she was assessed in the occupational rehabilitation program it was noted that she still had some tenderness over the left trapezius and to a lesser extent on the right. This was the first mention of any right-sided symptoms.

The worker was discharged as fit to return to work with limitations on March 6, 2000. The discharge report noted that the worker's functional ability was no longer limited by the left elbow in lifting, however, she had right shoulder and neck pain which was greatly aggravated by work tasks. The worker reported intermittent right shoulder and neck pain aggravated by all shoulder range of motion on the right and work tasks such as pill crushing and bed winding. Although her left shoulder had improved, her right shoulder had become worse with the continuous use of her pill crusher at work. The worker continued with the graduated return to work and on March 23, 2000 was cleared for modified full-time work. Her physician stated she was to avoid repetitive heavy lifting and use an electric pill crusher. The worker had an aggravation of her symptoms on April 8, 2000 after manually cranking up beds with her left arm. She only missed one shift and then was off work for non-compensable surgery.

Following recovery from her non-compensable surgery the worker continued to be disabled by her left lateral epicondylitis. A steroid injection improved her elbow symptoms, however, despite physiotherapy; she remained symptomatic in her shoulder

area. Her physician reported persisting bilateral neck and scapula pain and she was unable to return to work.

The worker was referred to a neurologist but nerve conduction studies were normal. An MRI of her neck showed a central bulge at C3-4 but no nerve compression. She was assessed for an occupational rehabilitation program in October, 2000. The assessing physician concluded that there was no reason why the worker could not participate in an occupational rehabilitation program with regards to her left shoulder, however, most of her difficulties were on the right side and it should be further investigated if it was accepted as part of the worker's claim.

The worker attended the occupational rehabilitation program, however, her recovery and return to work planning was affected by her unresolved right shoulder problem. The worker's left shoulder improved but her right shoulder remained symptomatic.

The worker's claim was reviewed by a Board medical advisor and as outlined in his memo of November 10, 2000, he felt it was unlikely that the worker's right shoulder symptoms were as a result of the work incident. He also felt it was speculative that the right shoulder symptoms were resulting from the worker protecting her left shoulder. Given this opinion, the case manager denied acceptance of the right neck and shoulder symptoms and rendered the decision appealed by the worker.

The worker's attendance at the occupational rehabilitation program was interrupted due to her right shoulder problems, however, it had been estimated that she would have been discharged by December 8th. The case manager extended the worker's benefits to the end of that week relying upon the Board's policy at item 21.14 of the *Rehabilitation Services and Claims Manual* (RSCM).

The worker was reviewed by an orthopaedic specialist on March 5, 2001. He concluded that the worker's problems were predominantly left lateral epicondylitis and a mild left shoulder impingement. He also recommended that she be seen by a rheumatologist for assessment of a possible myofascial pain syndrome. If she did not have a myofascial pain syndrome he recommended a course of Sonacur and physiotherapy for the left elbow.

The Board case manager concluded that there was no basis to re-open the worker's claim but would review it after the referral to the rheumatologist. In a report of March 28, 2001, the worker's physician noted that the worker was permanently disabled and needed a disability pension assessment. Further reports indicated no change in her ongoing neck, left shoulder, forearm pain and right shoulder pain.

The worker was seen by an orthopaedic surgeon on May 15, 2001 who felt she had symptoms consistent with chronic ongoing bilateral rotator cuff tendonitis possibly with impingement.

The worker was also assessed by a rheumatologist on May 22, 2001 who diagnosed chronic left lateral epicondylitis and chronic neck and shoulder girdle pain which could be considered due to myofascial pain. He recommended she avoid aggravating factors and hopefully her condition would improve with time. The worker's physician continued to report on her ongoing neck, scapula and shoulder pain which he considered a permanent disability. Further reports to June 2003 indicated no change in the worker's condition.

A Board case manager reviewed the rheumatologist's reports and concluded that the worker's disability was significantly related to a myofascial pain disorder which had not been accepted under any of her claims. As a result, he found no basis to alter his previous decisions and concluded there was no evidence of a measurable permanent functional impairment with respect to the accepted shoulder and left elbow injuries and there was no ground for a disability awards referral.

The worker was represented through her union and in support of her appeal provided the following new evidence:

- December 12, 2001 medical legal report from the worker's attending physician stating the worker had chronic right shoulder and neck pain and continued to be disabled due to ongoing left shoulder and elbow symptoms plus the right shoulder and elbow symptoms and bilateral neck symptoms. He felt both her right and left-sided symptoms were equally disabling and as a result she suffered a permanent disability.
- December 17, 2001 medical opinion from the rheumatologist who diagnosed a chronic left lateral epicondylitis and chronic neck and shoulder girdle pain which was soft tissue in nature. He felt the incident of November 1999 could have contributed to her myofascial pain but did not know if there was a connection between the left shoulder injury and the subsequent development of the right shoulder symptoms.
- April 5, 2002 medical legal report from the worker's orthopaedic surgeon who concluded the worker had chronic upper extremity myofascial pain with some right shoulder rotator cuff tendonitis. He felt the symptoms and pathology likely pre-dated the injury of November 1999 but were exacerbated by the injury. He felt much of the worker's pain was not related to the rotator cuff tendonitis but related to the chronic myofascial pain. He did not recommend Sonacur treatments for the elbow symptoms and felt when he examined her on September 2001 there was not evidence of any permanent functional impairment although she had chronic ongoing pain in her shoulders.

The worker testified that she had commenced nursing in 1964 and first injured her shoulder in 1984. Since 1984 she has always had some ongoing right shoulder symptoms with any lifting or heavy activity. She had other shoulder injuries in 1989 through 1992 and 1993. She returned to work under her 1993 claim in March of 1994. After that claim she stopped helping to do lifts and relied upon the staff to do lifting. She

used her left arm more to try and avoid stressing her right arm. She tried to crush pills and wind up beds using her left arm.

Under the current claim the worker was on a three to eleven shift and at approximately 10:20 a very agitated noisy resident began disturbing others in the ward. The worker was alone and attempted to move the bed out of the ward herself. She was shifting it back and forth and it jammed against wheelchairs that were in the hallway. Her left shoulder felt very sore and the next day the right shoulder and left elbow were sore as well. The worker felt sure that she had discussed her right shoulder when she first saw her doctor.

When she attended the occupational treatment program at a local hospital, her right shoulder got worse with the lifting and exercises. Her left shoulder and elbow improved but her right shoulder complaints didn't. During her graduated return to work she found that crushing pills, moving the medicine cart, and rolling patients affected both shoulders and her left elbow. The worker managed her symptoms by taking extra strength Tylenol and using hot packs on her neck. She explained that although there was an automatic pill crusher on the ward, it was not always available since it was shared with another injured employee. The worker found her right shoulder and left elbow symptoms worsening. On April 10th she was winding a bed with a very heavy patient which significantly flared her elbow and shoulder symptoms.

The worker was off for non-compensable surgery on April 12th. She did not return to work after her surgery since both her shoulders were sore, although the right was worse than the left. At the time the worker's claim was re-opened she stated that her right shoulder and left elbow were the worse problems. The worker was diagnosed with myofascial pain syndrome by the Board's visiting specialist and this is confirmed by a rheumatologist. The visiting specialist also diagnosed bilateral epicondylitis but did not recommend surgery. The worker stated she was seen by the orthopaedic surgeon who gave her two cortisone shots in her right shoulder. The first one provided some relief but the second did not. Since then, she has had no other active treatment. She officially retired in September 2002 and has been on CPP disability. The worker stated there has been no change in her condition since that time although it fluctuates with activity. Any extended reaching or lifting causes her elbow symptoms to flare and the only treatment is rest.

The worker's representative submitted that:

- The worker's right shoulder symptoms are a result of the worker protecting her left shoulder and arm and this is supported by the medical opinions of her doctor and orthopaedic surgeon.
- The worker aggravated her pre-existing right shoulder condition during her treatment at the rehabilitation program and on her graduated return to work.
- The worker's right shoulder symptoms worsened as a result of the November 1999 injury.

- That the worker has been diagnosed with a myofascial pain syndrome which her physicians relate to the November 1999 work incident.
- The worker should have continued wage loss benefits while her right shoulder condition was further investigated until her condition plateaued as of her visit to the orthopaedic surgeon on September 17, 2001.
- The worker is unable to return to work due to her November 1999 injury and is entitled to a referral to disability awards for consideration of any pension entitlement.
- The worker is not seeking vocational rehabilitation assistance.

Reasons and Findings

Issue #1

The worker has an extensive history of right shoulder problems. However, there was no particular mention of right shoulder problems around the time of her November 1999 incident nor did the right shoulder symptoms appear to be a significant problem when she was assessed for the work conditioning program in January of 2000, although she did have some right tenderness. The medical information on file indicates that the worker aggravated both her right and left-sided symptoms while on the graduated return to work. The Board case manager accepted that the Board had some limited liability as a result of this aggravation and the medical advisor admitted it was possible the worker's right shoulder symptoms resulted from the worker protecting her left shoulder. The opinions of the worker's attending physician and the orthopaedic surgeon are that the worker's pre-existing right shoulder symptoms were exacerbated by the November 1999 injury and I accept those opinions. I find the greater weight of evidence supports that the worker's pre-existing right shoulder symptoms were aggravated as a result of her claim injury.

Issue #2

The Board case manager concluded that the worker would have recovered from her left shoulder and elbow symptoms by the time she was discharged from the occupational rehabilitation program on December 10, 2000. Although the worker did not continue with the program as a result of her then non-compensable right shoulder symptoms, a review of the medical evidence after that date shows persistent left as well as right shoulder pain and a worsening left lateral epicondylitis. The visiting specialist assessed her problems as predominantly lateral epicondylitis in the left elbow, mild left shoulder impingement as well as a myofascial pain syndrome. The rheumatologist also diagnosed a chronic left lateral epicondylitis and suggested the worker would have to avoid aggravating factors and hopefully it would improve.

In light of these reports I conclude that the worker had not recovered from her compensable injury by December 10, 2000 at the time her wage loss benefits were

terminated. She continued to undergo investigation and treatment regarding her accepted left shoulder and elbow complaints in addition to her right shoulder and myofascial pain complaints. The orthopaedic surgeon considered there was possibly some rotator cuff tendonitis which was not ruled out until an ultrasound in June 2001. The only treatment recommended by the orthopaedic surgeon was cortisone injections and after her final cortisone injection on September 17, 2001 the worker had no further active treatment. Ongoing reports from her physician documented a permanent disability. The worker had not recovered from her compensable injury by December 10, 2000 and her claim should be re-opened for temporary benefits until she received her final corticosteroid injection on September 17, 2001 at which time reports indicate her condition was plateaued.

Issue #3

The occupational rehabilitation physician, the rheumatologist and the orthopaedic surgeon all felt the worker had bilateral myofascial pain. The visiting specialist who examined the worker's left upper extremity agreed with the assertion that she had myofascial pain syndrome as well as left lateral epicondylitis. Although the worker had symptoms in the right shoulder girdle which pre-dated the November injury, it was the opinion of the worker's attending physician, rheumatologist, and orthopaedic surgeon that the November 1999 injury exacerbated the worker's myofascial pain and as a result is related to that injury. The Board case manager felt the worker's myofascial pain complaints were not related to the worker's November 1999 incident, however, his opinion is countered by the medical opinions of the aforementioned doctors and I accept their expertise on this subject. I find that the worker's myofascial pain was aggravated by her November 1999 injury.

Issue #4

Policy item #96.20 of the RSCM states that a Board officer is required to refer a claim to the Disability Awards Department for further evaluation when:

1. A medical report indicates that a permanent disability exists or that there is a possibility a permanent disability exists.
2. Where a worker indicates there is a permanent disability as a result of the compensable injury, or states there is an ability to return to employment as a consequence of the injury.
3. Where there is any other indication of a permanent disability or potential permanent disability.

The worker's physician was reporting as early as May 2001 that the worker needed an assessment for permanent disability. The worker states she has a permanent disability and is unable to return to her pre-injury employment. She meets the requirements under the policy at item #96.20 and her claim should be referred to disability awards for further evaluation of any permanent functional impairment.

Conclusion

I vary the Board's decision of November 22, 2000 and find that the worker's pre-existing right shoulder problems were aggravated as a result of her November 1999 injury. The worker continued to be disabled beyond December 10, 2000 when her benefits were terminated.

I vary the Board's decision of March 30, 2001 which declined to reinstate the worker's wage loss benefits and as previously noted find her claim should be re-opened from December 10, 2000.

I vary the Board's decision of May 30, 2001 and find that the worker's myofascial pain syndrome was aggravated by her November 1999 injury. The worker has been unable to return to her pre-injury employment and there is an indication that she has a permanent functional impairment and her claim should be referred to disability awards for further evaluation in accordance with policy item #96.20. The worker is entitled to the costs of the medical legal opinions obtained in support of her appeal.

Lynn M. Wilfert
Vice Chair

LMW/cda

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