

Noteworthy Decision Summary

Decision: WCAT-2005-04542-RB **Panel:** Guy Riecken **Decision Date:** August 29, 2005

Refusal to Participate in Treatment – Suspension of Wage Loss Benefits – Section 57(2)(b) of the Workers Compensation Act – Item #78.13 of the Rehabilitation Services and Claims Manual, Volume I

This decision is noteworthy because it examines what constitutes a clear expert medical opinion as to whether relevant treatment is reasonably essential to promote the worker's recovery. The law and policy require an expert medical opinion or surgical advice on the claim file before a worker's wage loss benefits can be suspended under section 57(2)(b) of the *Workers Compensation Act* (Act).

The worker injured her low back while assisting a patient who was falling down. The worker was assessed for an occupational rehabilitation program (ORP) and found too acute to be admitted. She was later assessed again for the ORP. The ORP treatment team recommended active acute physiotherapy to increase the worker's tolerance for activity to prepare for her participation in an ORP. The worker participated in the active physiotherapy program, with complaints of increased pain and sleep disturbance. Her attending physician indicated that she was totally disabled and that no further therapy was recommended at that time. The worker stopped participating in the program. The Workers' Compensation Board, operating as WorkSafeBC, suspended the worker's temporary wage loss benefits because of her non-participation in the ORP.

The worker's appeal was allowed. The panel found that there was no clear expert medical opinion or advice from a surgeon or other physician on the claim file that the ORP was reasonably essential to promote the worker's recovery as required by section 57(2)(b) of the Act and item #78.13 of the *Rehabilitation Services and Claims Manual, Volume I*. A treatment recommendation from a physiotherapist or kinesiologist is not sufficient. The mere fact that the case manager spoke to a medical advisor before referring the worker to an ORP was not sufficient to indicate this advice had been provided by the medical advisor. The law and policy did not require a memorandum from a medical advisor or other physician that used the exact words of section 57(2)(b). It was possible to conclude that a particular treatment was reasonably essential to promote the worker's recovery from a memorandum in which a medical advisor clearly discussed the appropriateness and usefulness of the treatment for the worker's recovery. The medical evidence on the claim file included differing opinions about the appropriate kind of rehabilitation for the worker.

WCAT Decision Number : WCAT-2005-04542-RB
WCAT Decision Date: August 29, 2005
Panel: Guy Riecken, Vice Chair

Introduction

On November 6, 2001 the worker was employed as a registered nurse when she injured her low back while assisting a patient who was falling down. The Workers' Compensation Board (Board) accepted her claim for a lumbar strain. The Board paid temporary disability wage loss benefits to the worker from November 7, 2001 until October 20, 2002, when the benefits were suspended on the basis of the worker's non-participation in a Board-sponsored occupational rehabilitation program (ORP).

The worker appeals the Board's October 31, 2002 decision to suspend her benefits.

The worker and her representative, Janice Hight, attended an oral hearing in Richmond, B.C. on June 14, 2005. The employer's representative provided a written submission. Neither the employer or the employer's representative attended the oral hearing although notified.

Issue(s)

Whether the worker's benefits were properly suspended under section 57(2)(b) of the *Workers Compensation Act* (Act) due to her non-participation in the ORP.

Jurisdiction

This appeal was filed with the Workers' Compensation Review Board (Review Board). On March 3, 2003, the Appeal Division and Review Board were replaced by the Workers' Compensation Appeal Tribunal (WCAT). As this appeal had not been considered by 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.)

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, law and discretion 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.

Because the worker's injury occurred before June 30, 2002, the Act as it read prior to amendments that came into effect on that date apply to the worker's entitlement to compensation. The policies that apply are found in the *Rehabilitation Services and Claims Manual, Volume I* (RSCM I). (See: section 35.1 of the Act and RSCM I policy item #1.03).

Background and Evidence

On January 25, 2002 the worker was examined by Dr. A, a physical medicine and rehabilitation specialist as part of the initial assessment in a medical rehabilitation program (MRP). The worker described intermittent pain over her right upper buttock radiating down to the right lateral thigh. She also described longstanding infrequent tingling over the middle two toes bilaterally. On examination, Dr. A noted a normal gait and lumbar lordosis. The worker's back flexion was full. Her extension was limited to 50% of normal with axial low back symptoms, more on the right. Facet joint loading was uncomfortable, more on the right. The neurological exam was normal. Dr. A diagnosed mechanical low back pain secondary to the lumbar sprain injury and lumbar spondylosis. He recommended that the worker receive more active treatment, including physical therapy with dynamic lumbar stabilization exercises, as well as Celebrex.

A CT scan on February 2, 2002 showed diffuse degenerative changes that were most prominent at L4-5 and L5-S1, described as moderately severe. There was no evidence of a focal disc herniation.

Dr. A's February 26, 2002 follow-up report indicated the worker complained of increased symptoms. She had right lumbosacral pain with radiation to the right lateral proximal thigh. There were also new symptoms of numbness and tingling over the lateral aspect of both feet. Her pain occasionally radiated into the right lateral calf. She complained of infrequent right groin pain. On examination, her gait was normal. She had decreased flexion and extension. Again the neurological exam was normal. Dr. A diagnosed ongoing mechanical low back pain that was likely multi-factoral in etiology, including degenerative disc disease, facet arthritis and right sacroiliac mediated pain. Dr. A commented that the worker had not responded well to an active rehabilitation program and recommended gradual reactivation including a low impact aerobic program and continued core stabilization exercises. The alternative recommendation was that she be enrolled in an MRP.

On April 29, 2002 the worker was seen by Dr. F in the Board's Visiting Specialists Clinic. She complained of constant midline low back pain that was tolerable and not a

particular problem. She also described pain in a band-line region over the right buttock occasionally down into the middle of the buttock region and the groin that varied in intensity. She indicated that she had intermittent back problems since her 20s or 30s. These were usually mild and went away on their own. She had a previous back injury at work in 1999. Dr. F found the exact origin of the pain difficult to determine. He thought it may be emanating from the left sacroiliac joint, but was more probably referred pain from the L4-5 and L5-S1 degeneration. He recommended a very graduated exercise program simply in the form of increased walking each day as well as core stabilization and pelvic girdle strengthening exercises. Aggressive exercise was not in her best interest. He recommended water-based exercises or a very gentle carefully prescribed exercise program that does not aggravate her back problems.

After a team meeting on May 28, 2002 that was attended by Dr. B, a Board medical advisor, the case manager decided to refer the worker to an MRP.

The MRP assessment by Dr. Koelink on June 10, 2002 indicated that the worker's mechanical back pain was manageable with an appropriate core strengthening program. He recommended an aquafit exercise program with supervision.

In a claim log entry dated June 19, 2002 the case manager indicated that an ORP was indicated to deal with the worker's deconditioning. He spoke to the worker on the phone and noted that she agreed to attend an ORP if she did not have to drive too far.

The June 20, 2002 report from Dr. Hutchinson indicates that the proposed seven hour per day ORP, plus driving time each day, would not be helpful to the worker. It would be better if she could attend a program closer to her home.

An x-ray report from June 20, 2002 indicated severe degenerative disc disease at L4-5 and L5-S1 that was worse since the previous x-rays.

The June 24, 2002 ORP intake assessment indicated the worker was too acute to be admitted into the program. Nerve conduction studies were recommended.

A video surveillance report dated July 30, 2002 describes surveillance of the worker that was carried out on July 19, 28 and 29, 2002. The report (and accompanying video tape) indicate that the worker was seen on July 19, 2002 leaving her house and driving to a drug store where she was seen to carry a parcel under her arm. The worker also went to a bank, a bakery and a coffee shop. On July 28, 2002 the worker was seen going to a supermarket with her van where she pushed a shopping cart with six bags in it. She loaded the bags from the cart into the van. On July 29, 2002 the worker was seen leaving her house as a passenger in the van.

Information in the claim file indicates that the worker's husband died on July 28, 2002.

Nerve conduction studies from August 13, 2002 were normal for the worker's right leg except for minor chronic changes in two L5 muscles. There was no acute denervation. Nerve root damage could not be diagnosed with confidence.

On August 21, 2002 hip x-rays showed soft tissue calcification adjacent to the greater tuberosity.

A clinical care plan dated September 10, 2002 in which the case manager and Dr. B participated indicated that the worker probably had significant deconditioning and that she would be referred for an ORP assessment.

The September 16, 2002 ORP discharge summary from the Canadian Back Institute (CBI) indicated the worker was not accepted into the ORP. The ORP treatment team recommended active acute physiotherapy for two to four weeks with a kinesiologist to increase the worker's tolerance for activity to prepare for her participation in an ORP.

The worker attended at CBI for active physiotherapy under the supervision of a kinesiologist for approximately three weeks.

In his October 17, 2002 progress report Dr. Hutchinson indicated that the worker complained of increased pain due to therapy at CBI. The pain was interfering with her activities of daily living and her sleep. Dr. Hutchinson recommended that she discontinue therapy.

The October 18, 2002 discharge report from CBI indicated that the worker complained of increased pain in the active physiotherapy program and that she was getting only two to three hours of sleep each night. The worker was unwilling to continue the program in spite of regular modifications. The CBI team recommended that she participate in an ORP but that she also be assessed for the need for counselling to deal with anger, frustration, sleep disturbance and her perceived functional abilities.

In his progress report on October 28, 2002 Dr. Hutchinson indicated that the worker's pain level was the same, that she was totally disabled and that no therapy was recommended at the present time.

With respect to the video surveillance evidence the worker acknowledged at the oral hearing that she drove to a supermarket to buy food. She testified that she went out of the house most days and sometimes did errands like buying food. She had to take pain medication to be able to do those kinds of activities. She acknowledged that the video shows her carrying some grocery bags and lifting a case of pop into her car on the morning of July 28, 2002. She explained that because of her back condition, there were only a few items in each bag and they were not heavy. One of the bags had a ham in it. When I asked her at the hearing about the weight of the bags, she was unable to provide an estimate. She said that when she got home her son put the groceries away for her. She lay down to rest.

The worker testified that in the early afternoon on July 28, 2002 the police came to her home and informed her that her husband had died that morning. Dr. Hutchinson phoned the case manager at the Board and told him of her husband's death.

At the oral hearing the worker confirmed that the Board case manager told her in a telephone conversation in early September of the decision to refer her to CBI again for an ORP. The worker testified that she asked the case manager to send her to a different rehabilitation program because she knew people who attended the program at CBI without benefiting from it. She asked the case manager to send her to a program closer to where she lived so she did not have to travel so far. In her testimony the worker acknowledged that the case manager told her that if she refused to attend the ORP at CBI, her benefits would be suspended. She agreed to attend the program. She attended the initial assessment by a physiotherapist at CBI on September 16, 2002 that lasted about 15 minutes. Her impression was that it was a rather casual assessment. She started attending a program at CBI the next day. She then worked with a kinesiologist at CBI. As recommended by the assessment report, she did mainly simple stretching to get ready for the ORP. She also started walking 15 minutes at a time on a treadmill. This went on for about three weeks. The exercises were making her feel worse. She told her physician about this, including increased right leg pain, increased symptoms in her toes and lack of sleep. Her physician advised her not to proceed further with the program and wrote a note to that effect which she gave to CBI. She followed her doctor's advice and stopped attending CBI. She had no further contact with the case manager at the Board. She tried to reach him to discuss the ORP and her doctor's advice and left a voice mail message, but the case manager did not return her call. Shortly after that she got the letter telling her that her benefits were suspended.

The worker's representative provided the following documents to WCAT:

- A letter dated November 7, 2002 from Peter MacLean, a physiotherapist, which confirms that he examined the worker on November 7, 2002. Mr. MacLean indicates that the worker's lumbar flexion was almost zero, extension and right side flexion were very restricted and left side flexion was moderately restricted. All movements were painful. Straight leg raise on the left was full while on the right it was to 55 degrees. The left Achilles tendon reflex was reduced while on the right was present. The left patellar reflex was present while the right was reduced. The slump test on the left was negative while on the right it was positive.
- A character reference letter dated November 15, 2002 from W.
- An undated character reference letter from R.
- A consultation report dated April 15, 2003 from Dr. Dommissse, an orthopaedic surgeon. Dr. Dommissse confirms that x-rays show the worker has marked disc

degeneration at L4-5 and that the worker has minimal motion at that level. Some narrowing of the L5-S1 disc space is also present. Dr. Dommissie is of the opinion that the worker's pain is likely radiating from the degenerative changes at the L4-5 level. He would consider a fusion of the lower lumbar spine only if her symptoms are markedly severe and only after a discogram evaluation of the lower spine. Dr. Dommissie does not feel that the worker is able to manage the demands of long-term care nursing.

- A consultation report dated June 8, 2004 from Dr. Schamberger, a physical medicine and rehabilitation specialist. Dr. Schamberger's impression is that the worker's problems relate primarily to malalignment and to her sprain/strain injury to the right sacroiliac joint and/or lumbosacral junction. He opined that there is probably an element of mechanical back pain related to the degeneration of the lower disc and facet joints. He also noted the worker's obesity. He recommended that the worker do daily exercises to maintain and achieve alignment, along with massage therapy and physiotherapy. He also recommended weight loss through a combination of reduced calories and increased activity and possible further measures such as injections to settle down muscle spasm and decrease pain.
- A letter dated August 30, 2004 from a physiotherapist.
- A medical-legal report dated October 13, 2004 from Dr. Hutchinson. Dr. Hutchinson describes the worker's ongoing symptoms and disability. He opines that the worker's participation in the ORP at CBI was not essential to promote the worker's recovery.
- A letter dated February 9, 2005 from Cheri Goller, a massage therapist.

Findings and Reasons

The worker's representative submits that the case manager did not apply the criteria or follow the process required by the Board's policy before suspending the worker's benefits and that the criteria for the suspension of benefits under section 57(2)(b) of the Act were not met. She submits that there is no medical opinion in the claim file that the ORP was reasonably essential.

In a written submission to WCAT the employer's representative emphasizes the medical evidence in the claim file that the worker suffered a strain/soft tissue type of injury. The employer's representative submits that medical information is that such injuries resolve. She also emphasizes the medical imaging evidence of marked disc degeneration at L5-5 and submits that there is no medical evidence that the worker's ongoing symptoms are the result of the November 6, 2001 work injury.

Under sections 29(1) and 30(1) the worker is entitled to receive wage loss benefits as long as she continues to be temporarily disabled by her compensable injury. As explained in RSCM I policy items #34.50 and #35.30, temporary disability ceases either when the injury resolves entirely or when it stabilizes and becomes permanent. If the injury does not resolve entirely and the worker is left with a permanent disability, the worker is assessed for possible entitlement to a permanent disability award under sections 22 or 23 of the Act.

Although a worker remains temporarily disabled, section 57(2)(b) of the Act provides that the Board may reduce or suspend compensation if “the worker refuses to submit to medical or surgical treatment which the [Board] considers, based on expert medical or surgical advice, is reasonably essential to promote his or her recovery.”

RSCM I policy item #78.13 provides that the term “medical treatment” in subsection 57(2) is not limited to treatment performed by doctors. It includes, for example, therapy by paramedical personnel. This policy also provides that although the decision on whether to reduce or suspend benefits is made by the adjudicator, there must be medical advice. Under section 57(2)(b) there must be a clear medical opinion on file that the relevant treatment is “reasonably essential to promote recovery.” There must also be evidence that the worker was offered the treatment and knows that the Board considers it reasonably essential. There must also be evidence that the worker was in a position to make a choice and refused the treatment. The worker must also be given a chance to explain before any decision is made. The policy also recognizes that section 57(2)(b) is not intended to exclude all patient choices, and even where the requirements of the section are satisfied, the adjudicator is not bound to reduce or suspend the benefits, but has a discretion whether or not to do so.

In this case I find that there is not a clear medical opinion in the claim file that the ORP was reasonably essential to promote the worker’s recovery.

The following medical opinions are relevant to the Board’s referral of the worker to the ORP and to the decision to suspend her benefits:

- In his April 29, 2002 consultation report Dr. F noted that the worker had exhausted most forms of treatment but that she would benefit from a “very graduated exercise program simply in the form of increasing her walking each day.” Dr. F also considered the worker needed some regular core spine stabilization exercises and pelvic girdle strengthening exercises. He opined that manipulation and aggressive exercise is not in the worker’s best interest. He suggested a water-based program or a very gentle, carefully prescribed exercise program that does not aggravate her back hip problems.
- On May 28, 2002 Dr. B participated in a clinical care plan that noted Dr. F’s recommendation for a graduated exercise program. The plan was for the worker to be assessed in an MRP.

- In the MRP assessment report from June 10, 2002, Dr. Koelink indicated that he did not believe that enrolment in the MRP would be helpful other than for medical management. Dr. Koelink recommended that the worker discuss treatment options with her family physician. Dr. Koelink recommended an aquafit program.
- In his June 20, 2002 progress report Dr. Hutchinson noted that the worker was being referred to a rehabilitation program for seven hours daily and that attendance at the program would require her to commute for one hour per day. He opined that this would be more harmful than helpful.
- The June 27, 2002 discharge report from the ORP indicates that the worker was too acute to participate in the program. Further testing was suggested, and in the meantime the worker was encouraged to continue with a gentle program of core stabilization exercises, ongoing weight reduction and pool exercises as tolerated.
- The claim log memo from the case manager dated September 9, 2002 indicates that at a team meeting attended by a medical advisor it was determined that the worker would be assessed and treated in an ORP.
- The September 17, 2002 ORP discharge report indicates that the worker was not accepted into the program. The ORP treatment team recommended that the worker receive active acute physiotherapy. The report indicates that the worker, the physiotherapist and the Board case manager concurred that the worker continue with two to four weeks of physiotherapy and active treatment with a kinesiologist for one to two hours daily with the goal of increasing her tolerance to activity so that she could participate fully in an ORP.
- The October 18, 2002 discharge report from the CBI Physiotherapy and Rehabilitation Centre indicates that the worker withdrew from the program on October 17, 2002 after reporting increased pain and stiffness since beginning the active rehabilitation program and that she felt the treatment team was not listening to her. She explained that she could not complete 6.5 hours of treatment which was planned to start on October 21, 2002 with the full ORP. The treatment team recommended that the worker participate in an ORP, but that she also receive a consultation to determine whether formal counselling would be a benefit as anger, frustration, sleep disturbance and perceived functional ability seemed to be the most notable barriers to her participation in treatment.

I infer from the content of the September 12, 2002 claim log memo that the case manager considered the input from the medical advisor who attended the team meeting in deciding to refer the worker to an ORP for assessment and treatment. The identity of the medical advisor is not revealed in the memo. Nor does the memo indicate what opinion, if any, the medical advisor provided with respect to the suitability or necessity of

the ORP or the role it would play in promoting the worker's recovery. There is no memo in the claim file directly from a medical advisor with respect to the ORP. The mere fact that the case manager spoke to a medical advisor before referring the worker to an ORP does not indicate to me what advice the medical advisor gave.

I do not consider that section 57(2)(b) and RSCM I policy item #78.13 require a memo from a medical advisor or other physician that uses the exact words from that section. It would be possible to conclude that a particular treatment is "reasonably essential to promote the worker's recovery" from a memo in which a medical advisor clearly discusses the appropriateness and usefulness of the treatment for the worker's recovery without the medical advisor necessarily quoting the exact words of section 57(2)(b) of the Act.

In this case, however, there is no memo or other document on file in which a medical advisor or external medical consultant to the Board discusses whether the treatment the worker was to receive at CBI in September and October 2002 was essential for her recovery. In fact, the medical evidence includes differing opinions about the appropriate kind of rehabilitation for the worker. Dr. F and Dr. Hutchinson both expressed concerns about what kind of physical rehabilitation would be suitable. Dr. F recommended gentle aquatic exercise rather than "aggressive" exercise and Dr. Hutchinson was of the opinion that a full ORP program would do more harm than help. The evidence is that the worker refused to participate in the full 6.5 hours per day ORP that was to start on October 21, 2002 on the advice of Dr. Hutchinson. Clearly there was an issue to be decided in the claim as to what degree and kind of physical rehabilitation was appropriate. I conclude from the various comments by physicians in the claim file that there may have been different kinds of physical therapies that the worker would benefit from. The fact that one kind of physical therapy offered by a particular service provider was chosen by the case manager does not necessarily mean that it was "reasonably essential" or that it was the only form of treatment that was appropriate to promote recovery at that point in the worker's claim.

I note that the October 18, 2002 discharge report from CBI recommended that the worker participate in the ORP and that she also be assessed with regard to her emotional condition and sleep disturbance as these were seen as interfering with her ability to participate fully in an ORP. The discharge report was prepared by a registered physiotherapist and a kinesiologist. While they have particular areas of training and expertise that is relevant to the Board's assessment of a worker's ongoing abilities and treatment, I do not consider the requirement in section 57(2)(b) for "expert medical or surgical advice" to be satisfied by a recommendation from a physiotherapist or kinesiologist. The language in that section of the Act clearly contemplates that the expert advice be received from a surgeon or other physician. In any event, the ORP discharge report recommends participation in an ORP, but does not discuss whether it would be to any degree essential for the worker's recovery, or whether it was simply one of several suitable forms of treatment.

Section 57(2)(b) requires that before suspending benefits, the decision about whether a particular treatment is reasonably essential must be made on the basis of expert medical or surgical advice. I find there is insufficient evidence on which to conclude that the case manager received “expert medical or surgical advice” that the treatment in the ORP at CBI was reasonably essential to promote the worker’s recovery. The existence of such medical advice is a mandatory prerequisite for the suspension of benefits under section 57(2)(b) of the Act. I conclude that this requirement of section 57(2)(b) was not met in this case and that the suspension of the worker’s benefits was not in accordance with that section.

I do not consider the video surveillance evidence from July 2002 to be significant one way or the other to the issue in this appeal. The worker testified that the grocery bags she lifted into the van only contained a few items and were fairly light. Nothing seen in the video contradicts the worker’s testimony. I accept that the bags were probably not very heavy. Their actual weight is unknown. The video does not show the worker performing activities the same as or equivalent to those required in her job as a registered nurse. The video evidence does not lead me to conclude that the worker was able to return to work in July 2002 and does demonstrate that a particular form of treatment was reasonably essential to promote her recovery.

The worker’s appeal is allowed. The decision to suspend her benefits effective October 20, 2002 was not in accordance with section 57(2)(b) of the Act. The worker is entitled to the continuation of benefits from October 20, 2002 onward. The Board will determine the nature and extent of that entitlement.

Conclusion

I vary the Board’s October 31, 2002 decision. The suspension of benefits was not in accordance with section 57(2)(b) of the Act. The worker is entitled to the continuation of her benefits from October 20, 2002 onward. The Board will determine the nature and extent of that entitlement.

The worker’s representative requested that the worker be reimbursed for the expenses related to providing the November 7, 2002 letter from Mr. MacLean and Dr. Hutchinson’s October 13, 2004 medical-legal report. I consider that it was reasonable for the worker to have obtained those reports for this appeal. The worker is entitled to be reimbursed upon submission of proof of having incurred those expenses, subject to the Board’s tariff for such evidence. This order is made under section 7(1)(b) of the *Workers Compensation Appeal Tribunal Regulation*.

The worker’s representative also requested that the worker be reimbursed for the physiotherapist’s letter dated August 30, 2004. I did not find this letter useful in considering the appeal, and given the relatively narrow issue in the appeal, I do not find that it was reasonable for the worker to have obtained this letter for the appeal. This also applies to the other letters and reports that the worker and her representative

provided to WCAT. Other than the letter from the physiotherapist dated November 7, 2002 and Dr. Hutchinson's report dated October 13, 2004, I decline to order that the worker be reimbursed for the expenses of obtaining the various letters and reports that were submitted to WCAT in support of her appeal.

Guy Riecken
Vice Chair

GR/rb