Noteworthy Decision Summary

Decision: WCAT-2005-06488 **Panel**: Andrew Waldichuk **Decision Date:** December 5, 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 II

This decision is noteworthy because it examines the general requirements set out in law and policy which need to be established before a worker's wage loss benefits can be suspended under section 57(2)(b) of the *Workers Compensation Act* (Act).

The worker developed sharp low to mid back pain while lifting cases of bleach. The worker's temporary wage loss benefits were suspended under section 57(2)(b) of the Act because of his refusal to participated in an occupational rehabilitation program (ORP).

The worker's appeal was denied. The panel found that the Workers' Compensation Board, operating as WorkSafeBC (Board), had reasonably exercised its discretion in suspending the worker's wage loss benefits. Section 57(2)(b) of the Act provides that the Board may reduce or suspend compensation when the worker refuses to submit to medical or surgical treatment which the Board considers, based on expert medical or surgical advice, to be reasonably essential to promote recovery. Policy item #78.13 of the *Rehabilitation Services and Claims Manual*, *Volume II* states that "medical treatment" is not limited to treatment performed by doctors, but includes therapy by paramedical personnel, which would include an ORP.

The panel found there was a clear medical opinion that the ORP was reasonably essential to promote recovery. This opinion was obtained before benefits had been suspended. The worker was offered the treatment and knew the Board considered it reasonably essential to promote recovery. The worker was in a position to make a choice and his less than satisfactory participation in the ORP was tantamount to a refusal of treatment. He had an opportunity to explain to the Board why he had refused the treatment before the Board made the decision to suspend the benefits. The panel did not find that the treatment involved a risk of an adverse side-effect, a questionable prospect of success, or was hazardous. The panel stated that because section 57(2)(b) of the Act gives the Board extraordinary power to essentially terminate benefits, even though there may be evidence of disability, it should be only used in strict compliance with law and policy.

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Panel: Andrew Waldichuk, Vice Chair

Introduction

The worker, a then 24-year-old warehouse order picker, completed an application for compensation with respect to an incident on June 8, 2004 when he developed sharp pain in his low to mid back, while lifting cases of bleach, which was so intense that it made him drop to his knees.

By decision dated September 30, 2004, a case manager at the Workers' Compensation Board (Board) considered section 57(2) of the *Workers Compensation Act* (Act), which allows for the reduction or suspension of compensation, and advised the worker that wage loss and medical treatment benefits would not be paid to him beyond August 25, 2004 because of his refusal to continue with a Board-sponsored treatment program.

The worker submitted a request for review of the case manager's decision to the Board's Review Division. On March 29, 2005, a review officer found that the worker had no further entitlement to compensation beyond August 25, 2004, and confirmed the case manager's decision. In the course of reaching his decision, the review officer decided that the worker's thoracic spine compression fractures and left-sided L5-S1 disc protrusion, as revealed by radiological imaging, were not related to the worker's June 8, 2004 workplace injury.

The worker, who is unrepresented, now appeals the review officer's decision to the Workers' Compensation Appeal Tribunal (WCAT).

The employer is participating in this appeal and is represented by one of its employees.

The worker requested an oral hearing. By letter dated June 15, 2005, the worker was advised that this appeal would proceed by way of written submissions. That decision does not bind me if I consider that an oral hearing is necessary. I am satisfied that a fair and thorough decision may be reached on this appeal without holding an oral hearing, since there are no material facts in dispute or serious issues of credibility.

Issue(s)

Are the worker's thoracic spine compression fractures compensable?

Is the worker's left-sided L5-S1 disc protrusion compensable?

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Is the worker entitled to wage loss benefits beyond August 25, 2004?

Is the worker entitled to health care benefits beyond August 25, 2004?

Jurisdiction

This appeal was filed with WCAT under subsection 239(1) of the Act.

Under section 250 of the Act, WCAT may consider all questions of fact and law arising in an appeal, but is not bound by legal precedent. WCAT must make its decision on the merits and justice of the case, but in so doing, must apply a policy of the Board's board of directors that is applicable in the case. Section 254 of the Act gives WCAT 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.

Background and Evidence

The worker wrote in his application for compensation that he was 5 feet, 11 inches tall and weighed 250 pounds. Information on file also shows that he went to an emergency ward immediately after the onset of his back pain.

On June 10, 2004, the worker's family physician, Dr. Randhawa, diagnosed the worker as having low back pain, which required physiotherapy and medication. Dr. Randhawa's report does not describe a history of back pain or related symptoms. He estimated that it would be more than 20 days before the worker could return to work in any capacity.

On June 11, 2004, the worker's chiropractor, Dr. Grewal-Basra, diagnosed the worker as having a thoraco-lumbar strain, based on findings of limited and painful lumbar range of motion, spasm of the lumbar and thoracic paraspinal muscles, and segmental hypomobility of the lumbar and thoracic regions of the worker's spine.

An anatomical symptom chart, which is found in the case history form that Dr. Grewal-Basra completed, shows that the worker's pain was localized in his low back. It does not refer to any other symptoms, such as numbness.

On June 17, 2004, the Board accepted the worker's claim for a low back strain.

The worker informed the Board on June 17, 2004 that Dr. Randhawa had referred him to a physiotherapist/chiropractor and that Dr. Grewal-Basra expected that he would be off work for three to four weeks.

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Although somewhat difficult to read, Dr. Grewal-Basra's clinical note entries of the worker's eight treatment sessions during June 2004 do not refer to symptoms beyond the worker's mid and low back regions.

An entitlement officer at the Board referred the worker to an occupational rehabilitation 1 (OR1) program. The worker was assessed in the OR1 on June 29, 2004. As shown in the intake assessment report, the worker advised the treatment staff that he was experiencing pain in the region of his lumbar spine, but no radiating pain, pins and needles, or numbness into either of his lower extremities. Based on an examination of the worker, the treatment team thought that he had a soft tissue injury of the lumbar spine with no neurological findings. The worker was considered to be an appropriate candidate for a five-week program within the OR1, with an expected outcome of fit to return to work at full duties, following a graduated return to work.

Information on file shows that the worker was associating an increase in his back pain with his attendance in the OR1, for which Dr. Randhawa prescribed additional medication.

On July 16, 2004, an OR1 therapist recommended that the worker be referred to an occupational rehabilitation 2 (OR2) program, owing to his ongoing pain complaints and lack of improvement.

The worker was discharged from the OR1 on July 20, 2004 with clinical findings similar to those at the time of his initial assessment. Upon discharge, the worker indicated that his symptoms involved the L1 to L4 region of his spine, bilaterally, with no pain, pins and needles, or numbness radiating into his lower extremities.

Upon the recommendation of a Board nurse advisor, the worker underwent a medical and return-to-work planning (MARP) assessment on July 21, 2004 for the purpose of clarifying diagnosis and a treatment plan.

Dr. England, an orthopaedic surgeon, examined the worker. Dr. England found that the worker's deep tendon reflexes, including knee and ankle jerk, were easily obtainable. He also noted that straight leg raising was negative bilaterally except for the left side, which produced non-radiating low back pain. As for diagnosis, Dr. England noted that the worker had been diagnosed as having a lumbosacral sprain or strain; however, he characterized the worker's symptoms as non-specific back pain, while commenting that the worker did not have any "signs or symptoms suggestive of facet syndrome or neural impingement from any cause."

In terms of further treatment, Dr. England recommended that the worker participate in an OR2 program. He told the worker that recovery was expected and that he did not have a progressive disease process.

The worker began attending the OR2 program on July 28, 2004, with the expectation that he would be fit to return to work without limitations on or about September 17, 2004. Upon admission, he had reduced active range of motion (flexion and extension) in his lumber spine, with some reduction in his lower extremity strength and poor core stability. His neurological examination was unremarkable, and lumbar traction and compression did not affect the worker's symptoms.

On August 5, 2004, the case manager informed the worker that he would not receive wage loss benefits if he did not attend the OR2 program, upon learning from the OR2 staff that the worker had been absent that day because of back pain.

While in the OR2 program, the worker was assessed by Dr. Jiwa, a general practitioner, on August 10, 2004 because of a flare-up of his symptoms during the preceding week. According to Dr. Jiwa, the worker described how he felt an increase in his low back pain on August 4, 2004 while helping his wife unload groceries from the car. When he bent over and stood up straight, he reportedly felt symptoms similar to those at the time of his original injury. As the worker explained, he was now experiencing some numbness in both palms and the soles of his feet, along with a feeling of coldness in the same areas. In addition, he said that he had seen Dr. Randhawa and there was a CT scan pending on account of his persistent symptoms.

Upon her examination of the worker, Dr. Jiwa thought that he was extremely pain focused. Based on evidence of paravertebral muscle spasm, but no signs of nerve root tension, she diagnosed a musculoligamentous lumbar back strain and encouraged the worker to continue participating in the OR2 program.

Dr. Jiwa requisitioned x-rays of the worker's thoracic and lumbar spine on account of the worker's increased low back pain and decreased range of motion. The August 10, 2004 x-ray report stated that the worker's T8, T9, T10 and T11 vertebral bodies appeared mildly but uniformly decreased in height, which suggested chronic compression fractures.

The case manager documented in an August 13, 2004 claim log entry that Dr. Jiwa stated during a telephone conversation that the compression fractures were unlikely related to the worker's claim and that perhaps a bone scan should be done to clarify their origin.

A hospital emergency room record of August 16, 2004 shows that the worker presented with complaints of increased lower back pain, which was radiating to his right foot. He was also having pain with walking. On examination, the emergency room physician reported decreased range of motion in the worker's back. The worker was diagnosed as having a back strain and prescribed Demerol.

On August 17, 2004, the case manager met with the worker and the OR2 treatment team. During the course of that meeting, the worker said that he seemed to be getting

worse and his right leg was going numb. The case manager advised the worker that the OR2 was appropriate treatment for him and that he could be discharged if he did not participate, which meant that he would likely not be entitled to further wage loss benefits.

Dr. Randhawa maintained his diagnosis of low back pain in his report of August 18, 2004, while referring to the chronic compression fractures in the worker's thoracic spine. He estimated that it would be more than 20 days before the worker could return to work in any capacity.

According to the August 23, 2004 OR2 progress report, the worker had experienced an increase in his lumbar spine pain and a new onset of right lower extremity symptoms since beginning the OR2 program. He claimed that his walking tolerance was reduced. Furthermore, this report indicates that the worker had undergone a further assessment by Dr. Struthers, a general practitioner, on August 17, 2004, who had recommended that he continue with the OR2 and that there were no medical preclusions to attempting an appropriate gradual return to work.

The OR2 staff further reported that should the worker fail to progress by September 3, 2004, he would be discharged. On the other hand, if he progressed, a gradual return to work was contemplated by September 7, 2004 with the expectation that he would be discharged as fit to return to work without limitations on September 17, 2004 (the report refers to 2002 in error).

On August 23, 2004, the Board received Dr. Randhawa's clinical records dating from December 27, 2003 until August 2004 (the last date is indecipherable). He stated in his clinical note entries during July 2004 that the worker did not have radiation of symptoms or radiculopathy. Furthermore, there is a notation in Dr. Randhawa's August 5, 2004 clinical note entry that refers to the worker having an increase in his symptoms because of carrying groceries from the car. Additionally, Dr. Randhawa recorded later that month (the date is indecipherable) that the worker had low back pain, along with pain in his legs, more so on the right than the left.

The August 30, 2004 OR2 discharge report shows that the worker was discharged on August 25, 2004 as not fit to return to work. The OR2 staff reported that when the worker's physical examination results were compared to his initial examination, he had "significantly regressed with respect to lumbar spine/lower extremity range of motion and lower extremity strength." As well, the OR2 staff noted that the worker was demonstrating excessive pain behaviours, which were not present on initial examination.

The OR2 staff reported that the worker's pain behaviours precluded an assessment of his true functional levels at the time of discharge. Nonetheless, they reported that he did not meet certain pre-injury job demands, such as lifting, horizontal carrying,

repetitive and sustained squatting, trunk flexion, forward reaching, and standing/weight bearing tolerance.

The OR2 staff reported that the worker continued to be pain and medically focused during the program, despite medical clearance from two physicians. They mentioned that numerous attempts had been made to address these concerns and the worker's lack of participation. The following reasons were offered in support of the worker's discharge from the OR2:

> 1. His poor level of participation with the program goals and expectations and inconsistencies and demonstrated abilities despite these repeated attempts to inform [the worker] of his responsibilities.
>
> 2. The program is unable to confirm his ability to return to work due to excessive pain behaviours significantly limiting his functional and physical examinations despite medical clearance…
>
> 3. Lack of objective progress (physical and functional).

The OR2 staff further noted that the worker reported the following symptoms at the time of discharge:

- pain in the central T8 to T12 area, bilateral lumbar spine, right hip, and posterior thigh and calf;
- intermittent shooting pain down the right posterior thigh and calf;
- tenderness to palpation of the right Achilles tendon area;
- intermittent numbness in the right plantar, dorsal, medial, and lateral foot, along with the anterior right thigh and shin;
- intermittent sharp pain involving the left cervical region and the upper trapezius region, which began during pool therapy on August 24, 2004;
- left anterior generalized knee pain, which began during the preceding two weeks because of increased limping with walking;
- pain levels at 7 to 8 on the numeric pain scale of 0 to 10;
- decreased power in his right hand grip; and
- poor sleep due to pain.

An August 30, 2004 emergency room record, although somewhat difficult to read, shows that the worker sought medical attention on account of right leg pain and numbness in his right foot. He also returned to the emergency ward on September 9, 2004 with similar complaints.
The worker informed an office assistant at the Board on September 7, 2004 that he had withdrawn himself from the OR2 program because he felt unfit to continue.

On September 8, 2004, a member of the OR2 treatment team advised the case manager that they discharged the worker because of a lack of anticipated improvement if he remained in the program.

The case manager had a conversation with the worker on September 8, 2004, during which it was discussed how the worker was discharged form the OR2 because of his participation level. The worker said that he was participating as well as he could and expressed dissatisfaction with the OR2.

Dr. R, a Board medical advisor, recorded in a September 10, 2004 claim log entry that he was of the opinion that the worker's thoracic spine compression fractures were chronic and unrelated to the compensable injury. In his view, the mechanism of injury was not compatible with this type of fracture, and the diagnosis was still a lumbar strain.

Dr. Randhawa reported to the Board during September 2004 that the worker was unfit to return to work and was awaiting a bone scan and CT scan.

An x-ray of the worker's thoracic spine on September 24, 2004 revealed anteriorly wedged configurations at the T7 and T8 levels, along with rectangularly shaped vertebral bodies from T9 through T11. The radiologist thought that these findings were developmental, but raised the possibility that the worker had a very mild compression injury at T8. An x-ray of his lumbar spine on the same day suggested the presence of very slight scoliosis convex to the left and some straightening of the usual lordosis, which was suggestive of muscle spasm.

The worker underwent a CT scan of his lumbar spine on October 6, 2004, which revealed a small broad-based left posterolateral disc protrusion at L5-S1, which was displacing the left S1 nerve root posteriorly. The radiologist noted, however, that the exiting left L5 nerve root was not impinged upon.

On October 15, 2004, Dr. Randhawa reported that the worker's low back pain was radiating to his right heel.

Dr. Randhawa provided the Review Division with an October 20, 2004 letter, in which he described how the worker suffered acute low back pain on June 8, 2004 with radiation into his right leg and foot. Noting the October 6, 2004 CT scan findings, Dr. Randhawa was of the opinion that the worker's disc herniation was the source of his pain.

As set out in his November 5, 2004 claim log entry, Dr. R considered the CT scan report and offered his opinion that it contained an incidental finding, since the worker's right-sided complaints did not correlate with the left-sided L5-S1 disc herniation.

Reasons and Findings

The worker's entitlement in this case is adjudicated under the provisions of the Act as amended by the *Workers Compensation Amendment Act, 2002* (Bill 49). WCAT panels are bound by published policies of the Board pursuant to the *Workers Compensation Amendment Act (No. 2), 2002* (Bill 63). Policy relevant to this appeal is set out in the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II).

Are the worker's thoracic spine compression fractures compensable?

The initial indication of the worker having thoracic spine compression fractures is found in the August 10, 2004 x-ray report, which suggested chronic compression fractures at T8 through T11. Yet, the September 24, 2004 x-ray of the worker's thoracic spine only suggested the possibility of a very mild compression injury at T8, while noting some "developmental" findings at T7, T9, T10 and T11.

Assuming that that the worker had compression fractures at T8 through T11, I find that there is insufficient evidence to conclude that they were causally related to the mechanism of injury on June 8, 2004.

Drs. Jiwa and R expressed their opinions that the compression fractures were not related to the worker's claim. Without any compelling evidence to the contrary, such as clinical findings involving the worker's mid back region, I agree with their conclusions.

I am mindful of Dr. Grewal-Basra's reference to the worker having mid and low back symptoms; however, I give significant weight to the anatomical symptom chart in Dr. Grewal-Basra's case history form, which shows that the worker's pain was localized in his low back. I deny the worker's appeal on this issue.

Is the worker's left-sided L5-S1 disc protrusion compensable?

Judging by the information that the worker provided in his notice of appeal, it is evident that he attributes his ongoing back pain to his disc herniation, as revealed by the October 6, 2004 CT scan. Dr. Randhawa's October 20, 2004 letter to the Review Division supports the worker's position.

Like the review officer, I am uncertain if the worker's left-sided disc herniation has anything to do with his lower extremity symptoms, which tend to be right-sided. As Dr. R pointed out in his November 5, 2004 claim log entry, the CT scan findings and the worker's symptoms do not correlate with one another. As well, I note that the October 6, 2004 CT scan did not show nerve root impingement. Dr. Randhawa addressed none of these concerns in his October 20, 2004 letter.

Even though I am doubtful that the worker's lower extremity complaints stem from his left-sided disc herniation, I turn now to the issue of whether the worker's disc protrusion is causally related to his workplace injury.

Generally, physicians look for neurological findings, as evidenced, for example, by radiating pain or numbness in the lower extremities, when trying to determine if an injury has resulted in a disc herniation. Upon my review of the medical evidence, it is evident that this was done in the worker's case throughout the course of his treatment.

I am somewhat puzzled by Dr. Randhawa's comment in his October 20, 2004 letter that the worker suffered acute low back pain on June 8, 2004 with radiation into his right leg and foot, given that there is no indication of this in his June 10, 2004 report to the Board. Moreover, I note that Dr. Randhawa stated in his July 2004 clinical note entries that there was no radiation of the worker's symptoms or radiculopathy. As a result, I give no weight to Dr. Randhawa's suggestion that the worker's lower extremity symptoms began immediately after his workplace injury.

There is evidence that the worker felt an increase in his symptoms, similar to what he felt on June 8, 2004, while unloading groceries in his car in early August 2004, as reported by Drs. Jiwa and Randhawa. As Dr. Jiwa noted in her August 10, 2004 report, it was shortly after this that the worker began to have symptoms in his palms and the soles of his feet. By August 16, 2004, he had pain radiating down his right leg, for which he was prescribed Demerol by an emergency ward physician.

I accept that the worker likely sustained a non-compensable injury to his low back on August 4, 2004 while unloading groceries from his car, as reported by Dr. Jiwa. In my view, this was an intervening injury, which likely played a causal role in the nature and extent of the worker's complaints at the time of his discharge from the OR2 program on August 25, 2004. I make no findings, however, as to whether this non-compensable injury was of causative significance in bringing about his left-sided disc herniation.

Given the facts of this matter, and the absence of any persuasive clinical findings that may have associated the worker's symptoms before August 4, 2004 to a disc herniation, I find that there is insufficient evidence to conclude that the disc herniation revealed by the October 6, 2004 CT scan was causally related to the worker's workplace injury.

In my view, the clinical findings of the various medical personnel who examined the worker following his workplace injury are consistent with a lumbar strain, which did not result in lower extremity symptoms. I note Dr. England's diagnosis of non-specific back pain. Yet, his conclusion that the worker did not have any "signs or symptoms suggestive of facet syndrome or neural impingement from any cause" is compelling evidence, in my view, that the worker likely sustained nothing more than a soft tissue injury on June 8, 2004.

For the reasons stated above, I deny the worker's appeal on this issue.

Is the worker entitled to wage loss benefits beyond August 25, 2004?

The worker contends that he is entitled to wage loss benefits until February 2005, which is when he resumed employment with a new employer, after leaving the country to attend to the medical needs of his father. By contrast, the employer contends that the worker's continuing back complaints are not related to his compensable low back strain.

In light of my finding that the worker likely sustained a non-compensable injury on August 4, 2004, I have considered whether this is a case contemplated by the policy in item #22.14 of the RSCM II, which applies in those situations where recovery from a compensable injury is interrupted by a non-compensable condition. It allows for the continuation of benefits during the estimated recovery period associated with the compensable injury or, alternatively, the suspension of benefits while the worker recovers from the non-compensable condition.

Although this policy may be relevant to the facts before me, I find that it is of little assistance in deciding this matter since it was the worker's participation, or lack thereof, in a Board-sponsored treatment program that triggered the termination of his benefits on August 25, 2004.

Section 57(2)(b) of the Act provides that the Board may reduce or suspend compensation when the worker refuses to submit to medical or surgical treatment which the Board considers, based on expert medical or surgical advice, to be reasonably essential to promote recovery.

RSCM II policy item #78.13 expands upon section 57(2)(b) of the Act and states that "medical treatment" is not limited to treatment performed by doctors, but includes therapy by paramedical personnel. I find that this includes the OR2 program that the worker was attending.

The policy also states that when making a decision under section 57(2)(b), there must be input of medical advice before benefits are reduced or suspended. Additionally, it provides that there must be a clear medical opinion that the treatment is reasonably essential to promote recovery, evidence that the worker was offered the treatment, and knew that the Board considered it reasonably essential to promote recovery, along with evidence that the worker was in a position to make a choice, and refused treatment. Furthermore, the worker must have been given a chance to explain before a decision is made. Finally, the policy notes that decisions under section 57(2)(b) of the Act are discretionary, and a refusal to undertake treatment may be reasonable if the proposed treatment involved risk of an adverse side-effect, a questionable prospect of success, or was hazardous.

As set out in other WCAT decisions (see for example *WCAT Decision 2003-00988-ad* available on WCAT's website at www.wcat.bc.ca), section 57(2)(b) of the Act gives Board officers extraordinary power to essentially terminate benefits, even though there may be evidence of disability, and therefore it should only be used in strict compliance with the law and policy.

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The review officer carefully assessed each of the requirements of RSCM II policy item #78.13 and found that they were satisfied by the facts of this matter.

Like the review officer, I accept that Dr. England's opinion, as expressed in the July 27, 2004 MARP discharge report, suggests that the worker's participation in the OR2 program was reasonably essential to promote recovery. As well, I am satisfied on the basis of Dr. England's report, the worker's participation in the OR2 program, and the meeting that was held with the case manager, the worker, and the OR2 treatment team on August 17, 2004 that the worker knew that the Board considered this treatment to be essential to his recovery.

In terms of the requirement that the worker was in a position to make a choice, and refused the treatment, I am mindful of the competing evidence on file as to whether the OR2 staff discharged the worker for certain reasons or whether the worker refused the treatment and discharged himself from the program.

The worker wrote in the information attached to his notice of appeal that he quit the program upon realizing that that he was about to discharged from the OR2 if he did not comply with the demands imposed upon him. The evidence shows that this is not a clear case of someone refusing treatment. Rather, it is evident that concerns regarding the worker's level of participation in the OR2 were developing over time. Regardless of whether the OR2 staff discharged the worker or he discharged himself, I accept that the worker's lack of participation in the OR2 was a significant factor that led to his discharge on August 25, 2004. In my view, the worker's less than satisfactory participation in the OR2, as summarized in the OR2 discharge report, was tantamount to a refusal of treatment.

In his notice of appeal, the worker expressed his concern about his pain level and the amount of weight that he was being asked to lift in the OR2. As a result, I have considered whether it was reasonable for the case manager to exercise her discretion to suspend the worker's benefits given the nature and extent of his symptoms at that time. Drs. Jiwa and Struthers assessed the worker during the course of the OR2 and found that there were no medical contraindications to him continuing. Since there is no compelling medical evidence to the contrary, I see no basis to question the case manager's use of her discretion in implementing section 57(2)(b) of the Act.

I further accept that the worker was given ample opportunity to explain his non-participation in the OR2 prior to the case manager's September 20, 2004 decision, as documented by the case manager's September 8, 2004 claim log entry based on her conversation with the worker.

I am satisfied that the requirements of section 57(2)(b) of the Act and policy item #78.13 of the RSCM II were met in this case, and the case manager properly suspended the worker's benefits on August 25, 2004.

The suspension of benefits under section 57(2)(b) of the Act is not the same as declaring a temporary disability resulting from the injury resolved or stabilized. Neither this section of the Act nor the policy in item #78.13 of the RSCM II provides authority to terminate a claim based on an estimate of recovery as if the treatment had been completed, unlike the policy in item #22.14 of the RSCM II.

The review officer was aware of this and went on to decide if the worker had any further entitlement to wage loss benefits beyond August 25, 2004. In doing so, he considered sections 29(1) and 30(1) of the Act, which provide that wage loss benefits are paid where there is evidence of temporary total or partial disability.

As well, the review officer applied the policy in items #34.10 and #35.10 of the RSCM II, which suggest that consideration should be given to the nature of a worker's physical impairment when determining if he or she remains temporarily disabled on account of the compensable injury, and therefore entitled to wage loss benefits under section 29(1) or 30(1) of the Act.

The finding in the OR2 discharge report that the worker had "significantly regressed with respect to lumbar spine/lower extremity range of motion and lower extremity strength" at the time of his discharge on August 25, 2004 is compelling evidence that there had likely been a significant change in the worker's physical impairment by that time. Furthermore, I am mindful of the deterioration of the worker's symptoms, which sent him to hospital during August and September 2004 on account of his lower extremity symptoms.

In weighing the evidence, I find that there had been a significant change in the worker's physical impairment by August 25, 2004 such that any disability he had at that time was unlikely related to his compensable low back strain. I agree therefore with the review officer's finding that the worker had no further entitlement to wage loss benefits beyond August 25, 2004.

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Is the worker entitled to health care benefits beyond August 25, 2004?

Section 21(1) of the Act allows the Board to provide reasonably necessary health care benefits to an injured worker.

The policy in item #73.20 of the RSCM II states that coverage for necessary health care continues for as long as the worker continues to experience the effects of a compensable injury or occupational disease, notwithstanding that he or she may not be disabled from working or may be retired from the workforce.

Dr. Randhawa wrote in his October 20, 2004 letter that the worker's disc herniation was the source of his pain. Yet, I have found that the worker's disc herniation is non-compensable, notwithstanding my concerns that the worker's ongoing symptoms do not correlate with the October 6, 2004 CT scan findings.

In keeping with my finding that the worker likely sustained a non-compensable injury to his back on August 4, 2004, I find that there is a remote possibility that the worker's compensable low back strain played a causal role in the symptoms that he was experiencing on August 25, 2004. Without any persuasive medical evidence that suggests otherwise, the evidence, in my view, does not satisfy the requirements of policy item #73.20 of the RSCM II. As a result, I find that the worker was not entitled to health care benefits under section 21(1) of the Act beyond August 25, 2004. I deny his appeal on this issue.

Conclusion

I confirm the Review Division's March 29, 2005 decision.

The worker did not request reimbursement of any expenses. In the event that the worker incurred an expense associated with Dr. Randhawa's October 20, 2004 medical letter, the worker is to be reimbursed in accordance with the tariff established by the Board. I find that it was reasonable for the worker to have sought Dr. Randhawa's letter in connection with the review and appeal proceedings.

Andrew Waldichuk
Vice Chair

AW/gw