DECISION OF THE WORKERS' COMPENSATION APPEAL TRIBUNAL

Introduction

[1] On November 12, 2012, the worker sustained a right shoulder injury when the automatic door of the building where she works closed on that shoulder. She filed a claim for compensation with the Workers' Compensation Board (Board)[1] for a right shoulder injury that included a diagnosis of right shoulder tendonitis.

[2] A Board entitlement officer denied the claim in a decision that was confirmed by a review officer with the Board's Review Division on September 20, 2013 (*Review Reference #R0160112*).

[3] A vice chair with the Workers' Compensation Appeal Tribunal (WCAT), allowed the worker's appeal from the Review Division decision, in part (*WCAT-2014-01846*, dated June 18, 2014). The vice chair accepted that the worker had sustained a minor contusion to her right shoulder that arose out of and in the course of her employment on November 12, 2012, but concluded that the worker's right shoulder tendonitis was neither caused nor aggravated when she was struck by the automatic door on November 12, 2012. The vice chair declined to take jurisdiction over whether the worker suffered a right rotator cuff tear in the work incident.

[4] In an April 28, 2015 decision, a Board case manager denied the worker's claim for a right rotator cuff tear. A review officer confirmed this decision on May 3, 2016 (*Review Reference #R0194907*).

[5] The worker has appealed the May 3, 2016 decision to WCAT with the assistance of her representative. The representatives for both the worker and the employer have provided WCAT with written submissions.

Issue(s)

[6] The issue is whether the worker's right rotator cuff tear arose out of and in the course of her employment on November 12, 2012.

Jurisdiction and Method of Appeal

[7] This appeal was filed with WCAT under section 239(1) of the *Workers Compensation Act* (Act). 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. Policy relevant to this appeal is set out in the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II).

[8] The worker asked that her appeal proceed on the basis of written submissions.

[1] operating as WorkSafeBC

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[9] The rule in item #7.5 of the WCAT *Manual of Rules of Practice and Procedure* (MRPP) provides that WCAT will normally conduct an appeal by written submissions where the issues are largely medical, legal, or policy based and credibility is not at issue. After reviewing the evidence, the submissions, and the guidelines for considering an oral hearing in item #7.5 of the MRPP, I conclude that an oral hearing is not required to ensure a full and fair consideration of the issues in the appeal. Credibility is not in issue and the appeal involves weighing the medical evidence and applying law and policy to facts in relation to which there is no material dispute. I have based my decision on the information in the claim and appeal files.

Background

[10] Prior to making the April 28, 2015 decision, the case manager obtained a medical opinion from Dr. Mason, a Board medical advisor.

[11] Dr. Mason reviewed the medical information on the claim file noting the following:

- Chart note November 13, 2012 – '*R shoulder pain x weeks. Door at work hit it yesterday'*. Impression – rotator cuff tendinitis. The attending physician did not provide evidence of significant objective findings related to the worker's right shoulder in that there were no findings reported of bruising, swelling; the attending physician noted a reduced ROM secondary to pain without indicating the actual range
- December 11/12 – injection of Depo-medrol right shoulder by attending physician.
- February 28, 2013 letter from Dr. Brown, naturopath – worker '*was assessed for right shoulder dysfunction/pain; evaluation revealed instability and extremely reduced functional strength of rotator cuff, acromioclavicular ligaments and acromioclavicular joint; as well as, rib subluxation pattern of 2-3 ribs'*.
- December 9, 2013 letter from physiotherapist – clinically noted that worker had right shoulder flexion of 100 degrees, abduction of 60 degrees and internal rotation to S2. Resisted testing documented weak and painful supraspinatus; strong and painful infraspinatus and strong and pain-free subscapularis. The therapist provided opinion that the worker sustained a right supraspinatus tear due to the direct impact on shoulder by door at work.[2]

[emphasis in the original]

[12] Dr. Mason also referred to an earlier medical opinion that had been provided by Dr. Struthers, also a Board medical advisor, regarding the worker's right shoulder injury. Dr. Struthers had said:

> In my opinion, a light impact on the shoulder (as you have accepted) would be unlikely to be a significant contributor to an acute shoulder injury, except perhaps a minor contusion …; it may have served to draw the worker's attention to the underlying tendinitis.

[2] All quotations reproduced as written, unless otherwise indicated.

[13] Further, during a team meeting of Board personnel that was held on February 4, 2013, a third Board medical advisor, Dr. Wong, had provided the following opinion:

> The impact to the shoulder by the closing door on [November 12, 2012] would be considered of light force as the mechanism for opening and closing the door is controlled by an automated door opener/closer. This light force impact would not have significantly affected the diagnosed right shoulder tendonitis.

[14] In addition, Dr. Mason noted the following medical information:

- Physio reports indicate through Jan/Feb 2013 the worker's right shoulder symptoms were improving
- MRI right shoulder July 7/13
    - Moderate degenerative and hypertrophic changes of the acromioclavicular joint
    - Complete full-thickness tear of supraspinatus and infraspinatus tendons with at least 4.5 cm of retraction and moderate/severe associated muscular atrophy
    - '*near complete loss of the acromiohumeral interval and contact between the articular cartilage of the humeral head and the inferior surface of the acromion'*; note made of moderate-sized osteophyte on humeral head
    - Impression – chronic full thickness tears of supraspinatus and infraspinatus tendons.

[emphasis in the original]

[15] Dr. Mason explained that the accepted mechanism of injury was consistent with a contusion to the shoulder. She said that, in order for a contusion to a shoulder to result in significant rotator cuff tears (full thickness supraspinatus and infraspinatus tears as documented in July 2013 MRI), there would need to have been significant force applied. Dr. Mason noted that there had been no evidence provided that the worker's right arm and shoulder were in a vulnerable position or were mechanically overloaded at the time of the contusion. Further, there had been no evidence provided that the mechanism of door closing was sudden (and quick) and forceful. Moreover, clinically, there was no evidence provided in the initial medical chart note in November 2012 that there was any swelling of the shoulder or signs of bleeding such as one would associate with an acute tear or contusion.

[16] Dr. Mason concluded as follows:

> The findings on MRI are more supportive of a degenerative condition that has progressed over time, unrelated to the November 2012 contusion. There are studies in the literature that suggest a large portion of rotator cuff tears are actually asymptomatic …. With aging the circulation to rotator cuff decreases resulting in tendon degeneration that can lead to weakening of tissue and even rotator cuff tear.

[17] After reviewing the evidence, the case manager accepted Dr. Mason's opinion. As set out in the April 28, 2016 decision, the case manager made the following findings:

- The mechanism of injury was of minor force, sufficient to cause only a minor contusion injury.
- There was no evidence immediately post incident of swelling or bleeding which would indicate the occurrence of an acute tear or contusion.
- The full thickness rotator cuff tear seen on the MRI, on the balance of probabilities, was a pre-existing condition.
- The mechanism of injury did not cause a right shoulder, full thickness tear nor did it accelerate or aggravate the pre-existing tear.

[18] The case manager denied that the right shoulder full thickness rotator cuff tear arose out of and in the course of the worker's employment and also denied that the tear resulted from an aggravation, or an acceleration, of a pre-existing degenerative condition.

[19] The worker provided the Review Division with additional medical evidence. This consisted of a January 1, 2015 opinion and clinical records from Dr. Gill, the worker's current family physician, as well as a November 20, 2015 medical-legal report from Dr. Leith, an orthopaedic surgeon.

[20] After reviewing the evidence, the review officer concluded that it was necessary to obtain medical clarification. She noted that Dr. Leith and many of the other treatment providers for the worker had offered opinions regarding causation of the worker's right shoulder condition based on the worker's report that she sustained a direct and heavy impact when the door closed on her shoulder. In this regard, Dr. Gill had said in a January 1, 2015 opinion that, "… according to the histories documented within the clinical records reviewed, there was a significant amount of impact applied to the right posterolateral shoulder."

[21] There is video evidence on the claim file which includes footage of the worker demonstrating how she was struck on the right shoulder by the automatic door that hit her on November 12, 2012. The worker explained that she was close to this external automatic door when it closed and it struck her on her right shoulder.

[22] The review officer asked Dr. Dunn, a Review Division medical advisor, to review the video evidence and provide an opinion as to whether the mechanism of injury the worker identified could plausibly produce a rotator cuff tear.

[23] Dr. Dunn reviewed all of the evidence, including medical chart notes, decisions from the Review Division and WCAT, the medical-legal opinions, and the video evidence. In an April 8, 2016 opinion, Dr. Dunn set out his understanding of the mechanism of injury:

> This 59-year-old female (55 at the time of the work incident) was struck on the posterior lateral aspect of her right shoulder while walking through an automatic door at work November 12, 2012.
>
> I watched a video clip wherein the worker demonstrated how an automatic door struck her on the shoulder. She indicated in the video that it struck her on the

> shoulder that was already sore. There is no measurement of the force likely to have occurred during the incident. I note that the worker stopped the door with her hand during the demonstration, and this certainly seemed to be quite easy.

[24] Later, Dr. Dunn also noted that, in the June 18, 2014 decision, the WCAT vice chair documented that the worker had testified she had a sore right shoulder since June 2012.

[25] Dr. Dunn summarized the medical evidence that followed the worker's report of the right shoulder injury:

> On November 13, 2012 Dr. Campbell documented that the worker had right shoulder pain for weeks. A door struck her yesterday. Range of motion was decreased secondary to pain, 'positive supraspinatus positive teres minor'. Diagnosis was **rotator cuff tendinitis.**
>
> Physiotherapy assessment December 5, 2012 documents right anterior shoulder pain after getting hit with the door at work. There was decreased range of motion, positive speed's test, weakness + +, right supraspinatus was tender. A supraspinatus tear was questioned.
>
> December 11, 2012 the right shoulder was injected with Depo Medrol.
>
> Another set of physiotherapy notes document a December 31, 2012 visit indicating right shoulder pain for a while. Increased in the summer therefore has August 20 as date of injury. Was having treatment with massage. Pain increasing and then a cortisone shot in mid December which improved. Slowly getting to this point over time.
>
> Right shoulder MRI on July 7, 2013 documents a complete full-thickness tear through the supra and infraspinatus tendons. Chronic is more likely in view of the associated muscular atrophy (radiologists opinion). There is also muscle retraction. There were degenerative changes of the AC [acromioclavicular] joint. There was some atrophy in the teres minor. There was complete loss of the acromial humeral interval and contact between the articular cartilage of the humerus and the inferior surface of the acromion. There was a moderate size marginal osteophyte on the humeral head. Mild chondromalacia of the glenohumeral joint was suspected.
>
> The worker's first assessment by an orthopedic surgeon, Dr Patel, occurred February 5, 2014. This was approximately 1 year and 3 months or 15 months after the work incident. Dr. Patel points to the osteophyte of the humeral head indicative of rotator cuff arthropathy.
>
> Subsequently, Dr. Kim [an orthopaedic surgeon] and Dr. Leith also clinically correlated the rotator cuff pathology.
>
> [emphasis in the original]

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[26] By way of background information, Dr. Dunn provided the following discussion of rotator cuff disease and rotator cuff tears:

> The rotator cuff is a group of muscles and tendons that secures the arm to the shoulder joint and allows the arm to rotate. These muscles lie deep to the externally visible deltoid muscle. The rotator cuff can be injured in a multitude of mechanisms as it is a dynamic stabilizer of the shoulder and involved in many actions.
>
> Rotator cuff tears become more common over 40 years of age. In younger patients, these injuries typically result from acute severe trauma. In middle-aged or older patients, a more common presentation is chronic impingement syndrome, often resulting in rupture of the cuff. After years of just normal use, the older individual may develop an impingement syndrome and rotator cuff tear.
>
> Impingement occurs when during humeral flexion, the rotator cuff tendons and bursa become impinged between the acromion and the greater tuberosity of the humerus. Over time, this impingement leads to tendon degeneration and eventual tears.
>
> In 1972, Neer first introduced the concept of rotator cuff impingement to the literature, stating that it results from mechanical impingement of the rotator cuff tendon beneath the anteroinferior portion of the acromion, especially when the shoulder is placed in the forward-flexed and internally rotated position.
>
> Neer described 3 stages in the spectrum of rotator cuff impingement. Stages one and two generally occurring over ages 25-40. Stage 3 commonly affects patients older than 40 years and commonly requires surgical anterior acromioplasty and rotator cuff repair. Rotator cuff tears, biceps ruptures, and bone changes occur in this stage. Significant tendon degeneration is the hallmark of stage 3 patients who often admit to prolonged periods of pain, particularly at night, weakness can be bothersome as further rotator cuff degeneration occurs.
>
> Most full-thickness rotator cuff tears, particularly over 40 years of age and more so over 50, are chronic tears and more likely represent the final pathway of chronic subacromial pathology.
>
> Age-related tendon changes are also significant in the development of rotator cuff tendon pathology.
>
> Injury is not required in this demographic for rotator cuff pathology, including tears, to be present and to become painful and disabling.
>
> Magnetic resonance (MR) imaging studies, as well as postmortem studies, have suggested a significant incidence of degenerative changes in the rotator cuff in otherwise asymptomatic individuals, including rotator cuff tears.

> A large proportion of injured workers are in the over 40 age group and often present after acute shoulder injury with clinical impingement and rotator cuff tendinopathy with or without rotator cuff tears. These types of presentations, if after suitable shoulder injury and new post injury symptoms and findings, are usually best characterized as aggravations of pre existing rotator cuff tendinopathy and/or impingement syndrome, recognizing the natural history of rotator cuff disease.

[27] Dr. Dunn noted that the worker's history of shoulder symptoms prior to the work incident was clearly documented. He said that the history of findings and disability recorded in the medical evidence, as well as the MRI findings of chronic massive rotator cuff tear made it highly likely that she was suffering the effects of rotator cuff disease prior to November 12, 2012. He wrote:

> This is the most logical explanation given what is understood of this condition in this age group and objective review of the facts available. In other words, all of the pathology on MRI did not occur temporally subsequent to the work incident. This would just not make medical/scientific sense.

[28] Dr. Dunn said that, as a consequence, an opinion on causation should include the premise that the worker did have gradually increasing pain and decreased function in the right shoulder prior to the work incident of November 2012, most probably secondary to rotator cuff tendinopathy. He noted that there were no available chart notes to review for about one year prior to the work incident and so a comparison of the worker's pre-injury and post-injury condition could not be made. Dr. Dunn acknowledged that this was important when considering s important in considering causation. Nevertheless, he also wrote as follows:

> The physical findings demonstrated post work incident are not necessarily those of acute injury. They could certainly be secondary to chronic rotator cuff disease especially given this worker's later imaging findings and gradually worsening pain and dysfunction. It is not logical to state that because the worker had pain, decreased power and decreased range of motion when examined for the first time after November 12, 2012, that she therefore must have recently damaged the rotator cuff (tear or aggravate disease). Gradually increasing pain, difficulty with opening doors and pain with computer mousing would indicate that a dedicated shoulder exam would unlikely be normal prior to November 12, 2012, but any estimation would be speculation and whether there is a significant difference after the incident can't be determined without the notes. My opinion below will assume there are no chart notes for a year prior to the incident.

[29] Dr. Dunn also said that, when assessing causation, the nature of the incident will be very important. He wrote:

> It is clear that the history provided by the worker to the orthopedic surgeons reviewing the worker 1 and 2 years post incident indicates a very forceful mechanism of injury. A significantly forceful direct blow to the posterolateral shoulder is not the usual mechanism for rotator cuff injury but it **could** cause injury to the internal structures, including the rotator cuff tendon (s).

> The video evidence demonstrates an automatic door on the outside of the building. The worker, who was present in the video, indicated that she was struck on the right posterolateral shoulder as the door started to close. The force was not measured. Based on my review of the video, it looks like very little force was required for the worker to stop the door with her hand.
>
> ….
>
> Note that while it is clear that there may be no external signs such as bruising or swelling with rotator cuff injury or pathology, certainly, with a significant and forceful blow, there would more likely be some external findings consistent with this.

[30] Dr. Dunn concluded that, likely, the incident consisted of only minor force: "i.e. an incident unlikely involving enough force to bring into play the rotator cuff such that it could be injured (tear or aggravation of tendinopathy)." He said that a 55-year-old with gradually increasing pain and decreased function of the shoulder could experience further increased pain and dysfunction without any traumatic event, as this would be consistent with the natural history of rotator cuff disease. He explained that tears are present as part of the natural history, with or without symptoms, and, in such a setting, a very minor incident could simply bring the underlying progressive disease more to an individual's attention rather than actually causing a new injury or aggravation. He provided the following example:

> Consider that if one's shoulder is sore with door opening and computer mousing, a minor bump to it would hurt, even without causing new injury (including aggravation of underlying pathology).

[31] Dr. Dunn also provided an explanation of the two medical terms tendonitis and tendinopathy:

> Many currently practicing practitioners were taught, and many still believe, that patients who present with overuse tendinitis have a largely inflammatory condition (this is the "itis") and will benefit from anti-inflammatory medication. This is not the case however. Pathological studies have confirmed that this is not an inflammatory process but rather and 'osis' or 'opathy' process. Nomenclature for the clinical presentation of tendon disorders should reflect the true histopathological basis underlying clinical presentation. The term tendinitis [tendonitis] should be replaced by the term 'tendinopathy' or 'tendinosis' (for example, rotator cuff tendinopathy) as this acknowledges that the condition is not tendinitis. There is a shift in documentation of tendon disorders amongst treating physicians including general practitioners and orthopedic surgeons however the term tendinitis is frequently used when the correct term would be tendinosis or tendinopathy.

[32] Dr. Dunn noted that, in the worker's case, the attending physician, "who would very commonly see shoulder pain presentations in 50+ year olds," diagnosed rotator cuff tendonitis. In Dr. Dunn's opinion, this was likely meant as tendinopathy or tendinosis, which was a diagnosis that would include rotator cuff tears if they were present.

[33] Dr. Dunn also considered whether a progression in the pathology in the worker's right shoulder could be attributed to the work incident. In this regard, Dr. Leith had referred to an x-ray in February 2014 showing a decreased acromioclavicular (AC) humeral interval that was not present in November or December 2012. The x-rays were not available to Dr. Dunn. However, he said that the change in imaging from 2012 to 2014 did not represent new rotator cuff pathology but, rather, progression of rotator cuff pathology and impingement. In other words, this was a progression which could occur naturally. Dr. Dunn concluded as follows:

> Considering all of the evidence I am of the opinion the workers rotator cuff pathology was not caused by the work incident. This most likely pre - existed the work incident by many months and was the likely source of the pre incident increasing pain and disability the worker indicated.
>
> For the following reasons discussed above in detail:
>
> - The worker's pre-work incident history of gradually increasing pain and disability,
> - The nature of, and minor force in the incident,
> - The worker[']s post incident presentation consistent with rotator cuff pathology, not necessarily acute injury
> - The imaging demonstrating chronic rotator cuff tear (radiology opinion)
> - The current medical understanding of rotator cuff pathology
>
> I am of the opinion that it is unlikely the work incident of November 2012 caused or aggravated the workers rotator cuff pathology, including the tear.

[34] The review officer accepted and relied on this opinion in the May 3, 2016 decision, noting that Dr. Dunn appeared to be the only one who had had the benefit of reviewing the video evidence.

Submissions and New Evidence

[35] Both representatives provided WCAT with written submissions.

[36] The worker also prepared an affidavit in which she deposed that she did not have any major injuries to her right shoulder prior to the work accident. In particular, prior to the accident: she did not have a constant ache in her shoulder; she did not experience sharp pains in her shoulder; her symptoms did not wake her up or keep her up at night; using a mouse on a computer did not cause symptoms in her right shoulder; and, she only discontinued unnecessary movements with her right arm after the accident. The worker submitted that her evidence in this regard was misinterpreted by the review officer and by Dr. Dunn. The worker also deposed that, although she did experience some "minor aches and discomfort" prior to the accident," these were only caused by opening heavy laboratory doors in the hospital, which she had to do 20 times a day, on average. She said that these aches and pains were "very minor in nature," and "did not prevent [her] from any kind of movement or completing any tasks at work."

[37] In addition, one of the worker's co-workers prepared an affidavit, affirmed on October 3, 2016, in which she provided a detailed account of the November 12, 2012 incident when the worker's right shoulder was hurt as the door hit her.

[38] Further, the worker obtained a second medical-legal opinion from Dr. Leith. In preparing this second opinion, dated October 20, 2016, Dr. Leith reviewed all of the medical evidence that had been available to Dr. Dunn, and also reviewed the video evidence. Dr. Leith stated that his review of this additional information did not alter the opinion that he had provided in his first report of November 20, 2015. He wrote:

> It remains that the event that occurred with the door resulted in acute increased pain to the right shoulder and work disability. There was no other cause for the symptoms that developed immediately following the subject work incident.

[39] Dr. Leith also confirmed that, as he had previously indicated, it was not likely that the work incident resulted in an acute tear to the rotator cuff. However, it did cause the worker's shoulder to become more acutely symptomatic and progressive. He said that, absent the event, she would have been able to continue to work indefinitely and would not have likely developed the acute demise in her overall function and symptoms that she experienced.

[40] With regard to the mechanism of injury, Dr. Leith said that he had reviewed the video of the door involved and this confirmed that the door struck the workers right shoulder along the posterolateral aspect. In Dr. Leith's view, the video did not provide a valid basis for determining the forces that were transferred to the right shoulder and felt by the worker at the time of her injury. Further, he said that the mechanism of injury was not really relevant since the more relevant matter was the timing of the onset of her symptoms, the acute nature of the symptoms, and the degree of disability that occurred immediately following the injury. He wrote:

> These variables are much more relevant and of higher priority in determining whether the event caused an injury or symptoms consistent with injury and led to [the worker's] current problems.

[41] Dr. Leith noted that, following the injury, the clinical records all documented that the worker was hit by a heavy door that was closing, and also that the worker had immediate difficulty reaching the arm overhead and out to the side due to pain and weakness. In contrast, there was no indication from any of the clinical records that pre-date the injury of any symptoms or complaints of this degree affecting the right shoulder. Instead, the only record of prior right shoulder problems were noted by Dr. Kim in a February 13, 2014 letter where the worker provided the history of having very mild pre-existing activity-related right shoulder pain. Dr. Kim also noted that the worker's shoulder became much worse with pain and weakness with restricted motion following the work injury event.

[42] One of the foundations for the review officer's decision was the finding that the worker had been experiencing symptoms of right shoulder tendinitis since June 2012.

[43] Given the absence of any record of right shoulder symptoms in the clinical records that pre-dated the incident with the door, Dr. Leith said that he was "at a loss" as to how the review officer drew the conclusion that the worker's right shoulder was unaffected by the injury event. In any event, even if she was having some symptoms to the right shoulder prior to the door event, her symptoms dramatically changed immediately following the event; following the basic biologic principles of injury, the clinical presentation after the traumatic event confirmed it did cause injury.

[44] Dr. Leith then confirmed that, of the various possible scenarios he had outlined in his original report, it was most likely that the worker had a pre-existing tear that was asymptomatic or minimally asymptomatic at the time of the door event: "it was rendered acutely more symptomatic by the door event and thus would be considered an aggravating event." Dr. Leith said that the most likely scenario, and indeed the only possible scenario, was that being struck by the door directly over the posterolateral aspect of the shoulder, which was already at risk, resulted in decompensation with acute symptoms of pain, weakness, and loss of function of the shoulder.

[45] Dr. Leith had been asked to comment on whether he agreed with the reasoning and conclusions in Dr. Dunn's April 8, 2016 opinion. He agreed with Dr. Dunn that the worker did not suffer an acute rotator cuff tear in the November 12, 2012 event. However, he disagreed that the event was not the cause of her clinical presentation following the event and the evolution of symptoms that had occurred since that event. With regard to the absence of medical records of symptoms prior to November 12, 2012 that Dr. Dunn had acknowledged, Dr. Leith said that, normally, patients with symptomatic and problematic rotator cuff tears or rotator cuff disease will present to their treating physicians or to other ancillary healthcare professionals. Thus, the absence of records supporting this that document complaints or physical examination findings of there being a problem supports that the worker was not experiencing problems related to the rotator cuff prior to the November 2012 event. This further supported that the door event brought on symptoms in the right shoulder, acutely.

[46] Dr. Leith also said that the absence of external signs such as bruising or swelling was not a requirement for the establishment of an aggravation to pre-existing rotator cuff disease to make it more symptomatic:

> [The worker] had an at risk shoulder and shoulders with rotator cuff tears that are asymptomatic do not require as much force to cause decompensation and clinical presentation of more significant rotator cuff symptoms such as pain, weakness and loss of active motion.

[47] In essence, Dr. Leith disagreed with Dr. Dunn based on his understanding that there was a "definite and immediate change" in the worker's clinical presentation following the November 12, 2012 event, which was inconsistent with Dr. Dunn's view that the worker's pre-existing rotator cuff had simply progressed.

[48] Dr. Leith summarized his opinion as follows:

> To summarize, the facts include that [the worker] was struck by the door along the posterolateral aspect of the right shoulder. Following this event, she presented with acute pain, weakness and loss of motion to the right shoulder. It has never been documented and she denied having any symptoms to this degree prior to the event. Imaging done after the event indicate[s] that she did have pre-existing rotator cuff disease and a rotator cuff tear. This was not symptomatic or was minimally symptomatic prior to the door event. It was rendered much more symptomatic immediately following the event and caused a decompensation of the right shoulder condition.

> Therefore, this event was an aggravating injurious event causing her current clinical state. Her symptoms were brought on sooner than otherwise would have occurred. Absent the door event, she would not be where she is currently with respect to the symptoms and loss of function of the right shoulder.

[49] In addition, the worker's appeal materials include chart notes and other medical documents that duplicate material that is already on the claim file.

[50] In brief, through her representative, the worker submitted that Dr. Leith's analysis should be accepted and preferred to the other opinions on file as it was the most detailed and reasoned evidence, he was the most qualified to provide opinion evidence about the worker's orthopaedic injuries and their causation, and he had actually seen and physically examined the worker. The worker submitted that the evidence, as clarified in affidavit, supports that the November 12, 2012 workplace accident was of causative significance in acutely causing, accelerating, or aggravating the worker's pre-existing tear to the point of disability; the claim should be accepted under section 5(1) of the Act or, alternatively, under section 6(1) of the Act.

[51] Further, the worker sought reimbursement for the $4,150 expense of obtaining Dr. Leith's October 20, 2016 report. She also asked for reimbursement of $3,225 of the expense for obtaining Dr. Leith's November 20, 2015 report, being that portion of Dr. Leith's bill that remained after reimbursement of the maximum allowable under the Board's fee schedule (invoiced at $4,725, but reduced to the Board rate of $1516.22).

[52] The employer supported the Board and Review Division decisions. The employer submitted that Dr. Dunn's opinion should be given considerable weight since Dr. Dunn reviewed the file in its entirely, including the medical opinions and the video evidence, and commented on the mechanism of injury. Based on that opinion, the employer submitted that the November 12, 2012 work incident did not cause or aggravate the worker's rotator cuff pathology.

Reasons and Findings

[53] The standard of proof that applies in this appeal is the balance of probabilities, but this is modified by section 250(4) of the Act. Section 250(4) provides that, where the evidence supporting different findings on an issue respecting the compensation of a worker is evenly weighted, WCAT must resolve that issue in a manner that favours the worker.

Rotator Cuff Tear

[54] Section 5(1) of the Act provides that a worker is entitled to compensation for a personal injury arising out of and in the course of his or her employment.

[55] Policy item #C3-14.00 of the RSCM II sets out the meaning of the phrases "arising out of the employment" and "in the course of the employment". It states that "arising out of the employment" generally refers to the cause of the injury or death. In considering causation, the focus is on whether the worker's employment was of causative significance in the occurrence of the injury or death. Both employment and non-employment factors may contribute to the injury or death. The employment factors need not be the sole cause. However, in order for the injury or death to be compensable, the employment has to be of causative significance, which means

more than a trivial or insignificant aspect of the injury or death. “In the course of the employment” generally refers to whether the injury or death happened at a time and place and during an activity consistent with, and reasonably incidental to, the obligations and expectations of the employment.

[56] Further, in cases where a worker has a relevant pre-existing degenerative condition, policy item #C3-16.00 of the RSCM II must be considered. It provides that if a worker’s pre-existing condition or disease is a deteriorating condition, the medical evidence is examined to determine whether or not, at the time of the injury, the pre-existing deteriorating condition or disease was at a critical point at which it was likely to result in a manifest disability. If the injury is one the worker would have sustained whether at work, at home, or elsewhere, regardless of the employment activity, then the employment was not of causative significance; the injury is considered to have resulted from the pre-existing deteriorating condition or disease and is not compensable. Conversely, if the injury is one that the worker would not have sustained for months or years, but for the exceptional strain or circumstance of the employment activity, then the employment is of causative significance, and the injury or death may be compensable.

[57] Policy item #C3-16.00 also provides that, in all cases, the medical and factual evidence is considered together, in order to determine the causative significance of the pre-existing deteriorating condition or disease, and the employment activity or situation, in the resulting injury or death.

[58] The medical evidence, including the opinions from Dr. Leith and Dr. Dunn, confirms that, prior to November 12, 2012, the worker had pre-existing, degenerative rotator cuff pathology in her right shoulder. The opinions of both Dr. Leith and Dr. Dunn also confirm that the November 12, 2012 incident did not cause the worker to suffer a new, acute tear to the right rotator cuff. Rather, the only area of real dispute between Dr. Leith and Dr. Dunn is whether the worker’s underlying degenerative condition had reached a point where it would have become a manifest disability regardless of the November 12, 2012 accident. Dr. Dunn believes it had reached that point, whereas Dr. Leith believes it had not and that the November 12, 2012 incident aggravated the pre-existing pathology.

[59] Policy item #97.34 of the RSCM II provides guidance in these circumstances. It provides that, where there is a conflict in medical opinion, the Board officer must analyze the opinions and conflicts as best as possible on each issue and arrive at his or her own conclusions about where the preponderance of the evidence lies. The policy further explains that it should never be assumed that there is a conflict of medical opinion simply because the opinions of different doctors indicate different conclusions. A difference in conclusion between doctors may or may not result from a difference in medical opinion. For example, the difference could result from different assumptions of non-medical fact. In those situations, the Board officer must consider whether the relevant non-medical facts have been clearly established.

[60] In this case, the difference of opinion between Dr. Dunn and Dr. Leith arises from their different understanding of the relevant fact. Most significantly, Dr. Dunn understood that the worker had significant right shoulder symptoms that were progressively worsening from June 2012 onward and that the accident itself involved only minimal impact on the posterolateral aspect of the worker’s right shoulder. In contrast, Dr. Leith understood that the November 12, 2012 workplace accident was contemporaneous with an acute change in the worker’s overall right shoulder

condition and that, prior to that accident, the worker had no or only minimal right shoulder symptoms.

[61] I am satisfied that, based on the evidence that was available to Dr. Dunn, his understanding of the facts was not unreasonable. The worker did identify June 2012 as the date of symptom onset under her claim for activity-related right shoulder tendinitis, and clearly identified her condition as progressive. Additionally, as shown above, the medical evidence most directly contemporaneous to the December 12, 2012 workplace accident did not identify that event as pivotal in changing the worker's symptoms.

[62] However, in this appeal, the worker has provided new evidence that gives clarification to the facts that was not previously available. The affidavit the worker provided in support of her appeal is the first instance where she has provided evidence under oath. It provides a version of the facts that is consistent with the evidence the worker provided early in the claim and to her health care providers. I acknowledge and accept that it is possible to interpret the worker's application for compensation under the tendinitis claim as indicating that she began to experience progressively worsening symptoms in her right shoulder in June 2012, and these restricted her activities from that date (as found by the review officer). However, the application for compensation was made by telephone and consists of a transcription of statements the worker provided to the officer who completed the application. It must be read within the context of all of the evidence, including that from the worker's healthcare providers and the questionnaire the worker completed in January 16, 2013 in conjunction with her tendinitis claim. In these sources, the worker identified the November 12, 2012 workplace event, or early November 2012, as the date on which there was a significant change in her right shoulder symptoms and level of disability. I have not identified any reasonable basis for discounting the worker's new evidence and clarification and I accept it.

[63] Dr. Dunn did not have the benefit of the new, clarifying evidence that the worker has filed in support of her appeal and, consequently, based his opinion on an understanding of the facts that is no longer supported. Conversely, Dr. Leith based his opinion on an understanding of the facts that is consistent with the evidence that is now available. I prefer and accept his opinion. It is based on a thorough analysis of the factual situation as established in the evidence now available, and provides a reasoned response to all of the concerns about causation that Dr. Dunn raised.

[64] The absence of medical evidence from the period between June 2012 and November 12, 2012, when the worker did have some right shoulder symptoms, means that it is not possible to accurately assess the extent of the worker's pre-existing, degenerative rotator cuff pathology prior to November 12, 2012. However, with the benefit of Dr. Leith's October 20, 2016 opinion, I am satisfied that the evidence is at least evenly balanced in favour of a conclusion that the worker would not have become disabled, but for the exceptional circumstance of the November 12, 2012 workplace accident. In the circumstances, I find that that accident resulted in a compensable aggravation of the worker's degenerative right shoulder condition. She is entitled to acceptance of her claim.

Expenses

[65] Section 7 of the *Workers Compensation Act Appeal Regulation* provides that WCAT may order the Board to reimburse the parties to an appeal for certain appeal expenses related to an appeal. As set out in item #16.1.3 of the WCAT MRPP, WCAT will generally order reimbursement of expenses for obtaining written evidence where the evidence was useful or helpful to the consideration of the appeal, or it was reasonable for the party to have sought the evidence. The principles established in the MRPP apply both to evidence that is obtained at the appeal level and to that which is obtained at the review level.

[66] Item #16.1.3.1 of the MRPP speaks specifically to expert reports. It states that WCAT will usually order reimbursement of expert opinions at the rate established by the Board for similar expenses. The balance is the responsibility of the party who obtained the report.

[67] The rates that are payable by the Board for physicians' reports are established on the basis of negotiations between the Board and the British Columbia Medical Association.

[68] Excerpts from the fee schedule for medical-legal and psychological matters are found in Appendix 11 to the MRPP.

[69] Appendix 11 indicates a medical-legal report (fee code #19932) will recite symptoms, history, and records and give diagnosis, treatment, results, and present condition. This is a factual summary of all the information about when the injured worker will be able to return to work and might mention whether there will be a permanent disability. The current rate under this fee code is $932.74.

[70] Appendix 11 indicates a medical-legal opinion (fee code #19933) will usually include the information contained in a medical-legal report and will differ from it primarily in the field of expert opinion. This may be an opinion as to the course of events when these cannot be known for sure. It can include an opinion as to long-term consequences and possible complications in the further development of the condition. All the known facts will probably be mentioned, but in addition there will be the extensive exercise of expert knowledge and judgment with respect to those facts with a detailed prognosis. The current rate under this code is $1,558.20 and, as of October 20, 2016, was $1,535.17

[71] A WCAT panel has the discretion to award reimbursement of an expert opinion in an amount greater than the rate established by the Board in limited circumstances. If the bill or account exceeds the Board fee schedule, the party seeking reimbursement of the full amount must explain the reasons the account exceeds the fee schedule and why the panel should order reimbursement of the full amount. Examples of the limited circumstances include those where the case is so difficult that it required significant time and effort, the report is lengthy, or the detail and analysis in the report is uncommon.

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[72] In this case, the worker submitted that reimbursement for the full amount that Dr. Leith billed for his October 20, 2016 medical-legal opinion should be directed for the following reasons:

- Dr. Leith is a renowned expert in his field and has been qualified as an expert by the Supreme Court of British Columbia on 25 occasions.
- He provided a comprehensive medical-legal report, which was expert in nature.
- His report goes beyond the typical expert report meant to be reimbursed under the tariff system in its detail and benefit to the relevant issues in the appeal.

[73] I acknowledge that Dr. Leith is recognized as an expert in the field of orthopaedic medicine. However, I am not persuaded that there is a basis for directing reimbursement for the October 20, 2016 opinion that exceeds the applicable amount in tariff item #19933. The supplemental October 20, 2016 report and the earlier report provided to the Review Division are consistent in nature to those that WCAT typically receives from qualified specialists who have been retained by parties to give opinions regarding causation. The reports are also consistent with the description of what is expected in order to warrant reimbursement at the tariff rate, as set out tariff item #19933.

[74] Keeping in mind that the rates established for reimbursement have been established jointly by the Board and the British Columbia Medical Association, I have not identified any principled basis upon which to grant the worker's request for reimbursement of the full amount that Dr. Leith billed for his reports.

[75] With regard to the October 20, 2016 opinion, I also note that the letter of retainer to Dr. Leith specifically included a term regarding reimbursement, and limited it to the amount in tariff item #19932. However, since I accept that the October 20, 2016 opinion is consistent with the description in tariff item #19933, I do not consider that reimbursement should be limited to the lesser amount provided for in tariff item #19932. I find that the worker is entitled to reimbursement for the expense of obtaining Dr. Leith's October 20, 2016 medical-legal opinion at the maximum rate provided for in tariff item #19933.

[76] The amount the Board reimbursed the worker for the expense of obtaining Dr. Leith's November 20, 2015 medical-legal opinion was the maximum provided for under tariff item #19933 as of the date of that opinion. I am not persuaded that this amount should be supplemented. The worker is not entitled to additional reimbursement for the expense of obtaining Dr. Leith's November 20, 2015 medical-legal opinion.

Conclusion

[77] The worker's appeal is allowed and the Review Division's May 3, 2016 decision is varied in accordance with the above reasons. Although the evidence does not support that the worker suffered an acute rotator cuff tear on November 12, 2012, it does support that the worker suffered a compensable aggravation of the pre-existing pathology in her right rotator cuff on that date. The worker is entitled to acceptance of her claim on that basis.

[78] In accordance with the above reasons, the worker is entitled to reimbursement for the expense of obtaining Dr. Leith's October 20, 2016 medical-legal opinion at the maximum rate provided for in tariff item #19933. The worker is not entitled to additional reimbursement for the expense of obtaining Dr. Leith's November 20, 2015 medical-legal opinion, beyond that which has already been paid by the Board.

[79] There was no request for reimbursement of any additional appeal expenses. Therefore, I make no further order in that regard.

Deirdre Rice
Vice Chair

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