DECISION OF THE WORKERS' COMPENSATION APPEAL TRIBUNAL

WCAT Decision Number: A1607061
WCAT Decision Date: September 5, 2018

Introduction

[1] The worker, while employed as a truck driver, sustained a left knee injury in 2012, during a workplace incident. The Workers' Compensation Board (Board), operating as WorkSafeBC, accepted his claim, after two left knee surgical repairs (December 2012 and September 2013), for a permanent aggravation of pre-existing degenerative changes in the anterior and posterior horn of the medial meniscus. The Board also accepted chronic pain. The worker received temporary disability wage loss benefits until March 2014. Thereafter, the Board provided a permanent partial disability pension award equal to approximately 11.98% of total disability, effective March 2014.

[2] In early 2015, the worker's representative asked the Board to adjudicate a number of additional conditions under the claim.

[3] Eventually, a Board case manager issued a June 1, 2016 decision letter.

[4] As set out, she decided to accept a patellar tendon tear as a compensable condition, but declined to accept a third meniscal tear as a consequence of Board-sponsored treatment in January 2014. Additionally, the case manager declined to provide any further temporary disability wage loss benefits or physiotherapy treatment coverage.

[5] The worker requested a review of that decision by the Board's Review Division.

[6] A review officer, in a November 23, 2016 finding, confirmed the Board's decision regarding the compensability of a third meniscal tear and the worker's entitlement to coverage for further physiotherapy treatment. However, she referred the issue of entitlement to further wage loss benefits back to the Board for further determination, in light of the acceptance of the new compensable condition – the patellar tendon tear.

[7] By way of implementation, another Board case manager, in a February 10, 2017 decision letter, concluded the left partial patellar tendon tear had considered resolved by June 6, 2014. Therefore, the worker was entitled to temporary disability wage loss benefits to that date.

[8] The worker requested a review of that decision by the Board's Review Division.

[9] A different review officer, in a September 14, 2017 finding, decided the patellar tendon injury had not resolved by June 4, 2014 and was temporarily disabling up to August 7, 2014. Parenthetically, the review officer noted the worker had received vocational rehabilitation

benefits past August 7, 2014 and, as such, his decision might not result in any further benefit entitlement. He left that to the Board to determine, in any event.

[10] The worker now appeals both review officers' findings to the Workers' Compensation Appeal Tribunal (WCAT). During the WCAT appeal process, the worker continues to be represented by legal counsel. Although invited to do so, the accident employer is not participating.

[11] Because the worker, through his legal counsel, did not request an oral hearing, a WCAT assessment officer determined the appeals would be "joined" and would proceed by way of written submissions.

[12] Accordingly, legal counsel provided a written submission, along with additional evidence.

[13] In late September 2017, and based on section 246(2)(c) of the *Workers Compensation Act* (Act), I asked a WCAT appeal coordinator to contact the worker's treating orthopaedic specialist, Dr. Lee, because I wanted to Dr. Lee to provide additional medical opinion evidence.

[14] Dr. Lee's subsequent October 20, 2017 letter to WCAT was then disclosed. In January 2018, legal counsel indicated he did not have any further submissions to make.

[15] In an April 12, 2018 interim decision, I referred a matter back to the Board for determination, while suspending the current appeals until the Board made that further determination.

[16] Based on section 246(3) of the Act, I found the Board should determine whether there had been a significant change in the worker's medical condition that the Board had previously decided was compensable, or whether there had been a recurrence of the worker's injury, by at least the August 2014 MR arthrogram, such that the Board might reopen the claim for additional compensation benefit entitlement – wage loss and physiotherapy.

[17] Shortly thereafter, the Board case manager, in his June 12, 2018 determination letter, found there was significant change in the worker's compensable left knee condition, effective July 14, 2016.

[18] Legal counsel then provided an additional submission in mid-August 2018.

[19] Thereafter, a WCAT appeal coordinator determined that all submissions were again complete and the appeals were returned to me for a decision.

Issue(s)

[20] The issues in these appeals relate to:

- The compensability of an additional left knee meniscal tear.
- The worker's entitlement to further wage loss benefits.
- The worker's entitlement to additional coverage for physiotherapy treatment.

- Pursuant to section 96(2) of the Act, whether there had been a significant change in the worker's medical condition that the Board had previously decided was compensable, or whether there had been a recurrence of the worker's injury, such that the worker's claim should be reopened for compensation benefits.

Jurisdiction

[21] The worker appeals two Review Division decision findings – November 23, 2016 (*Review Reference #R0209188*) and September 14, 2017 (*Review Reference #R0221911*) – pursuant to section 239(1) of the Act.

[22] I have also have exclusive jurisdiction over the Board's subsequent June 12, 2018 determination letter, pursuant to section 246(4) of the Act.

Background and Evidence

[23] The case manager, in a lengthy May 25, 2016 memorandum, again reviewed the worker's claim and asked a Board medical advisor for a further opinion related to legal counsel's January 2015 request for a new decision related to the acceptance of new injuries, payment of temporary total disability benefits, and payment of health care benefits, including physiotherapy.

[24] In part, the case manager noted the Board had received reports from the worker's attending physician, Dr. Lee, and an August 2014 MR arthrogram which indicated a suspected small new tear at the superior aspect of the posterior horn of the medial meniscus. The case manager also acknowledged a prior WCAT decision in 2015, which upheld the original plateau date and stabilization of the permanent conditions by March 30, 2014. She also noted the worker had been assessed for a permanent functional impairment pension in March 2015, some many months after the "new injuries" were noted. She did not think that accepting the "new injuries" would allow for further temporary wage loss benefits, or would change the outcome of the permanent functional impairment assessment.

[25] Board medical advisor Dr. Meetarbhan, in a May 29, 2016 response memorandum, specifically considered the incident report dated January 2014 when the worker alleged that he had "tweaked" his knee during exercises. After referring to the scanning results, Dr. Meetarbhan mentioned those findings needed to be correlated to be meaningful. The medical advisor could not confirm the worker did or did not have a tear. The evidence suggested this was not clinically significant anyway, using either a biological or biomechanical model. The medical advisor could not conclude the worker sustained a new meniscal tear as a result of the "mechanism of injury" at the occupational rehabilitation 2 program, in January 2014. It was more likely than not that if a tear was present, it was representative of the natural progression of the worker's pre-existing degenerative condition in the left knee. The medical advisor went on to indicate that further physiotherapy was unlikely to improve pain or function, since the worker already had the benefit of an active program and physiotherapy is considered a "passive modality."

[26] The case manager then issued the June 1, 2016 decision letter under appeal.

[27] In part, the case manager mentioned she could not conclude there was "clearly a new meniscal tear" and this would therefore not be accepted as another injury. The Board had already accepted a permanent aggravation of pre-existing degenerative changes in the anterior and posterior horn of the medial meniscus in the left knee. Whether or not there was a "new tear" was a moot point. The case manager went on to accept the left patella tear, but concluded that that tear had healed, according to scanning in late August 2014. Based on the June 2015 WCAT finding, the case manager could not consider payment of any temporary disability benefits beyond March 30, 2014. She also did not approve any further physiotherapy under the claim (the case manager referred specifically to Board policy items #C14-101.01 and #22.00).

[28] The review officer, in her November 23, 2016 finding, regarding the compensability of the third meniscal tear, in part, noted that Dr. Lee, in August 2016, recommended a further surgical procedure – an arthroscopic debridement. Dr. Lee indicated that irregularity could be coming from post-surgical changes from the previous arthroscopies. Because the review officer noted Dr. Lee did not mention a tear and did not address the distinction between a possible new injury and the natural progression of the worker's pre-existing degenerative condition, the review officer gave Dr. Lee's opinion little weight. She determined the worker had not sustained a third meniscal tear as a consequence of treatment for the compensable left knee injuries.

[29] The same review officer, after finding the Board had the jurisdiction to adjudicate the worker's further wage loss benefits, because the Board had accepted a new compensable condition – the patellar tendon tear – referred that matter back to the Board for adjudication. She also found that further physiotherapy treatment was not reasonably necessary to address the worker's compensable permanent left knee condition.

[30] That finding was subsequently implemented by the Board and varied by the review officer's subsequent September 14, 2017 decision.

Evidence at WCAT

[31] The worker's representative, in his brief July 20, 2017 submission, mentioned that because the subject matter of the appeal was outside the area of the worker's attending physician's expertise, WCAT should request a medical-legal report from orthopaedic specialist, Dr. Lee, who performed surgery on the worker's left knee.

[32] Legal counsel attached a copy of Dr. Lee's operative report, dated June 17, 2017, with respect to the June 12, 2017 left knee arthroscopy, with partial medial meniscectomy.

[33] In part, intraoperatively, Dr. Lee noted the medial meniscus had a "bit of tear particularly in the medial and posterior horn," which was debrided. (It appears the Board also received a copy of the operative report in late July 2017).

[34] In my September 21, 2017 memorandum, I asked the WCAT appeal coordinator to contact Dr. Lee, because I wanted Dr. Lee to provide a reasoned medical opinion regarding whether the worker sustained a third meniscal tear, which more than likely resulted from his activity in the occupational rehabilitation 2 program, on January 20, 2014. I also wanted Dr. Lee to comment on whether that, as a result of that additional injury, the worker was further disabled and

required additional physiotherapy. I enclosed relevant information for Dr. Lee's review. I also noted I was aware of the June 12, 2017 left knee surgery and Dr. Lee's intraoperative findings.

[35] Shortly thereafter, Dr. Lee, in a brief October 20, 2017 report, after considering the mechanism of stretching the hamstring, without any significant twisting or torqueing motion (at the occupational rehabilitation 2 program in January 2014), agreed that other than the temporal relationship of the worker's increasing pain after the incident, it would be difficult to draw a causal relationship between the stretching exercise and the third meniscal tear. The "third" tear was more likely the result of the natural progression of degeneration due to both the aging process and the two previous arthroscopies.

[36] As to whether as a result of that additional injury, the worker was further temporarily disabled and required additional physiotherapy, Dr. Lee, in part, mentioned that after a review of the two MRI scans – July 2016 and September 2017 – the radiologists' reports, as well as his intraoperative photos, his operative findings were consistent with the MRI – the meniscal tear found was partly attributed to the previous meniscectomy. The meniscal tear could also be attributable to degenerative changes, which by nature are generally the typical pattern of a horizontal intrasubstance tear, without fragment displacement. Dr. Lee noted that these tears can be attributed to the previous meniscectomy, as well as a global degenerative process. Furthermore, Dr. Lee noted that he debrided the scar tissues around the arthroscopy port hole – the various scar tissues he had thought was the source of the worker's pain. Dr. Lee's hope was after all non-operative options were exhausted – including a cortisone injection and extensive physiotherapy – the arthroscopy would be the last resort in trying to help the worker manage his knee pain. With respect to physiotherapy, Dr. Lee agreed that a reasonable amount of post-surgical physiotherapy (three to six months) would be beneficial in terms of regaining the range of motion and muscle strength. He agreed with Dr. Meetarbhan that any additional physiotherapy beyond that initial period would likely not yield much benefit.

Section 246(3) Referral

[37] Because I was satisfied that there was a matter that should have been determined by the Board but was not, I referred that matter to the Board for determination, suspending the current appeals until the Board made that determination.

[38] I pointed out that, in my respectful view, the case manager, in May 2016, restricted her inquiry to only considering whether there had been a "new" left knee injury and did not fully consider the opinion of the Board medical advisor Dr. Meetarbhan, that if any tear was present, it likely represented the natural progression of the worker's pre-existing degenerative condition, in the left knee.

[39] I pointed out the case manager was clearly aware, as referenced in the June 1, 2016 decision letter, that a permanent aggravation of pre-existing degenerative changes in the anterior and posterior horn of the medial meniscus was compensable under the claim, particularly given the repeat arthroscopy in September 2013.

[40] I pointed out that notwithstanding the worker's allegation that he sustained a "new" left knee tear on January 20, 2014, there was a sufficient basis on which the Board could have considered whether there were sufficient grounds to reopen the worker's claim – with respect to not only

further medical intervention, but also the additional compensation entitlements as requested by the worker's attending physician, by legal counsel, and the worker himself.

[41] I also pointed out that retrospectively, the Board has the benefit of Dr. Lee's June 12, 2017 operative report. I noted that intraoperatively, Dr. Lee referred to a "bit of tear" in the medial and posterior horn of the medial meniscus. I noted this information may now provide correlation between scanning findings, as referenced by Dr. Meetarbhan in the May 29, 2016 clinical opinion memorandum.

[42] On April 20, 2018, the Board case manager again asked Dr. Meetarbhan to review the claim. After obtaining additional medical reports, including Dr. Lee's post-operative consultation, the case manager asked whether there had been a significant change, or recurrence, of the compensable left knee condition, by at least August 2014.

[43] In his clinical opinion memorandum (June 11, 2018), Dr. Meetarbhan referred to Dr. Lee's August 29, 2016 consultation and the recommendation of a further arthroscopy, based on the interim MRI scan results (July 14, 2016). This apparently demonstrated some irregularities along the medial meniscus, which could be attributed to post-surgical changes from the previous arthroscopies.

[44] Dr. Meetarbhan pointed out that both the pre-operative and post-operative diagnoses indicated a left knee meniscal tear, as well as fibrous scar tissue. Dr. Lee noted the worker did have significant firm scar tissue on the anteromedial portal next to the patella, corresponding to the location of the worker's complaints. The fibrous scar tissues were debrided and Dr. Lee noted that the medial meniscus had a bit of tear, particularly in the medial and posterior horn, which was debrided to a stable edge. In the medical report commissioned by WCAT, Dr. Lee mentioned the tear could be attributable to degenerative changes, but also partly to the previous meniscectomies. Interestingly, the follow-up consultation report from Dr. Lee (October 31, 2017) indicates no real benefit from the surgery.

[45] In response to the question posed, Dr. Meetarbhan mentioned there had been a progression of the worker's previously compensable medial meniscal tear, partly on the basis of the compensable surgeries performed and partly on the basis of degenerative changes, which would be part and parcel of the natural progression of the degenerative condition. This would therefore constitute a significant change in the compensable condition, based on the new medical evidence available. The earliest possible evidence of this was on the July 14, 2016 MRI scan based on Dr. Meetarbhan's analysis "of the medical on file to date."

[46] The case manager then issued the June 12, 2018 determination letter.

[47] Legal counsel, in an August 14, 2018 subsequent submission (referencing both Review Division findings) submitted the worker disagrees that July 14, 2016 should be the effective date of any reopening.

[48] He reiterated that based on his "main submissions," the MR arthrogram of August 27, 2014 constitutes the earliest radiological evidence of the third meniscal tear, and not the July 14, 2016 MR arthrogram.

[49] At the very least, August 27, 2014 should be used as the reopening date, because the worker experienced symptoms well before this date and it cannot be assumed that the tear simply manifested on the date of the MR arthrogram. The worker likely suffered the third tear much earlier, as follows:

- On January 31, 2014, the worker "tweaked" the knee during physiotherapy at the occupational rehabilitation 2 program.

- Orthopaedic surgeon Dr. Kim, in mid-February 2014, referred to the worker's sharp anteromedial knee pain, with pain and a tender protuberance at the anteromedial aspect of the knee. Dr. Kim queried an articular loose body, or an extruded anterior horn of the medial meniscus, often associated with meniscal tears.

[50] In the alternative, legal counsel referenced the August 27, 2014 MR arthrogram which confirmed Dr. Kim's earlier observations about the meniscus and was "most suggestive" of the meniscal tear. The radiologist's opinion represents "strong" evidence, meeting the balance of probabilities standard.

[51] In the further alternative, legal counsel noted the permanent functional impairment evaluation, on March 10, 2015, referenced the worker's left knee complaints, over the medial, anterior, and posterior aspects of the left knee. He submitted this was further evidence of the tear "being extant" in early 2015.

[52] The medical evidence now supports that the third meniscal tear manifested in early 2014 and was confirmed radiologically on August 27, 2014. It would be appropriate to use a date between January 31 and August 27, 2014, for the date of reopening, rather than the Board's suggested date of July 14, 2016.

Findings and Reasons

[53] Section 96(2) of the Act provides that the Board may on its own initiative, or on application, reopen a matter that had previously been decided by the Board, if there had been a significant change in a worker's medical condition that the Board had previously decided was compensable, or there had been a recurrence of a worker's injury.

[54] Board policy item #C14-102.01 points out that a significant change means a change in the worker's physical condition and does not mean a change in the Board's knowledge about the worker's medical condition. A physical change would also be a physical change that would on its face warrant consideration of a change of compensation, or rehabilitation benefits or services. In relation to permanent disability benefits, a significant change would be a permanent change outside the range of fluctuation in a condition that would normally be associated with the nature and degree of a worker's permanent disability. A claim may be reopened for repeat temporary disability, regardless of whether a permanent disability award has been provided. A claim may also be reopened for any permanent changes in the nature or degree of a worker's permanent disability.

[55] Board policy item #C14-101.01 provides that the need to adjudicate new matters not previously decided and make decisions on those matters may occur at various points during the adjudication of a worker's claim. Situations in which the Board may make a new decision on a matter not previously decided includes acceptability of additional medical conditions identified during the adjudication of a claim, or the acceptability of further injury. The Board also has broad discretion under section 21 of the Act to make decisions regarding health care benefit entitlement at various points during the claim as the nature and severity of a worker's compensable injury changes and/or there is a determination that additional treatments or services will assist in the worker's recovery. Where there is a request to retroactively change a past decision, or the Board officer reconsiders a prior decision regarding health care, the restrictions on reconsideration apply.

[56] I find the overwhelming weight of the evidence indicates there was a significant change in the worker's accepted permanent aggravation of pre-existing degenerative changes in the left knee medial meniscus. The worker's claim should be reopened for appropriate compensation benefits, by March 5, 2015, when the worker was initially examined by Dr. Lee. I also find the left knee patellar tendon injury was temporarily disabling up to August 7, 2014. Therefore, I allow the worker's appeals, in part, varying the review officer's November 23, 2016 finding (*Review Reference #R0209188*), while confirming the review officer's September 14, 2017 finding (*Review Reference #R0221911*), and varying the June 12, 2018 determination letter. I leave it to the Board to determine the nature and extent of the worker's compensation entitlement after March 5, 2015.

[57] I have the definite benefit of a retrospective review of the worker's claim, which includes further medical evidence from Dr. Lee (October 20, 2017), as well as a further claim review by Dr. Meetarbhan, based on my section 246(3) interim decision and referral back to the Board (April 12, 2018).

[58] After considering all of legal counsel's submissions, I find there had been a significant change in the worker's left knee compensable condition (a permanent aggravation of pre-existing degenerative changes in the anterior and posterior horn of the medial meniscus) such that the provisions of section 96(2) of the Act and applicable Board policy apply. The worker's claim should therefore be reopened for appropriate compensation benefits – health care and wage loss.

[59] While the Board, in a June 12, 2018 determination letter, determined, based on Dr. Meetarbhan's opinion, there had been a significant change in the worker's compensable left knee condition, effective July 14, 2016, I do not agree with that effective date. Based on my review of the claim file information, and after considering legal counsel's submissions, I am satisfied that the worker's compensable left knee condition changed significantly, as described and confirmed by Dr. Lee in his initial consultation on March 5, 2015.

[60] While I acknowledge the worker reported changes in the left knee before this date (as pointed out by legal counsel), Dr. Lee was able to physically examine the worker, review scanning findings, and develop a treatment plan based on his interpretation of scanning findings that demonstrated signs of "meniscus repair" with some scar tissue formation. Dr. Lee also, while noting that previous physiotherapy had not helped, nevertheless suggested additional physiotherapy, as well as cortisone injections. Cautiously, Dr. Lee mentioned that debridement

surgery, with removal of scar tissue, might cause the formation of "even more complex or tethered scar tissue."

[61] In my view, Dr. Lee's consultation and treatment recommendations accord with the provisions of Board policy item #C14-102.01. Dr. Lee's medical evidence speaks to the change in the worker's physical condition, warranting consideration of the change in compensation entitlements, regardless of whether a permanent partial disability award had been provided.

[62] Dr. Lee's later consultation reports speak to the worker's continued discomfort, leading up to the July 2016 MRI scan and the left knee surgical procedure on June 17, 2017.

[63] Regarding the worker's potential entitlement to additional temporary disability benefits, resulting from the partial patella tendon tear, I agree with the review officer's September 14, 2017 finding and analysis of the evidence. The worker's patella tendon injury was therefore temporarily disabling up to August 7, 2014.

[64] Like the review officer, I note it appears the worker received vocational rehabilitation benefits beyond August 7, 2014 and the Board will need to consider that in the provision of further benefit entitlement, regarding health care and wage loss.

[65] I am mindful that legal counsel did not make a specific submission to WCAT regarding the review officer's September 14, 2017 finding. In a brief January 4, 2018 letter to WCAT, he relied on submissions already provided – which essentially focused on the left knee meniscal tear issue.

Conclusion

[66] For the above-noted reasons, I allow the worker's appeals, in part. I vary the review officer's November 23, 2016 finding (*Review Reference #R0209188*) and the Board's June 12, 2018 determination letter, finding there had been a significant change in the worker's compensable left knee medical condition – a permanent aggravation of pre-existing degenerative changes in the anterior and posterior horn of the medial meniscus – such that the worker's claim should be reopened for appropriate compensation benefits, as of March 5, 2015. However, I confirm the review officer's September 14, 2017 finding (*Review Reference #R0221911*), finding the left patella tendon injury was temporarily disabling up to August 7, 2014.

[67] I leave it to the Board to determine the nature and the extent of the worker's compensation entitlement – wage loss and/or health care (physiotherapy) – after March 5, 2015, leading up to the worker's left knee surgery on June 17, 2017 and thereafter.

[68] There was no specific request for any appeal expenses and, as none are apparent, I make no additional finding in that regard.

Dana Brinley
Vice Chair