WORKERS COMPENSATION APPEAL TRIBUNAL

BETWEEN:

WORKER
CASE ID #[personal information]

APPELLANT

AND:

WORKERS COMPENSATION BOARD OF
PRINCE EDWARD ISLAND

RESPONDENT

DECISION #112

Appellant	Worker, as represented by Maureen Peters, Worker Advisor
Respondent	Brian Waddell, Solicitor representing the Workers Compensation Board
Place and Date of Hearing	May 13, 2009 Loyalist Lakeview Resort 195 Harbour Dive Summerside, Prince Edward Island
Date of Decision	September 30, 2009

1. This is an Appeal by the Worker of IRO Decision IR-08-34, dated July 22, 2008.

FACTS, EVIDENCE AND BACKGROUND

2. On [personal information], the Worker, who was employed as a [personal information] fell down some stairs while [personal information] and suffered a twisting injury of his left knee.

3. Dr. William Scantlebury, the Worker's family physician, examined the Worker on November 29, 2005, and diagnosed the Worker's injury as a meniscal tear of the left knee and referred the Worker to Dr. Stephen Miller, an orthopaedic surgeon.

4. Dr. Miller's consult report to Dr. Scantlebury, dated December 16, 2005, reads in part:

> *Clinical examination of this reveals obvious patellar tendon contusion, and medial collateral ligament injury. His collateral is not unstable and the medial meniscus is only minimally tender and I would suggest that it looks like a purely extraarticular pattern of injury that should resolve. I have advised him that the patellar tendon is likely to remain symptomatic.*

5. On December 28, 2005, the Board accepted the Worker's workplace injury claim for medical aid benefits effective [personal information].

6. In a consult report of Dr. Miller to Dr. Scantlebury, dated May 31, 2006, Dr. Miller states in part:

> *MRI of the knee done in the past does show meniscal injury. The gentleman has some mild arthritis in there; clinically he is not doing well. Clinical examination reveals medial joint line tenderness. The gentleman is aware of the options in terms of arthroscopy and he wishes to have that done.*

7. On June 26, 2006, the Worker underwent a scope, debridement and partial medial meniscectomy of the left knee.

8. On August 8, 2006, Dr. Miller examined the Worker and in a consult report to Dr. Scantlebury, states in part:

> *The gentleman's clinical situation is excellent. He is back to work with full function and there are no issues. Follow-up is on a PRN basis.*

9. On January 24, 2007, Angie Fullerton, the Board's Entitlement Officer, received a call from Sports Center Physiotherapy requesting authorization for physio treatment for the Worker's left knee.

10. In an Inter Office Memorandum dated January 24, 2007, Ms. Fullerton states in part:

> *I called (naming the Worker) to discuss the circumstances around his need for physio. He explained that it never healed completely, not like his right knee. I advised him I have a consult from Dr. Miller on August 8, 2006, which states his clinical situation is excellent and he had full function and no issues. He said at that time it was fine. He said he feels just being on it and working is causing it pain. He said he has been* [personal information] *and he dropped something on his foot (right foot) while working* [personal information] *(filed with WCB* [personal information] *and he feels because he had been limping his knee (left) got sore.*

11. By letter of Ms. Fullerton to the Worker, dated January 26, 2007, the Board denied the Worker's request for further physiotherapy on the basis that the Worker's need for further treatment was not related to his injury of [personal information].

12. On October 4, 2007, Dr. Miller examined the Worker and in a consult report to Dr. Scantlebury he states in part:

The patient's clinical examination reveals obvious pain and localized medially. Examination also reveals mild crepitation, pain localized to the medial joint line and retro-patella crepitation as well with some discomfort there.

Clinically we know from his previous scope that he has medial and patella arthritis, which is posttraumatic, and degenerative meniscal tear. His symptoms seem to be gradually progressing but not as dramatic as before and certainly not a surgical solution. The gentleman is a candidate for anti-inflammatories perhaps and steroids if this proves fruitless.

We will probably make arrangements for an MRI of the knee to try and evaluate the full extent intra-articularly and see the relative contributions of arthritis versus meniscus and to confirm that all meniscal fragmentation was removed at the time of surgery.

13. On October 24, 2007, the Worker filed a recurrence injury claim with the Board describing his recurrence as follows:

Pain never gone away, continues to this day.

14. No specific incident at work precipitated the Worker's left knee pain.

15. On December 17, 2007 Dr. Miller examined the Worker and in a consult report to Dr. Scantlebury, he states in part:

He is seen with regard to his knee and review of his MRI. The MRI shows ACL abnormality but not a discrete or obvious tear.

My recommendation for this gentleman is in fact for a scope and debridement. I feel that this gentleman's situation is clearly related to the injury (my emphasis) and in my estimation his knee is more symptomatic than justified by the abnormality that we see.

16. Dr. Scantlebury by report to the Board dated January 16, 2008, provided a medical history of the Worker which reads in part:

On September 21, 2004, (naming the Worker) presented to myself for a complete physical exam. He told me he had knee issues from the past and had been seeing Dr. Steven Miller regarding this. He

had findings consistent with osteoarthritis of the knee. On October 15, 2004, he presented with a painful knee, which he states was a flare-up of his old injury. He had tenderness and swelling of the knee and was given anti-inflammatories. On October 28, 2004, he was not fully improved so he received a supply of a different anti-inflammatory. On February 10, 2005, he returned stating he was having some flare-ups over the past months. He stated he had a surgery done on his knee by Dr. Miller in the past so he was referred back to him at this point. On October 5, 2005, he had seen Dr. Miller (consult will be submitted with this letter). On November 29, 2005, (naming the Worker) was seen regarding a reaggravation of his knee due to an incident at work a few days prior. He had tenderness and swelling of the patellar tendon and medial knee, with reports of knee locking. He was given refills of his anti-inflammatory and was to return to see physiotherapy again, and he was going to see Dr. Miller again on December 16, 2005. He was prescribed a knee brace at this visit.

On March 15, 2006, he returned stating the knee was "getting worse again". He had been improving with physiotherapy but had no treatments the previous two months. He was referred back to physiotherapy. On March 29, 2006, he returned stating he was not improving. He was going to continue physiotherapy and medication as needed and follow up with Dr. Miller. He was seen May 31, 2006, and Dr. Miller arranged for another arthroscopy.

On January 22, 2007, (naming the Worker) returned regarding his knee. He stated he would still occasionally get flares of knee pain and swelling since his surgery. Although better overall, he stated he was never "100 percent". He found the strength was diminished and it would tire easily with use. He was still tender medially with crepitus. He was going to resume physiotherapy and try pennsaid. On February 15, 2007, I gave him a new prescription for his knee brace. On March 12, 2007, he was referred back to Dr. Miller due to persistent symptoms which were getting less relief with usual measures. He continued to have pain medially. On October 4, 2007, he visited Dr. Miller again who booked a MRI. After this was done, he returned to Dr. Miller on December 17, 2007, and he arranged for another arthroscope. He stated he felt (naming the Worker) "situation is clearly related to the injury.

17. By letter (decision), dated February 26, 2008, Ms. Fullerton advised the Worker that his recurrence injury claim had been denied, stating in part:

> *I asked the Board Medical Advisor (Dr. Steven O'Brien) to review your file. His medical opinion, dated February 11, 2008, states,*
>
> > *There was also an MRI of the left knee done on May 13, 2004, with a question of ligament tear. This report states, "There is mild lateral subluxation of the patella with early degenerative type signal in the lateral facet...No significant ligamentous or meniscal tear." However, the fact that the MRI was done in May 2004, a year and a half prior to this date of injury, would indicate that there had to be ongoing knee problems, or an MRI would not have been done.*
> >
> > *A repeat MRI done in July 2005, again, prior to his date of injury of* [personal information]*, and at this time the MRI shows, "There is minor blunting and slight irregularity of the body of medial meniscus along the free edge. The possibility of a small bucket handle tear or radial tear in this location cannot be excluded. This is again indicative of left knee problems prior to his date of injury,* [personal information]*, which initiated this claim.*
> >
> > *Therefore, this is further evidence that (naming the Worker) did have pre-injury problems that were clearly established prior to his injury of* [personal information]*, and that his current problems are more probably related to his* [personal information]*, left knee problems then to his work place injury, which was treated successfully by Dr. Stephen Miller, Orthopedic Surgeon, and on August 8, 2006, had obviously reached a medical plateau when Dr. Miller states, 'The gentleman's clinical situation is excellent.'*

Ms. Fullerton states later in the letter:

> *In summary, the key components which have weighed my decision include, but are not limited to:*
> - *Dr. Miller's consult of August 6, 2006, which clearly states your injury of* [personal information]*, had healed.*
> - *Evidence of left knee pathology prior to the initiation of this claim, i.e. meniscal tear and osteoarthritis.*
> - *No claim for left knee prior to the incident of* [personal information]

- *Dr. O'Brien's medical opinion.*

Information on file states that your original compensable injury had healed. In view of this, I cannot relate the symptoms you are experiencing to the original compensable injury which initiated this claim.

In conclusion, I do acknowledge your need to seek medical attention for your left knee symptoms, however based on the review of your file; I do not find a causal relationship between your current symptoms and the injury originally accepted under this claim. Therefore, your claim for compensation for your left knee symptoms is denied.

18. On May 22, 2008, the Worker filed a Notice of Request for Internal Reconsideration of the Board's Decision of February 26, 2008.

19. By IRO Decision IR-08-34, dated July 22, 2008, Shauneen J. Hood, the Internal Reconsideration Officer, denied the Worker's reconsideration request stating in part:

In reviewing the medical documentation on file, I note the worker has a pre-existing condition in his left knee. This is documented as follows:

- *X-ray left knee - QEH - July 8, 2002 - medial joint space narrowing... suggestive of early OA*
- *MRI left knee - QEH - May 13, 2004 - mild lateral subluxation of the patella with early degenerative type signal in the lateral facet ... no significant ligamentous or meniscal tear*
- *MRI left knee - QEH - July 14, 2005 - ... could represent a small bucket handle tear or radial tear.*
- *Medical report - Dr. Miller, October 5, 2005 - ... The MRI does reveal changes in the meniscus consistent with a tear... My feeling is that this gentleman can probably hold off in terms of surgical intervention.*

The Worker sustained an injury on [personal information]*, when he fell down some stairs as he was* [personal information]*. This was approximately seven weeks after seeing Dr. Miller for his left*

knee and approximately four months after having an MRI of the left knee.

The Workers Compensation Board Policy -04-09 - Pre-Existing Conditions states, "Pre-existing condition" means any condition inherent in the worker at the time of the accident." In this case, the worker had been receiving medical attention for his left knee for a three year period prior to his work place injury in [personal information].

Further, Policy 04-09 states, "Where the worker is injured as a result of a work-related accident, and the injury is aggravated by a pre-existing physical condition inherent in the worker at the time of the accident, the worker shall be compensated for the full injurious result until such time as the worker, in the opinion of the Workers Compensation Board, has reached a plateau in medical recovery. Plateau in medical recovery means there is little potential for improvement or any potential changes in the condition are in keeping with the normal fluctuations which can be expected with that kind of injury.

In a physiotherapy report dated July 7, 2006, the physiotherapist states, "...he was walking two miles, three times per week and doing strength training. Range of motion: full flexion/extension.

Dr. Miller's report dated August 8, 2006, states the worker's "clinical situation is excellent. He is back to work with full function and there are no issues."

From the information in these two reports, it would appear the worker had reached a medical plateau in his medical recovery.

Five months later, in January 2007, the entitlement officer gets a call from the physiotherapist stating the worker had dropped something on his foot out west and because of his limping, his left knee was sore again. They were requesting approval for treatment.

The worker noted in his letter which outlined his history of left knee injuries and was attached to his Notice of Request for Internal Reconsideration that his current need to seek medical attention is related to the events of [personal information]*; however, Dr. Miller's report of August 2006 states his "clinical*

> *situation is excellent. He is back to work with full function and there are no issues."*
>
> *There is also information on the worker's file stating he had dropped something on his foot when he was out west working which brought upon his left knee problems. This would be considered a new incident and not related to the* [personal information] *work place injury on PEI.*
>
> *In weighing the evidence on file, I find the evidence supports the worker having recovered from the injury which initiated this claim and that he had reached a medical plateau in his recovery which was supported by evidence from Dr. Miller and Sports Centre Physiotherapy.*
>
> *The fact of the matter remains, the worker went back to work with full function and it was not until he injured himself while working out west that he started having problems again with his left knee. This would be considered a new and intervening event unrelated to his* [personal information] *work place injury.*
>
> *Therefore, the worker's request for internal reconsideration has been denied.*

20. By Notice of Appeal to WCAT, dated August 18, 2008, the Worker appealed the Internal Reconsideration Decision of Ms. Hood dated July 22, 2008, stating grounds of appeal:

> *The IRO ignored my May 20, 2008, internal reconsideration arguments and the evidence in my file record which support my need for pending left knee surgery on August 27, 2008, is, in a significant and material way, due to and has resulted from my work injury* [personal information].
>
> *The IRO completely ignored my request for a Permanent Impairment Assessment and award. The facts support that the WCB did approve my work injury* [personal information] *initially and did accept my case with a working diagnosis of "meniscal tear left knee". This permanent knee damage did require a surgery on June 26, 2006.*

The IRO was wrong to not determine I was entitled to a Permanent Medical Impairment (PMI) assessment for the purposes of an award.

The WCB must approve my case for additional compensation benefits for my permanent left knee injury to be retroactive from date of initial denial and ongoing as required. These shall include medical aid, wage loss and rehabilitation benefits and a PMI Award.

ISSUE

21. The issue is whether the Worker's left knee pain at the time of his Recurrence Injury Claim on October 24, 2007 was causally related to the Worker's [personal information] compensable work-place injury.

DECISION

22. Both the Board and WCAT are bound by the *Workers Compensation Act* (the Act) and by Board Policy, pursuant to Section 56.(17) of the Act.

23. Board Policy: POL-04-08 deals with the subject of RECURRENCE.

24. Recurrence is defined as follows:

> *6. "Recurrence" means a return of disabling conditions, supported by objective medical evidence that can be reasonably related to an injury caused by a previous work-related accident. Recurrence of the condition must be medically compatible with the previous injury, and decisions to accept or deny recurrences must rely on medical evidence supporting this relationship.*

25. Objective medical evidence is defined as follows:

> *4. "Objective medical evidence" means evidence presented through a physical examination including diagnostic tests*

of a worker and reported by the treating or family physician.

26. The Policy also reads in part:

> *1. A recurrence must be medically compatible with the previous work injury, and decisions to accept or deny recurrences must rely on medical evidence supporting this relationship.*
>
> *2. Recurrence claims are acceptable when:*
> *the conditions causing the current physical or functional abnormality (i.e., impairment) are medically compatible with the previous work injury; and*
> *no other variables have intervened as a significant cause of the current impairing conditions.*
>
> *3. Medical Compatibility*
>
> *To assess medical compatibility, the worker's medical history is compared with the current condition to determine the probability that the current symptoms are a direct result of the injury which initiated the original claim.*
>
> *Matters such as pre-existing conditions, the passage of time, the effects of natural physical deterioration processes or aggravating lifestyle factors, and the anatomical area which was originally accepted as part of the claim will be considered when assessing these cases.*
>
> *4. Continuity of Symptoms*
>
> *Continuity of symptoms, supported by medical reports, during the period between recovery from the original injury and the onset of the current condition is a reliable indicator of a direct causal relationship.*
>
> *Specific indicators that may assist in determining continuity of symptoms include:*
>
> *i. evidence of continuing medical care since the original injury;*
> *ii. work restrictions or job modifications following the original injury; or*

iii. continuing Extended Wage Loss Benefits entitlement for the original injury.

27. After considering the evidence, the Panel finds, on the balance of probabilities, that the Worker's left knee pain symptoms reported to the Board on October 24, 2007, were causally related to the Worker's [personal information], work-place injury.

28. Although the Worker continued to work following his injury of [personal information], the Worker states in his Worker's Report "that the pain never gone away, continues to this day."

29. The Panel accepts the Worker's statement of his continuing symptoms as credible.

30. Dr. Miller in his consult report to Dr. Scantlebury, dated December 17, 2007, gave his professional opinion that the Worker's situation is clearly related to the injury.

31. Dr. Miller is an orthopedic surgeon who treated the Worker for several years with respect to the Worker's left knee problems.

32. Although Dr. Miller did not specifically state that the Worker's situation is clearly related to the injury [personal information], it is reasonable to conclude that this was the injury Dr. Miller was referring to.

33. The Board would undoubtedly have sought further clarification from Dr. Miller, if the Board thought otherwise.

34. The Tribunal finds that the Worker suffered a recurrence injury, i.e. a return of disabling conditions, supported by objective medical evidence reasonably related to the Worker's injury [personal information].

35. Accordingly, the Tribunal reverses IRO Decision IR-08-34, dated July 22, 2008.

36. The Board should provide compensation benefits to the Worker for his recurrence injury in accordance with the Act and Board Policy.

Dated this 30th day of September, 2009.

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John L. Ramsay, Q.C., Vice-Chair
Workers Compensation Appeal Tribunal

Concurred:

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Jean Tingley, Employer Representative

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Ralph MacLean, Worker Representative