WORKERS COMPENSATION APPEAL TRIBUNAL

BETWEEN:

WORKER
CASE ID #[personal information]

APPELLANT

AND:

WORKERS COMPENSATION BOARD OF
PRINCE EDWARD ISLAND

RESPONDENT

DECISION #116

Appellant	Worker, as represented by Maureen Peters, Worker Advisor
Respondent	Brian Waddell, Solicitor representing the Workers Compensation Board
Place and Date of Hearing	June 17, 2009 Loyalist Lakeview Resort 195 Harbour Drive Summerside, Prince Edward Island
Date of Decision	October 28, 2009

1. This is an Appeal by the Worker of IRO Decision IR-06-02, dated January 24, 2006.

FACTS, EVIDENCE AND BACKGROUND

2. On December 22, 1981, the Worker, [personal information], sustained a [personal information] in a motor vehicle accident in the course of his employment.

3. The diagnosis provided by Dr. J. L. Saunders, the treating physician, was a contusion of the Worker's thoracic spine.

4. On May 12, 1982, the Worker was examined by Dr. Edwin D. Crawshaw, an orthopaedic surgeon.

5. Dr. Crawshaw's medical report reads in part:

> *He stated that he was mainly aware of anterior chest pain since he was struck here and had contusions over the front of his chest but in the next day or so he gradually became more aware of back pain which became more acute. This has continued and he sought medical help for this from this time.*
>
> *It was associated with a sensation of heaviness and stiffness affecting the left leg, not exactly amounting to severe pain but more in the way of a discomfort which affected the lateral side of his knee area and never involved the foot, or ankle,* [personal information] *and he found that after a half an hour* [personal information] *this sensation occurred and was relieved by* [personal information] *and walking around. No radicular pain occurred with coughing and sneezing and no increased back pain could be felt with sneezing. He has been able to walk around quite satisfactorily but attempts at heavy lifting do cause him to have pain in his back. On careful questioning he disclaims having any pains in his back previously, and said he never previously had x-rays, never had any injuries to his back and in fact was active in all sorts of sports until six years ago and has retained a partial*

interest in this respect, since. He disclaimed any other medical problems, of any nature whatsoever. ...

On examination spinal motion is quite full and free in flexion and indeed in extension, but some discomfort at the limits of these motions was apparent and also on lateral bending, but not much. He had some tenderness in the lumbosacral spine area, and this was particularly on pressure applied to the spines of L4 and L5. There was no abnormal skin folds on his back and leg lengths were equal. Straight leg raising was normal with negative Laseque's signs and negative Bowstring signs. Pressing of both SI joints produced no particular discomfort. ...

Review of his x-rays showed a rather startling situation, there was a pan intra-articularis defect at L4 with apparent forward slipping of L4 and L5, and this forward spondylolisthesis was about 25% degree with an apparent retra-spondylolisthesis at L5 on sacrum. This gave a rather peculiar shape to the spinal canal on the lateral films. L5 vertebra was rather a peculiar shape too, it was rounded and it is apparent that the overall alignment between L4 and sacrum is satisfactory, if it is considered that this vertebra is somehow prolapsed posteriorly; indeed, a very odd looking picture and there is nothing here to indicate that this is due to the recent trauma. I believe if it had been in any way the result of the recent trauma the man would likely have been acutely diplegic. Another incidental finding is a spina bifida of the 12th thoracic vertebra involving the posterior elements, and this congenital abnormality would seem to indicate that the changes below are also of congenital origin.

I would feel, therefore, that <u>the recent accident is causing symptoms undoubtedly, but that it has exacerbated a previously existing spinal deformity</u> (my emphasis), and at the moment I would see no indication for surgical intervention. His symptoms do not appear to warrant it. However, it may well be that an extensive spinal fusion from L4 to sacrum would be warranted purely from the point of view of the spinal anomaly, to prevent problems in the future. However, since the patient has existed with this problem all his life so far, again I do not really feel that this is the case, and would wonder if perhaps conservative measures might not be appropriate first, in any event perhaps using a lumbosacral support. ...

> *I think the situation is this, the man's back will probably change, and I would think without the trauma he would inevitably at some point in time develop some arthritic changes, possibly requiring stabilization by spinal fusion (my emphasis).*

6. On October 13, 1982, the Worker was examined by Dr. D. C. MacMichael, an orthopaedic surgeon.

7. Dr. MacMichael's medical report reads in part:

> *His back troubles did not start for three or four days. At the present time, his complaints are of stiffness in his low back if he is in one position for very long, particularly sitting. ... He has had no previous injury to his back and his past health has been otherwise good. ...*
>
> *Physical examination reveals a healthy young man with perhaps a very minimal slight flexion deformity of his back when walking. On examination of his low back there is a palpable step in the lower lumbar areas. Full flexion and extension are present with some discomfort in the low back area at the extremes of motion. Lateral flexion and rotation are all normal. ...*
>
> *In review of the x-rays, he has a spondylolisthesis of about 30% or so at L4-5 with what looks like a defect in the pars, but also what appears to be a stretching out of the inferior facette. This is probably a congenital thing. In the flexion-extension views taken by Dr. Ling in April, there was no evidence of any abnormal motion at this level.*
>
> *I think this gentleman's problem is mainly that of a muscular pain. The fact that it did not come on for four days after the injury suggests that there was no significant disc or bony or facette joint pathology (my emphasis). I see no reason why he could not get back to his normal activity of lifting as much as he wants to, and I would put no restrictions on his activity.*

8. The Worker received WCB benefits for his back injury but were terminated as of October 29, 1982, based on the medical reports of Dr. Crawshaw and Dr. MacMichael.

9. On June 25, 2001, the Board received a letter signed by the Worker which reads in part:

> *... he was in a* [personal information] *accident about 22 years ago... He was on comp. for 5 mos. Now the Dr. wants us to see if Workers Comp. can reopen his file, he has been having a lot of problems over the years but now he's to a point where I don't think he can work anymore. He's in a lot of pain all the time. Dr. Phelan is sending you some information about his condition. ... Some problems were spurs on spine, vertebra out of place, arthritis, has to have physio therapy.*

10. On July 30, 2001, the Worker was examined by Dr. Daniel LeBlond, Director, Department of Physical Medicine and Rehabilitation, QEH.

11. Dr. LeBlond's consult report to Dr. Paul Phelan (the Worker's family physician) reads in part:

> *This patient presents having had chronic back pain for over 20 years. As you well know he was involved in a work related accident back 20 years ago* [personal information]. *This apparently led to an acute onset of back pain which to this day the Worker claims he has had on a daily basis. The Worker has now been off for a period of 7 weeks as a result of his low back pain, however, in the last 2 years his symptoms of back pain have progressed from purely low back pain to pain radiating from the low back up towards the infrascapular region bilaterally. The paraspinal muscles along the thoracolumbar spine also apparently go into spasm from as little as 15 minutes of work and from prolonged sitting. The Worker has also had difficulty in sleep, he is now limited to no more than 2 to 3 hours of sleep as a result of achiness in his back. Prolonged*

standing at times will also make the patient's back somewhat worse. Walking can also aggravate pain if prolonged. ...X-rays of the lumbar spine show severe L4-L5 and L5-S1 disc degeneration with almost complete loss of the L5-S1 space combined with osteosclerosis of the facet joints. A large syndesmophyte between L5 and S1 is present indicative of previous instability. ...

On physical examination this patient appears in moderate distress at rest. The Worker has no asymmetry in leg length. He has a slight shift of his trunk to the left with a resulting right sided convex scoliosis at the lumbosacral spine. There is also evidence from moderate obesity and overall poor muscle tone. The Worker has good forward flexion with mild discomfort in his low back to full flexion across the lumbosacral spine. Recovery from flexion does not appear painful. Extension from neutral causes an increase in low back pain across the lumbosacral spine. Side flexion to the right cause ipsilateral discomfort. Side flexion to the left is also painful and causes left sided discomfort but less so than on the right. A combination of rotation to the right with extension and side flexion and also painful on the right.

To palpation there are multiple myofascial tender points through the lumbar and thoracic paraspinals including the iliocostalis toraces and lumborum. The quadratus lumborum is also painful bilaterally and there is tenderness to palpation over the interspinous ligaments from L3 down to S1 and over the lateral aspects of the spinous processes also from L3 down to S1, most severe at L5-S1. The facet region is also tender to touch bilaterally at that lower segment.

Assessment: This patient has severe and advanced lower lumbar spondylosis with osteoarthritis of the L5-S1 and L4-L5 facets combined with degenerative disc disease most severe at L5-S1. Over time this has led to instability and the formation of syndesmophytes. Unfortunately the lack of sleep and the increase in pain has led to secondary myofascial pain affecting the thoracolumbar muscles (my emphasis). At this time there is very little that I can offer this patient other than injections of corticosteroids to the lumbosacral facets at L5-S1 and possibly to the soft tissues attaching to the spinous processes at L5 and L4. ... I would recommend to you that he be referred to the spinal surgeon for consideration of fusion. I have explained to him that he should seek an employment which does not require repetitive

lifting as well as bending and that his chances of returning to gainful employment which requires the same is very unlikely.

12. Dr. D. Barry Carruthers, the Board's Medical Director, in a Medical Comment to File dated August 15, 2001, states in part:

I have reviewed the past medical history under this claim. ... This involved a [personal information] *accident in December 1981. When the worker is seen within a week of the accident, the anatomical area appears to be the thoracic spine and a diagnosis of a contusion is made. When the worker was seen on December 24, 1981, no objective findings are recorded. There is comment that he injured his shoulder and that his legs felt very weak. X-rays taken at the time involved the thoracic spine. Those x-rays showed no evidence of bony involvment.*

In February 1982, there is comment on low back and left leg pain. When seen on February 12, 1982, the worker was estimated as having ongoing disability for a further four days. When seen in March 1982, the focus is on the low back. The attending physician comments no permanent disability was anticipated. The worker was complaining of low back pain and muscle spasm at that point. X-rays taken in March 1982 show some pre-existing degenerative changes with lumbar disc space narrowing at the L5-S1 level. These noted radiological changes are long standing and cannot be reasonably considered as being caused by the motor vehicle accident which initiated this claim. It also appears now that the low back area is the focus of this worker's discomfort, as opposed to the upper back area, the anatomical area for which he first sought medical attention following the motor vehicle accident.

By April 1982, the pain keeps getting lower, going down to the pelvis and sacral areas. Further investigation with x-rays confirmed the spondylolysis of the spine. ...

I reviewed in detail the May 12, 1982 consultation by an Orthopaedic Surgeon, Dr. Crawshaw, who noted a full and free range of motion of the spine, no evidence of any neurological involvement and comment on x-rays of findings that were "rather

> *startling...". The surgeon goes on further to state that there was "nothing here to indicate this is due to the recent trauma. I believe if it had been in any way the result of the recent trauma, the man would have likely been acutely diplegic. Another incidental finding is a spina bifida of the 12th thoracic vertebra involving the posterior elements. This congenital abnormality would seem to indicate the changes below are also of congenital origin." Dr. Crenshaw's opinion was that even without the recent trauma, the worker was inevitably going to develop some post-arthritic changes requiring possible surgery.*
>
> *There is a further comment by Dr. MacMichael, Orthopedic Surgeon, dated April 13, 1982, in which there was comment that the* [personal information] *accident involved soft tissue, but did not feel the* [personal information] *accident involved disc, bony or facet joint pathology.*
>
> *Based on this, it is my opinion that this worker had reasonably recovered from the injuries sustained under the motor vehicle accident, certainly by October 1982. I base this opinion on comments by the orthopedic surgeon that there were no restrictions on his activity and the only physical findings at that time were compatible with an underlying congenital condition.*
>
> *I have reviewed the July 30, 2001, consultation by Dr. LeBlond. This consultation clearly supports the worker's primary difficulty as being secondary to the natural progression of "severe advanced lower lumbar spondylolysis with osteoarthritis of the L5-S1 and L4-L5 facet combined with degenerative disc disease, most severe at L5-S1 ..."*
>
> *Given this primary diagnosis, it would be my opinion that the worker's present disability relates to the natural progression of an underlying congenital condition.*

13. In a decision dated September 27, 2007, the Board's Entitlement Manager denied the Worker's request for WCB benefits, stating:

> *The evidence presently available confirms you recovered from the soft tissue injuries sustained in the* [personal information] *accident in 1981. Your present low back problems are related to your pre-exisiting congenital condition combined with severe advanced lower lumbar spondylolysis with osteoarthritis of the L5-S1, L4-L5 facet joint area and combined with degenerative disc disease.*

14. The Worker requested a reconsideration hearing of the Board's decision and later submitted additional information to support his request.

15. This resulted in the IRO's withdrawal of the reconsideration hearing on the basis that new evidence and all outstanding matters relating to the issues in dispute must be reviewed by the original decision-maker and a new decision letter issued prior to any request for a reconsideration hearing.

16. The Worker was seen by Dr. Barry E. Ling, an Orthopedic Surgeon, on November 7, 2001, and in an consult report to Dr. Phelan he states:

> *I assessed the Worker today with respect to ongoing back problems. He states that in 1980 or 1981 he was involved in a* [personal information] *accident while working and at that time was covered by WCB. He has had ongoing low back problems since that time - currently he has been off work since May or June of this year because of back pain and because of upper interscapular discomfort. His symptomatology consists of mechanical back pain in his lumbosacral area with no radicular component.*
>
> *His physical examination revealed decreased flexion of his L5 spine. Straight leg raising is full bilaterally and there is no specific neurological deficit distally. ...*
>
> *His x-rays show a spondylolisthesis of L4 on L5 with possibly a retro spondylolisthesis of L5 on S1. Indeed this may have initially been a posterior displacement of the vertebral body of L5.*
>
> *He also complains of interscapular discomfort which seems to be more muscular in origin than anything else. His physical examination with respect to this area is negative apart from superficial tendonitis. ...*
>
> *I would rather suspect his symptoms are a continuum and ongoing result of his low back injury in 1980 or 1981 (my emphasis).*

17. In light of Dr. Ling's consult report, Dr. Carruthers reviewed the Worker's file and in a Medical Comment to File dated February 14, 2002, he states:

> *I have reviewed the information on this claim and I have also reviewed the paper copy of the worker's assessment at the time of the injury. The issue is a diagnosis of spondylolisthesis at the L4-5 level. Dr. Ling commented that there may have initially been a posterior displacement of a vertebral body of L5 at the time of the initial injury.*
>
> *Spondylolisthesis is the forward slippage of one vertebral body on another. The five classes of spondylolisthesis are congenital, isthmic, traumatic, pathologic, and degenerative.*
>
> *Congenital spondylolisthesis is congenital deficiency of the superior sacral or inferior fifth lumbar facet or both, with gradual slippage of the fifth lumbar vertebra on the first sacral vertebra.*
>
> *Isthmic spondylolisthesis is a defect in the pars interarticularis, which permits forward slipping of the fifth lumbar verterbra.*
>
> *Traumatic spondylolisthesis is an acute fracture in the area of the pedicle, lamina, or facets that allows anterior slippage.*
>
> *Pathologic spondylolisthesis is secondary to structural weakness of the bone, such as osteogenesis imperfecta.*
>
> *The most common cause of spondylolisthesis is degenerative spondylolisthesis, which affects 4-10% of the population. Women are affected approximately five times more frequently than men. The grading system indicates the percentage of displacement of the superior vertebral body on the inferior vertebral body.*
> *Grade I: 0-25%*
> *Grade II: 25-50%*
> *Grade III: 50-75%*
> *Grade IV: > 75%*
>
> *The L4-5 level is affected most commonly, followed by L3-L4 level. The etiology of the slippage in degenerative spondylolithesis is the result of longstanding segmental instability. The pars interarticularis remains intact. With aging the posterior ligamentous structures deteriorate, along with the facet joints.*

The intervertebral disc then begins to degenerate, followed by progressive forward slippage of one vertebra on another. The most common presenting complaint in patients with degenerative spondylolisthesis is back pain.

This claim was initiated as a result of a [personal information] *in December of 1982 (should read 1981) and initially attention was directed more toward the shoulder than any other anatomical areas. Under this claim, complaints of back pain were also investigated.*

X-rays were taken of this worker's back in March of 1982 which showed disc disease at L-5, S-1 level with spondylolithesis at that level as well. The worker was seen by an Orthopedic Surgeon, Dr. Crawshaw in May of 1982. The examination noted a full range of motion of his back with no evidence of any neurological involvement.

Dr. Crawshaw further commented "Review of his x-rays showed a rather startling situation, there was a par intra-articularis defect at L-4 with apparent forward slipping of L-4 and L-5, and this forward spondylolithesis was about 25% degree with an apparent retra-spondylolisthesis at L-5 on sacrum. This gave a rather peculiar shape to the spinal canal on the lateral films.

L-5 vertebra was rather a peculiar shape too, it was rounded and it is apparent that the overall alignment between L-4 and sacrum is satisfactory, if it is considered that this vertebra is somehow prolapsed posteriorly, indeed, a very odd looking picture and there is nothing here to indicate that this is due to the recent trauma. I believe if it had been in any way the result of the recent trauma, the man would likely have been acutely diplegic. Another incidental finding is a spina bifida of the 12th thoracic vertebra involving the posterior clements, and this congenital abnormality would seem to indicate that the changes below are also of congenital origin."

Dr. Crawshaw's further comments were similar to that made by the Board Physician at the time, Dr. MacKenzie, that there was an aggravation of a pre-existing congenital condition.

In October of 1982, the worker was assessed by Dr. MacMichael, an Orthopedic Surgeon and again his comment was that this worker had on examination a full range of motion with a

> *neurological examination within normal limits. He also reviewed the x-rays occurring the worker had a congenital abnormality.*
>
> *Dr. Crawshaw, in his consultation went on further to prognosticate as to this worker's future difficulty with his back and it was opinion to which I agree, when he stated "I would think without the trauma he would inevitably at some point in time develop some arthritic changes possibly requiring stabilization by spinal fusion."*
>
> *Given these comments made some twenty years ago, given the above information on present medical knowledge of spondylolithesis, it would be my opinion that the probabilities are much less than 50% that the work incident that initiated this claim caused anymore than a temporary aggravation of a pre-existing condition and that his present difficulty more relates to natural clinical history of his underlying condition (my emphasis).*

18. The Worker was also seen by Dr. William M. Oxner on February 21, 2002, and in a consult report to Dr. Phelan he states:

> *He is a* [personal information] *year old gentleman who has a long history of low back and upper back pain. The pain at the present time and at the same time as he saw Dr. Ling in November of the last year, was located partly in his low back but the biggest part of his pain is in his interscapular region. He feels that there may be an element of pain radiating upwards but really his biggest problem is pain between his shoulder blades. I understand that he was working as a* [personal information] *until June of the past year and is currently off on disability. He did have a WCB claim back in 1981 when he had a low back injury but has not been on WCB benefits ever since. ....*
>
> *On examination, he is neurologically normal. He stands in a stooped forward posture and has marked difficulty with either flexion or extension. He has marked tenderness to light palpation in lower lumbar spine and has marked tenderness to light palpation in his upper thoracic spine. Straight leg raising causes back pain bilaterally but he did not have any pain with downward pressure on his head.*

I had a look at his X-rays which show that he does have a kyphotic lumbar spine and it is an angular kyphosis at the level of the L4/5 segment where he has a degenerative spondylolisthesis. The rest of his spine looks normal radiographically.

19. In a decision dated April 16, 2002, the Board's Entitlement Manager denied the Worker's request for WCB benefits stating:

> *You filed a claim on December 28, 1981, stating "*[personal information]*". When filling out Question 4A of the workers report of accident "What Injury Did You Sustain?", you stated you suffered a sore shoulder, chest, stomach, and your legs are weak.*
>
> *You saw a doctor on December 22, 1981, ... and he stated that you suffered a contusion to your thoracic spine, as a result of a* [personal information] *accident. He initially recommended that you be off one (1) week from work because of this injury, and he did not think there would be any permanent disability resulting from the accident.*
>
> *You received compensation benefits from December 23, 1981, until January 5, 1982, and again on February 16, 1982, until July 20, 1982. You were seen by two orthopedic surgeons, Dr. Edwin Crawshaw, in May of 1982, and Dr. Doug MacMichael, in October of 1982.*
>
> *Your claim was closed in July 1982 based on the report from Dr. Crawshaw, who indicated that there was no evidence of any neurological involvement. He also stated your complications were not a result from your* [personal information]. *You disagreed this decision and as a result you were sent to Dr. Douglas MacMichael. Dr. MacMichael noted you had a full range of motion and normal neurological examination. He also reviewed the x-rays and stated they showed you had a congenital (from birth) abnormality. Based on this fact, your claim remained closed.*
>
> *You had called me in the fall of 2001, stating Dr. Phalen told you you were now totally disabled and to try and reactivate your old claim from the* [personal information] *accident* [personal information] *in December of 1981.*

You saw Dr. Barry Ling in November of 2001, in which he noted your symptoms are a continuation of your low back injury of 1981 or your injuries may be related to a posterior displacement of a vertabral body of L-5. ...

I have reviewed your case as to the information on file, both internal and external, and note your claim was closed in 1982 because Dr. Crawshaw, said you were suffering from a pars intra-articular defect at your L-4 with forward slipping of your L-4 and L-5 disc level. Dr. Crawshaw noted the overall alignment was satisfactory and the vertabra is somehow prolapsed posteriorly indeed and is a very odd looking picture. There was nothing to indicate this was due to recent trauma. He felt you were suffering from a congenital abnormality (due from birth).

Your claim was closed in July of 1982, which you disagreed with, and you were eventually sent to Dr. Doug MacMichael who agreed with Dr. Crawshaw. He indicated you had a full range of motion with a neurological examination within normal limits. He also reviewed your x-rays and concurred with Dr. Crawshaw, your abnormality was congenital.

The Board Medical Consultant, Dr. Barry Carruthers, reviewed your medical reports and indicated the [personal information] *accident you suffered in 1981, caused a temporary disabling condition, which was an aggravation of a pre-existing condition related to your natural clinical history of spondylolisthesis (vertebra slippage). ...*

There is no objective medical information indicating you are presently suffering a relapse of a condition which resulted from a [personal information] *accident twenty-one years ago, therefore I have denied your request for reinstatement of Temporary Wage Loss Benefits (compensation benefits).*

20. The results of a bone density examination of the Worker on June 16, 2004, showed that the Worker's spine at L2-L4 was osteoporotic with a moderate fracture risk.

21. In a letter dated July 20, 2004 ,Dr. Phalen states that the Worker suffers from chronic pain and is seen and followed regularly for this.

22. The Worker was admitted to the Prince County Hospital through the Emergency Department on April 20, 2005, with an exacerbation of his low back pain.

23. On April 22, 2005, a letter from the Worker and his representative to the Board states that the Worker is in severe pain, chronic pain that has never subsided since his injuries in 1981, and requests the Board review his case.

24. A decision letter was issued by the Board to the Worker on June 3, June 28 and November 30, 2005, stating the issue of pain was addressed in previous decision letters dated September 27, 2001, and April 16, 2002, both of which addressed the Worker's pain, and a further review would not be completed.

25. On January 6, 2006, the Worker requested internal reconsideration of the Board's decision dated November 30, 2005.

26. On January 24, 2006, the IRO denied the Worker's reconsideration request identifying the reconsideration issue as follows:

> Is the Worker's ongoing chronic back pain related to his December 22, 1981, workplace injury?

27. The IRO stated the rationale/analysis for her decision:

- *The worker was injured in a* [personal information] *accident on December 22, 1981. The original diagnosis provided was contusion to the thoracic spine. It was not until a few days later that the worker noted symptoms in his low back region.*

- *It was noted the worker had pre-existing conditions, that being, a pars intra-articular defect at L4 with apparent slipping of L4-L5, 25% forward spondylolisthesis with an apparent retra-spondylolisthesis at L5 on*

sacrum, a peculiar shape to the spinal canal and spina bifida of the 12th thoracic vetebra.

- *On April 25, 2005, a letter was received from the worker and his representative requesting a review of the worker's file for chronic pain.*

- *Policy 04-64 - Chronic Pain states "chronic pain means pain that: continues beyond the normal healing time for the type of personal injury that precipitated, triggered or otherwise predates the pain; and does not apply to cases of persistent lingering pain due to discernable organic diagnosis."*

- *It was noted on August 23, 1982, by the Board Medical Advisor the worker suffered an aggravation of his congenital condition as a result of the accident on December 22, 1981.*

- *In this case, the worker was advised by Dr. MacMichael in October 1982, he could return to regular activity with no restrictions. This would indicate the worker had reached a medical plateau in his recovery and that he was compensated for the full injurious result of the workplace evidence. There is evidence on the file that the worker did return to employment.*

- *In reviewing the above definition on chronic pain, the worker has recovered from the injury which initiated this claim and the ongoing symptoms are related to the worker's pre-existing back conditions as outlined in the file.*

- *I also note when the worker was seen by Dr. Oxner in February 2002, he noted pain mainly in the interscapular region (between shoulders). This was not an area accepted on this claim. The original injury was contusion to the thoracic spine and later pain in the low back region.*

- *Based on this information and noting the worker has pre-existing back conditions, the worker's request for internal reconsideration has been denied. The worker is not eligible for compensation for chronic pain as his pain is due to a discernable organic condition.*

28. On February 14, 2006, the Worker filed a Notice of Appeal to WCAT appealing the IRO's decision of January 24, 2006.

ISSUE

29. The issue is whether the Worker's chronic back pain is related to his December 22, 1981, compensable workplace injury?

DECISION

30. WCAT is bound by the *Workers Compensation Act* (the Act) and Board Policy (unless ultra vires).

31. Board Policy Number: POL04-64 deals with the subject of chronic pain.

32. Chronic pain is defined in the policy as follows:

> 2. *"Chronic pain" means pain that:*
> - *continues beyond the normal healing time for the type of personal injury that precipitated, triggered or otherwise predated the pain; and*
> - *does not apply to cases of persistent lingering pain due to discernable organic diagnosis or a psychiatric condition.*

33. The part of the policy dealing with chronic pain as a recurrence of injury reads:

> 6. *Where a worker files a claim for benefits for chronic pain some time after treatment for a compensable injury has concluded and;*
>
> - *it was determined the worker was capable of returning to work; and*
> - *compensation benefits were discontinued*
>
> *the Workers Compensation Board will adjudicate the claim to determine entitlement to benefits for chronic pain.*

> To determine entitlement, the Workers Compensation Board must determine whether the chronic pain is related to the original compensable injury, a pre-existing condition, or a non-compensable condition (my emphasis).
>
> *Based on the adjudicative decision the Workers Compensation Board will conclude either:*
>
> - *there is no entitlement to further treatment or benefits; or*
>
> - *the chronic pain is a complication of the original injury and the worker is entitled to appropriate treatment and benefits.*

34. Recurrence is defined in the policy as follows:

> 8. *"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.*

35. Objective medical evidence is defined:

> *5. "Objective medical evidence" means evidence presented through a physical examination including diagnostic tests of a worker and reported by the treating or family physician.*

36. Board Policy Number: POL04-08 deals with the subject of recurrence.

37. The policy states:

> *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 my 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.

38. Board Policy Number: POL04-09 deals with the subject of pre-existing conditions.

39. The policy states:

> *2. Where the worker is injured as a result of a work-related accident, and the injury is aggravated by a pre-existing condition of the worker, compensation for the injury will be paid in full until the Board is satisfied the worker has reached a plateau in medical recovery for that injury.*

40. In the policy, pre-existing condition is defined as follows:

> *"Pre-existing condition" means any condition which, based on a confirmed diagnosis or medical judgment, existed prior to the current work-related injury.*

41. Aggravation is defined:

> *"Aggravation" means the worsening of a work-related injury due to a pre-existing condition.*

42. Plateau in medical recovery is defined:

> *"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.*

43. The medical reports of Dr. Crawshaw and Dr. MacMichael, dated May 12, 1982, and October 13, 1982, respectively, provide objective medical evidence that the Worker's work-related injury of December 22, 1981, was aggravated by a pre-existing condition of the Worker.

44. Dr. MacMichael advised that the Worker could return to regular activity with no restrictions, indicating that the Worker had reached a medical plateau in his recovery.

45. The Worker did return to work in 1982 and continued to work without work restrictions or job modifications until 2001, a period of about 20 years.

46. Although the Worker states that he continued to suffer pain during the years following his injury of December 22, 1981, the continuity of symptoms are not supported by any medical evidence during the period between apparent recovery from the original injury of December 22, 1981, and the onset of the current chronic pain condition.

47. There is no evidence of continuing medical care during that period.

48. There is no specific incident precipitating the Worker's chronic back pain.

49. Dr. Ling's statement in his medical report of November 7, 2001, "I would rather suspect his symptoms are a continuum and ongoing result of his low back injury in 1980 or 1981" , is supportive of the Worker's case, but by itself, falls short as sufficient objective medical evidence that the Worker's chronic back pain is a recurrence or is related to his injury of December 22, 1981.

49. The medical opinions of Dr. Crawshaw and Dr. MacMichael in 1982 with respect to the Worker's injury of December 22, 1981, Dr. LeBlond's report on July 30, 2001, and Dr. D. Barry Carruthers' medical opinion, in the absence of medical evidence to the contrary, indicate that the Worker recovered from his back injury of December 21, 1981, and that his current pain symptoms are related to his pre-existing back condition and not his injury of December 21, 1981.

50. Accordingly, the panel finds, on the balance of probabilities, that the Worker's chronic pain is related to his pre-existing back condition and not his injury of December 21, 1981, and is therefore not compensable.

51. Accordingly, IRO Decision IR-06-02, dated January 24, 2006, is confirmed and the Worker's appeal must be denied.

Dated this 28th day of October, 2009

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

Concurred:

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Donald Cudmore, Employer Representative

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Gary Paynter, Worker Representative