WORKERS COMPENSATION APPEAL TRIBUNAL

BETWEEN:

WORKER
CASE ID #[personal information]

APPELLANT

AND:

WORKERS COMPENSATION BOARD OF
PRINCE EDWARD ISLAND

RESPONDENT

DECISION #141

Appellant	Worker, as represented by Maureen Peters, Worker Advisor
Respondent	Brian Waddell, Q.C., Solicitor representing the Workers Compensation Board
Place and Date of Hearing	May 20, 2010 Inn on the Hill 150 Euston Street Charlottetown, Prince Edward Island
Date of Decision	August 19, 2010

1. This is an appeal by the Worker of Internal Reconsideration Decision IR-09-91 dated October 15, 2009, upholding a decision of the Workers Compensation Board (the "Board") dated August 5, 2009, which deemed that the Worker was capable of working 15 hours per week, at an average wage rate of $8.10 per hour.

FACTS, EVIDENCE AND BACKGROUND

2. The Worker, a [personal information], sustained a low back injury on July 18, 2002, at work while lifting a [personal information].

3. The Worker's claim for compensation benefits was accepted by the Board for "sciatica injury" and the Worker received temporary wage loss benefits from October 30, 2002 to January 20, 2003, at which time the Worker returned to work on an easeback program.

4. On July 11, 2007, the Worker filed with the Board a claim for a recurrence of his previous low back injury after an aggravation of his sciatica on July 4, 2007.

5. On July 18, 2007, the Board accepted the Worker's claim effective July 4, 2007, for recurrence of low back pain with sciatica.

6. The Worker underwent a series of investigations and treatments with regard to his back.

7. The Worker underwent an MRI of the lumber spine on October 2, 2007.

8. The MRI showed multi-level degenerative changes, most significant at the L4-5 level.

9. On November 13, 2007 the Worker was examined by Dr. R. Holness, a neurosurgeon in Halifax.

10. The consultation report of Dr. Holness received by the Board on December 7, 2007, reads in part:

> *...All along, for several years, he has had CT scans and more recent an MRI which show central, somewhat left sided L4-5 disk herniation. I do not think the imaging has changed that much over the years. His clinical picture, however, has fluctuated in a gradual downhill course with less periods of being able to be functional.*
>
> *On examination, I found him very difficult to examine because he guards so much....*
>
> *...I think what we have here is a patient who has a mechanical problem with his lumbar spine and chronic pain, with some degree of nerve root encroachment and a lot of mechanical features related to the abnormal disk and reaction to various episodes of exacerbation and remission. In this situation the role of surgery is controversial and surgical results on patients like this have been fraught with bad results requiring not only the patient to head on into further surgery, but in some small number of patients the surgery actually makes the patient worse. I think, therefore, in this patient's case to give him the benefit of doubt, he should be seen by a surgeon with speciality training in spinal surgery; more specifically a surgeon who can offer him the full gamut of surgery which would include, or may include minimal invasive approaches or a more aggressive approach including a spinal fusion of some sort. Even with that, I think the chances of failure are high. However, I cannot see anything else to offer this man...*

11. The Worker was later seen by Dr. E. P. Abraham, a spinal surgeon, in Saint John, on January 23, 2008.

12. Dr. Abraham's report dated January 23, 2008 reads in part:

> *...The history was reasonably well presented by the patient who has had a number of work related injuries resulting in chronic low back pain for perhaps five or six years where his original injury*

was in 2002. He subsequently reinjured his back in February 2007 and I think has been off of work since. I would guess that his original injury had to do with mainly mechanical low back pain. After his second injury he began to develop sciatica. When questioned carefully about his sciatica, however, there is no question that this has been back dominant pain and the vast majority of his syndrome has been back pain related. Once again, it is now his eleventh month since his second injury and he has been unable to return to work...

... When he saw Dr. Holness in Halifax, it was felt that he did have back dominant pain with some degree of nerve root irritation but Dr. Holness's feeling was that surgical intervention probably was not the way to go. Dr. Holness did mention, however, that it was reasonable for another spine surgeon's opinion and the reason why I am seeing him today.

...The way that he injured his back in February 2007 was when he was rolling an [personal information] *and slipped on a greasy floor, seemingly wrenching his back. When you listen to the Worker's story, there is no question that he is very preoccupied with his pain. He has also been avoiding a lot of menial tasks, not only around the house but also in the community. He told me a story of how he went to get twenty items in the grocery store recently and was almost a cripple when he came back.*

I examined him. This was an extremely difficult exam due to his excessive guarding...

I reviewed his investigations, including plain x-rays that were relatively normal. The MRI demonstrates a small contained posterolateral L-4 L-5 disc on the left (not on the right where his leg symptoms are located). At L-4 L-5 he had a very mild spinal stenoisis. Similarly, at L-3 L-4, he also has a mild spinal stenosis. There are no other signs of degenerative disc or osteoarthritis. After review of his history, physical examination and ancillary investigations, I would definitely not recommend surgery in the Worker's case. This is a rather unfortunate situation in that he has been disabled for so long that he has now developed some very difficult pain behavior which will become refractory to any type of treatment unless he gets himself to a Pain Clinic in the very near future. This would need to be a multidisciplinary approach to pain, including psychological support and evaluation...

> *...I really think it is worthwhile getting Pain Clinic involved and encouraging him to start stretching, strengthening, working through the pain and getting himself rehabilitated. This might mean admission to a rehab center, or something of that nature...*

13. On March 13, 2008, the Worker was assessed by Dr. R. T. Evans at the Atlantic Pain Clinic in Moncton.

14. Dr. Evans noted a complex chronic pain presentation and concluded that the Worker was an appropriate referral for interdisciplinary pain management.

15. Dr. Evans stated that a functional capacities evaluation ("FCE") would be appropriate at the conclusion of the Worker's enrolment in the Pain Clinic.

16. Dr. Evans also stated:

> *It would then remain for the Worker to proceed to a medically indicated gradual return to work at the level of functionality identified through the FCE process.*

17. In Dr. Evans' report of May 16, 2008, following the Worker's eight weeks at the Pain Clinic, Dr. Evans noted:

> *I implored him to put a little more effort into the adaptive coping aspects of his problem. I encouraged him to participate in a functional capacities evaluation and I certainly tried to encourage him that some form of occupational reintegration was indicated and therapeutic in his circumstances.*

18. Dr. Evans also noted that the Worker would likely have pain management problems going forward and suggested a trial of opioids, as well as facet block injections.

19. The Worker underwent a series of facet block injections on June 6 and 27 and September 5, 2008, under the care of Dr. Evans.

20. In a letter dictated by Dr. Evans on September 5, 2008, (and received by the Board on September 23, 2008) addressed to the Worker's family physician, Dr. Paul Kelly, and to the Board's Medical Advisor, Dr. Steven O'Brien, Dr. Evans stated in part:

> *...I think this man is certainly a candidate for radiofrequency neurolysis based on his placebo controlled double block diagnostic series on the 6th and 27th of June. Today's diagnostic block indicates that the radiofrequency procedure is going to have to involve both the L4-L5 and L5-S1 facet levels bilaterally...*
>
> *...As previously discussed with Dr. O'Brien, we do not have a satisfactory radiofrequency neuroloysis practitioner available to us in Atlantic Canada. Such a resource is available at the Queen Elizabeth II Health Science Centre in Halifax but, even with the diagnostic workup done by me, the wait list is still as at my last call to Halifax, on the order of 4 years. For that reason, I have been referring all of my comparative double block positive facet joint candidates to Dr. Gil Faclier at Sunnybrook Hospital in Toronto. Dr. Faclier is an eminent and published scholar in this area and the results we have obtained from him in properly selected candidates such as the Worker have been outstanding and as per the published outcome literature on radiofrequency neurolysis. I would recommend the Worker for this procedure as he can expect, based on literature, to have a pain-free interval of anywhere from 3 months to 3 years should Dr. Faclier be able to provide technically satisfactory radiofrequency neurolysis. At such time as pain recurs, the radiofrequency neurolysis procedure can be repeated with the same potential for a meaningful pain-free interval. I would also recommend the Worker for the procedure given that we have nothing further to offer him from a conservative pain management point of view.*
>
> *In the meantime, I have encouraged the Worker to proceed onto his scheduled functional capacities evaluation...*

21. On September 26, 2008, the Board's Case Coordinator requested a medical opinion from Dr. O'Brien with regard to the appropriateness of Dr. Evans recommendation for a referral to Dr. Gil Facier, Dept. Of Anethesia, Sunnybrook Hospital in Toronto and also for his diagnosis.

22. Dr. O'Brien's medical opinion of October 1, 2008 reads in part:

> *...In ODG Treatment in Workers' Comp, 2008, Sixth Edition, published by the Work Loss Data Institute, page 885, under Facet joint radiofrequency neurotomy, it states, "Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis. Studies have not demonstrated improved function."*
>
> *In Occupational Medicine Practice Guidelines, Low Back Disorders (Revised 2007), 2nd Edition, page 196, it states, "Radiofrequency neurotomy, neurotomy, and facet rhizotomy are not recommended for the treatment of any spinal condition." Under Rationale for Recommendation, it states,*
>
> > *Radiofrequency lesioning has been evaluated in quality studies...The highest quality studies are largely negative. The next lower quality study is more favorable, but used unconventional statistical testing. The lowest quality study had worrisome results in the placebo. Available systematic reviews also discuss additional significant methodological concerns. These concerns further limit the robustness of conclusions.*
>
> *Therefore, it is probably not appropriate, under this file, to make the referral to Dr. Gil Faclier at the Sunnybrook Hospital in Toronto.*
>
> *You ask what would be the clear diagnosis under this claim. The Worker's diagnosis at this point would be, as Dr. Profitt diagnosed in October 30, 2002, mechanical low back pain, this was confirmed by Dr. Renn Holness, Neurosurgeon in Halifax, and also the presence of a L4-5 disc herniation.*

23. The Worker participated in a Functional Capacity Evaluation (FCE) arranged by the Board on September 24 and 25, 2008.

24. The FCE measures a person's physical abilities and assists in determining the person's maximum physical tolerance and abilities in work related tasks.

25. This evaluation was carried out with the Worker over a two-day period by Valerie Handren, a licensed Physiotherapist.

26. The process involved activities such as standing, sitting, bending, crawling, kneeling, crouching, squatting, pushing, pulling, reaching, lifting, etc.

27. The Physiotherapist's report stated the Worker's perceived functional level and pain level as follows:

> *FUNCTIONAL LEVEL:*
> *The client states that his overall schedule of activity level is "quiet".*
>
> *Housework: He doesn't do.*
>
> *Stairs: He doesn't do because they have a mini home. In fact, that's one of the reasons he bought a mini home.*
>
> *Lawn care: No grass or lawn to cut.*
>
> *Standing: Less than 10 minutes at a time. He finds difficult.*
>
> *Driving: He finds it tough after 50 minutes. He would tend to break up a drive usually around 20 minutes and get out and walk around. As soon as he gets into Charlottetown, which is a 50 minute drive, he gets out of the car and walks around town.*
>
> *He notes that in his small car he is bent too much as opposed to the truck which gives him better seating but bounces too much.*
>
> *Grocery shopping: He does with his wife and he will carry and lift the light bags.*
>
> *Garbage: He will lift the light bags.*
>
> *Sleep: Variable. He finds that he tries to shift around to get comfortable and finds that he sleeps two hours here and there. He is most comfortable on his back but his right leg goes numb if he stays too long. The client states he sleeps approximately 6 hours off and on.*
>
> *Exercises: He does some of the exercises from the Pain Clinic.*
>
> *"Doesn't do too much".*

PAIN LEVEL:
The client describes his pain as all over the low back. His pain radiates down the right leg to the knee. He rates his discomfort level as ranging between 5 to 7 when asked on the first day of testing in August 2008.

On September 10, 2008, he rated his pain level between 4 to 7.

On September 24, 2008 he rates his pain level as increased slightly between a 6 to 8.

The client states that coughing and sneezing bothers his back and he tries to lean against support if he can.

The client states if sits or lies down flat on his back with his knees bent eases his pain.

GOALS:
The client states he would like to go to Sunnybrook in Toronto for some procedure recommended by Dr. Evans.

28. The Physiotherapist's report also stated in part:

The client's perceived abilities are inconsistent with those objectively evaluated within the FCE. On the Spinal Function Sort, which the client completes in reliable fashion on the second day of the assessment, he profiles himself that fall within the sedentary level. Within that he identifies only a few activities that he finds easy to do, and notes that he has definite restrictions on the amount of time undertaking any activity as well as the need to avoid forward bending and rotation. While the FCE does identify similar pattern of restriction; profiles levels that fall within the low end of the medium physical capability overall based on the second day findings.

SIGNIFICANT ABILITIES:

14. Sitting tolerance is tolerated on a minimum frequent basis with the client demonstrating frequent shifting. Most notable is the decreased weight bearing on the right buttock. It would be recommended that he break at 20 minutes.

15. Standing tolerance is tolerated on a minimum frequent basis. The client demonstrates a tendency for increasing

trunk flexion and leaning forward on to support. It would be recommended that he break at 15 minute time frame...

SIGNIFICANT DEFICITS:

1. *Floor to waist lift achieves maximums of 20 lbs. This activity is restricted by the deceased trunk extension, lack of control in recovery from the squat with the weighted squat. There is significant decrease in speed noted at the maximum levels achieved.*

2. *Waist to overhead lift attains maximums of 20 lbs, restricted by the decreased weight bearing through the right leg. The client demonstrates an inability to undertake this activity in lunge positioning with lack of trunk extension control noted. The client demonstrates decreasing trunk control with significant decreased weight bearing on the right leg following the activity.*

3. *Unilateral carry on the right attains maximums of 20 lbs. This activity is restricted by the deceased weight bearing through the right leg and significant decreased in trunk control with increasing flexion both forward and to the side. It would be recommended that heavier weights be carried on the left.*

4. *Stair climbing is tolerated on an occasional basis. The client demonstrates decreased use of the leg significantly worse with repetition. It would be recommended that he use the railing and double time as necessary.*

RECOMMENDATIONS:

This Functional Capacity Evaluation highlights an individual with low medium weighted capabilities overall. This is based on the second day presentation, which is significantly less weighted capabilities than the first day.

Profiled within this Functional Capacity Evaluation the decreased weight bearing capabilities and resisted work through the right leg, general restrictions in mobility through the trunk, particular extension. The client demonstrates poor active strength in both trunk extension and right side flexion.

Visible signs of effort are not accompanied with increased pulse rates during the Functional Capacity Evaluation. The client's medication for blood pressure control is a Beta-Blocker and effectively keeps his pulse rate down.

Certainly significant pulse rate increases were noted during earlier attempts at an FCE.

On the basis of this Functional Capacity Evaluations, and the client's medical history, I would recommend that these physical parameters be utilized to establish a safe return to work scenario.

29. Subsequent to the FCE and review of the results with the Worker, Peter Doucette, Vocational Counsellor at the Board, completed a Return to Work (RTW) Process Discharge Report dated April 17, 2009.

30. The conclusions and recommendations of the Vocational Counsellor were as follows:

Based on working with the Worker over the past fourteen weeks and considering the opinions expressed by the Functional Capacity Evaluation and other documents in the Worker's WCB file, to locate any suitable work that would be appropriate to his functional capacity as defined in policy 04-69 which states "suitable work" means work that a worker has the necessary skills to perform and is medically able to perform, and that does not pose health or safety hazards to the Worker or co-workers, as determined by the Workers Compensation Board. To determine these conditions I have reviewed the Worker's previous work history, education, transferrable skills, Functional Capacity Evaluation, labour market information, Service Canada Job Bank and WCB file and have determined the Worker would be capable of employment in the following areas:

Laundromat Attendant, NOC Code 6683.4, Light Physical Demand Capabilities at an average rate of $8.10/hr for a 15 hour work week.

Parking Lot Attendant, NOC Code 6683.5, Limited Physical Demand Capabilities at an average wage rate $8.10/hr for a 15 hour work week.

Ticket Taker, NOC Code 6683.6, Limited Physical Demand Capabilities at an average wage rate of $8.10 per hr. for a 15 hour work week.

The above note employment options identified are not intended to be exhaustive, and should not be considered as such. Job match information of the above occupations is also included with this report below.

Recommendation:

It is this Vocational Counsellor's recommendation that a wage rate of $8.10 for a fifteen hour, part time position, be utilized in determining the Worker's maximum earnings capability...

31. The three suitable, available occupations identified were laundromat attendant, parking lot attendant, and ticket taker.

32. These occupations all fall under group 6683, "Other Elemental Service Occupations", in the National Occupational Classification (NOC) system.

33. The following is the summary of the main duties for these occupations as provided on the NOC website:

- *Laundromat attendants replenish vending machines, provide change, explain operation of machines to customers, clean the laundromat and arrange for the repair of broken machines and may wash, dry and fold laundry for customers; may operate dry cleaning machines for customers.*

- *Parking lot attendants and car jockeys collect parking fees, issue ticket stubs, direct customers to parking spaces and park cars.*

- *Ticket takers and ushers collect admission tickets or passes from patrons at entertainment events and direct patrons to their seats.*

34. On June 11, 2009, Ms. Handren performed a Job Match Exploration at the request of Mr. Doucette for a part-time position by the Worker.

35. Ms. Handren concluded that the jobs identified by Mr. Doucette in his Discharge Report (Laundromat Attendant, Parking Lot Attendant and Ticket Taker) were appropriate job matches for the Worker and also the job of Switchboard Operator.

36. Ms Handren stated that these were safe job matches if done on a part time basis, and that positional tolerances would be accommodated by decreased work hours.

37. It must be noted however, that one of the critical job demands stated for each of these jobs is "sitting frequently or continuously", specifically:
Laundromat Attendant - sitting rarely to frequently
Parking Lot Attendant - sitting frequently to continuously
Ticket Taker - sitting continuously
Switchboard Operator - sitting frequently to continuously

38. A critical job demand for a Laundromat Attendant is also "standing occasionally to frequently."

39. Ms. Handren found that these critical job demands were not a job match for these jobs, but would be accommodated by decreased work hours.

40. The Worker was advised on August 5, 2009, that his Temporary Wage Loss (TWL) Benefits would be transitioned to Extended Wage Loss (EWL) Benefits effective August 30, 2009.

41. The Board enclosed its EWL Benefits Calculation, which indicated that the Worker was capable of earning $8.10 per hour for 15 hours per week for a total of $6,318.00 per year.

42. On August 26, 2009, the Worker filed a Notice of Request for Internal Reconsideration in respect of the Board's August 5, 2009, decision, and in particular, in relation to its calculation of the Worker's EWL Benefits.

43. The Worker's reasons for requesting reconsideration were:

> *(1) Problems with sitting/standing for more than 10 minutes at a time.*
> *(2) Dangers of being in the workplace while on medications.*
> *(3) Fear of falling and possibility of a worse injury.*
> *(4) Very limited strength in my back.*
> *(5) Driving only very short distances.*
>
> *I can only sit or stand for very short periods of time or the result is very painful and have to reside to my bed until I can cope with it again. On letters I have received from Peter Doucette, it has stated that I can go back to work for 15 hours per week. The jobs that he suggests that I can do are: Laundromat Attendant/ Parking Lot Attendant/Ticket Taker. I cannot do these jobs as they require sitting/standing. At any rate, if I were to do those jobs I will have to medicate myself with prescription Oxycodene and Tylenol 3 with codeine. I do not see myself being able to function on these medications and nor do I see any employer hiring me for the risk and safety of their company and myself. A crossing guard for example, outside in slippery/snow conditions would surely be a risk if I should fall. If I have to drive to Charlottetown to be a Parking Lot Attendant as there are none in Summerside, I would never be able to even try to work after that drive. As for Ticket Taking, are the employers to let me take breaks every 15 minutes as quoted by Valerie Handren, L.P.T. Diagnosis being written and quoted also by Valerie chronic mechanical back pain. I had been in a grocery store recently and fell to my knees with 2 bags of food. I have no strength in my back to hold myself up sometimes and that is where my fear of falling is. If I am forced to do these jobs who is responsible should I get hurt or fall and end up worse than I am or who will be responsible for the addiction that the medication will cause as I will have to take them every day which I avoid unless the pain is so severe that I can't function and cannot get the pain to subside at all. I spend most of my days in bed so I don't get the addiction. Bed helps me.*

44. On September 18, 2009, the Board received a letter from Dr. Paul Kelly, the Worker's family physician, dated September 14, 2009, which reads:

> *...This gentleman (the Worker) was seen in the office today. I reviewed the vocational summary by Mr. Doucette and reviewed the functional capacity evaluation by Valerie Handren.*
>
> *The jobs identified as suitable work for the Worker are laundromat attendant, parking lot attendant, and ticket taker. I asked the Worker his opinion on his capability to do these jobs and the answer was that he can sit for 10-15 minutes and stand for 10-15 minutes. He can rotate this once or twice and then he needs to lay down. I do not know of any laundromat attendant, parking lot attendant, or ticket taker who can spend 15-20 minutes laying down every hour or so.*
>
> *I do not believe these are reasonable expectations for this patient's capabilities. I understand he is appealing this decision and I would whole heartedly support that appeal.*
>
> *In summary, this gentleman is not capable of doing the kind of work laid out in the vocational assessment...*

45. On October 15, 2009, the Board's IRO denied the Worker's Reconsideration Request, stating:

> *I have reviewed the letter from Dr. P. Kelly received on September 18, 2009 and have determined that it does not constitute new evidence as outlined in the "New Evidence" policy. There is no objective information supporting Dr. Kelly's rationale but rather he relies on the worker's opinion as to his ability to perform these duties...*
>
> *Based on the information provided in the Functional Capacity Evaluation, the Job Match Exploration, the medical evidence from the Atlantic Pain Clinic and in considering the above noted policies (POL04-68, POL04-52 and POL04-60), it is my opinion the results were an accurate representation of the Worker's functional abilities. Therefore, the Case Coordinator's decision to estimate the Worker's earning capacity based on 15 hours of work per week was appropriate.*

46. On October 16, 2009, Maureen Peters, Worker Advisor, submitted a Notice of

Appeal to WCAT on the Worker's behalf stating:

Grounds of Appeal:

(1) That the IRO erred by failing to properly apply Section 41 (1) of the Act as well as Policy 04-68, Estimating Earning Capacity, in accordance with the purpose and objectives of the Act.

Relief Requested:
That the decision be set aside, and that the Board be directed to calculate Extended Wage Loss Benefits based on zero earning capacity

ISSUE

47. Was the decision to deem the Worker capable of working 15 hours a week appropriate?

DECISION

48. The Board and WCAT are both bound by the Workers Compensation Act (the Act) and Board Policy.

49. Section 41.(1) of the Act states:

> *The loss of earning capacity of a worker is the difference between (a) the worker's net average earnings before the accident; and (b) the net average amount the Board determines the worker is capable of earning after the accident, which amount shall not be less than zero.*

50. Board Policy Number: POL04-68 (Estimated Earning Capacity) is most relevant to this decision.

51. This Board Policy reads in part:

> *DEFINITION:*
> *In this policy:*
> *1. "Available suitable work" means suitable work, that, according to labour market information, is determined to exist on Prince Edward Island within a geographic location of 100 km from the worker's home.*

4. *"Loss of earning capacity" means the difference between the worker's net average earnings before the accident and the net average amount the Workers Compensation Board determines the worker is capable of earning after the accident.*

5. *"Suitable work" means work that a worker has the necessary skills to perform and is medically able to perform, (my emphasis) and that does not pose health or safety hazards to the worker, or co-workers, as determined by the Workers Compensation Board.*

POLICY:

1. *Where a worker has an impairment, as determined by the Workers Compensation Board, and is unable to return to the pre-injury employment or obtain alternate employment, including suitable work, at the same wage level or the worker refuses to seek or accept available suitable work, the Workers Compensation Board shall determine the worker's loss of earning capacity.*

2. *When a worker's actual wages are not known and the worker's earning capacity must be estimated, the Workers Compensation Board shall consider the following:*

   - *the pre-injury employment of the worker;*
   - *the worker's functional ability to work which may be determined by the use of a Functional Capacity Evaluation;*
   - *the average wages of the available suitable work;*
   - *the worker's work history, education, and analysis of transferable skills;*
   - *the geographic location; and*
   - *labour market research.*

3. *The Worker Compensation Board shall estimate the earnings capacity based on the average of three suitable, available occupations (my emphasis) identified by the Workers Compensation Board.*

52. The suitable, available occupations identified by Mr. Doucette and by Ms. Handren were laundromat attendant, parking lot attendant, ticket taker and switchboard operator.

53. After considering the Functional Capacity Evaluation, the RTW Process Discharge Report, Job Match Exploration, and the medical and other evidence with regard to the Worker's medical condition, this Tribunal finds, on the balance of probabilities that none of these four jobs are suitable occupations for the Worker due to his low sitting and standing tolerances.

54. At best, the evidence indicates that the Worker can only sit for 20 minutes at a time and stand for 15 minutes at a time without taking a break.

55. It is highly improbable that any employer could/would accommodate the Worker with such sitting or standing breaks for any of these occupations, even for a part-time position.

56. This is a common sense assessment.

57. The decision from the Court of Appeal of Alberta in the Case of Gahir v. Alberta (Workers Compensation, Appeals Commission) considered the issue of estimating a worker's earning capacity.

58. The Court held that when estimating earning capacity the Board must suggest actual employment that is reasonably available and that the worker could reasonably perform. "A mere finding of functional capacity is not enough. Employability under the system must not just be theoretical, but must be based in reality." "The workers' compensation system is not, however, an unemployment insurance system. It is designed to provide compensation for persons who are unable to work due to disability. It does not guarantee that there will be a job available for every injured employee."

59. This Tribunal finds that the occupations used to estimate the Worker's earning capacity were not reasonable, and were not based in reality.

60. Until such time as the Board identifies real prospects of employment for the Worker, i.e. suitable and available occupations, the Worker is entitled to Extended Wage Loss Benefits based on zero earning capacity.

61. Accordingly, this Tribunal reverses Internal Reconsideration Decision IR-09-91 dated October 15, 2009.

62. The Panel wishes to thank Ms. Peters and Mr. Waddell for their excellent presentations at the Hearing.

Dated this 19th day of August, 2010.

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

Concurred:

Don Cudmore, Employer Representative

Nancy FitzGerald, Worker Representative