WORKERS COMPENSATION APPEAL TRIBUNAL

BETWEEN:

WORKER
CASE ID # [personal information]

APPELLANT

AND:

WORKERS COMPENSATION BOARD OF
PRINCE EDWARD ISLAND

RESPONDENT

DECISION #160

Appellant	Worker, as represented by Maureen Peters, Worker Advisor
Respondent	Brian Waddell, Solicitor representing the Workers Compensation Board
Place and Date of Hearing	February 9, 2012 Inn on the Hill 150 Euston Street Charlottetown, Prince Edward Island
Date of Decision	May 28, 2012

1. This is an appeal by the Worker of a decision of the Internal Reconsideration Officer (the "IRO") of the Workers Compensation Board (the "Board"), IR#[personal information], dated [personal information], upholding a decision of the Board to close the Worker's claim for temporary wage loss benefits effective January 4, 2011.

FACTS, EVIDENCE AND BACKGROUND

2. The Worker, a service worker, injured her left eye at work on May 23, 2010, when she came into contact with some cleaning solutions.

3. On June 18, 2012, the Board advised the Worker that she was entitled to medical aid benefits for her claim (Worker's Report filed May 28, 2010) for her eye injury.

4. On June 21, 2010, the Worker saw her family physician, Dr. Terry Magennis, concerning her back.

5. The Physician's Report of Dr. Magennis for this visit states, "Recurrence of low back pain from previous injury" and his diagnosis "lumbar strain; referred *back pain."*

6. On July 6, 2010, the Worker filed a second Worker's Report claiming a recurrence of an earlier work related back injury sustained on September 14, 2008.

7. The Worker described the recurrence as follows:

> Previously hurt back helping [personal information], was off work on WCB with injury. Have had recurring back pain since injury

> and have been on medication off and on... tingling in both legs to feet.

8. An inter office memorandum of Angie Fullerton, the Board's Entitlement Officer, dated August 2, 2010, reads:

> I spoke with [Worker] regarding her low back pain. She said that in May she had a chemical splash into her eye at work, she jumped back quickly and "jarred" her back. She did say her back has been sore on and off since her injury in 2007, however had not missed work until this new incident. ...
>
> I discussed the claim with Kate Marshall, Manager Intake and Entitlement, and it was decided this is a new incident on May 23, 2010, when she jerked her back, causing a new strain injury.

9. By letter dated August 4, 2010, Ms. Fullerton advised the Worker that her claim as a result of her injury on May 23, 2010, was accepted for temporary wage loss benefits effective June 29, 2010, and that the diagnosis accepted under her claim was low back strain and foreign body to the left eye.

10. The Worker was approved for chiropractic treatment for her low back strain injury.

11. Dr. Melissa Wicks MacRae, a chiropractor, treated the Worker.

12. Dr. Wick MacRae's Chiropractic Report of August 18, 2010, states:

> Date of Injury: Re-aggravation of prior injury- 3 years ago.
>
> Diagnosis: probable bulged disc with associated joint dysfunction/nerve irritation.
>
> Client Report re. past/present symptoms and factors affecting recovery:

Chronic pain of the lumbar spine for 3 years will no doubt affect recovery. Pain increases after activities that include bending/twisting/reaching.

Functional Limitations: Avoid heavy lifting, awkward postures and repetitive movements of the lower back and SI joints (e.g. [personal information], bending, twisting, etc.)

Critical Job Demands:
Client Reported: [personal information] duties.

Treatment Goals and Interventions: Decrease pain and inflammation; restore joint motion.

Outcome: Status quo- Ongoing chronic situation.

Clinical Impression: We have only had 3 treatments since patient has returned from vacation. I am hoping that some consistent care coupled with modified work will aid in recovery. A workplace assessment by Occupational Therapy would be helpful in assessing exact activities. A consult with her Family MD is also recommended as she has reported some incontinence that she has been dealing with since the injury.

Physical abilities consistent with: Modified work- may need change in job duties.

Recommendations: Continued chiro with the expectation of STAYING AT WORK.

13. The Worker saw Dr. Magennis again on August 18, 2010.

14. His Physician's Report states, "Persistent back pain lower with referral to right leg", diagnosis- lumbar strain, and that it will be 1 month before the Worker will be able to return to work.

15. The Worker saw Dr. Magennis again on August 19, 2010.

16. His Physician's Report states, "Continues to have right sided back, groin and leg pain."

17. The Report further states that the Worker cannot return to full duties but can safely perform some pre-injury job duties except for some lower extremity limitation /restriction, and bending, twisting.

18. The Report further states, "Please assess to see if job duties modified would help."

19. The Worker was sent home on August 24, 2010, until such time as the Board's Occupational Therapist could be involved in modifying her work duties.

20. The Worker was assessed by Gail Gauthier, the Board's Occupational Therapist, on August 27, 2010, and the Worker began an ease back (modified duties) program on August 28, 2010.

21. The Worker went on full temporary wage loss benefits effective August 24, 2010, and was considered an "extra" on staff during her ease back process because of her inability to do all her work duties.

22. An Occupational Therapy Assessment Report by Ms. Gauthier, dated August 27, 2010, states:

> Reason for Referral: Ease back/Modified duties.
>
> MEDICAL/REHAB UPDATE:
> . She continues to take Lyrica and over the counter medication for her back (like Robaxicet).
> . She attends chiropractic treatment twice a week.
> . She is being followed by Dr. Magennis.
>
> Schedule: 7.5 hours per shift

BASIC DUTIES:

- [personal information] duties include:
  - labeling [personal information], putting [personal information] away
  - interviewing new [personal information]
  - stocking counter stores
  - cleaning bathrooms, family and hair dressing rooms, cleaning windows
  - sewing
  - cleaning tables and chairs, windows
  - emptying garbage
  - mopping, scrubbing
  - dusting
- Kitchen duties include:
  - cleaning ovens, steamers, windows, garbage cans, fridge, ice machine, tables and chairs
  - putting stock away
  - peeling vegetables
  - cleaning sinks

PHYSICAL DEMANDS:

- walking
- lifting
- forward bending
- twisting
- reaching

WORKER'S PERCEIVED OCCUPATIONAL PERFORMANCE

Strengths: She has been working full time hours.

Concerns: Twisting, bending, over reaching, overhead work; she mentioned she has issues of incontinence where she has to go every 2 hours or she will have an accident. She said she cannot stop it when it starts. She has seen a specialist but he said there is nothing he can do for her. Suggested she discuss this again with Dr. Magennis.

Perception of Discomfort: She continues to experience pain along her mid back down into her right hip and describes a sharp pain in behind her thigh. She also describes numbness into her right foot.

FUNCTIONAL ASSESSMENT: She was struggling at work since her original injury she states. She mentioned

vacuuming, sweeping, scrubbing, heavy lifting, reaching and awkward postures bothersome. She said she doesn't have much left ,to do any work at home so her husband does most of the household chores. She does have trouble sleeping at night.

AREAS OF CONCERN/PRECAUTIONS:

1. I have advised her to stay with modified duties for a few weeks to see if this will help.
2. At that time we will have to meet with her employer to discuss options.

RECOMMENDATIONS/PLAN TIME LINES:

1. Modified duties start August 28, 2010.
2. I have set this up for 3 weeks. Will reassess at that time.

23. The Worker struggled with her ease back program complaining that her work duties were causing her considerable pain and discomfort.

24. The Worker saw Dr. Magennis on September 13, 2010, and he reports, "Improving - less pain but continues to have discomfort" and to "continue modified duties."

25. On September 16, 2010, Ms. Gauthier extended the Worker's modified duties schedule, continuing at full hours and regular shifts.

26. The Worker saw Dr. Magennis on September 17, 2010, and he reports"right hip pain" and to continue "modified duties."

27. The Worker saw Dr. Magennis on September 21, 2010, and he reports chronic hip and leg pain and "not coping well with stress, fear of full duties, potential job loss".

28. The Worker saw Dr. Magennis on September 28, 2010, and he reports, "back pain improved" and he recommends that the Worker continue with modified duties pending reassessment.

29. The Worker saw Dr. Magennis on October 7, 2010, and he reports, "continues to have right groin/hip pain with flareups" and to continue "modified duties."

30. The Worker saw Dr. Magennis on October 26, 2010, and he reports "chronic pelvic/hip pain", to continue "modified duties", and clears the Worker for a functional capacity evaluation.

31. On October 26, 2010, a Functional Job Analysis (FJA) of the Worker's position was completed by Valerie Handren, a Physiotherapist, and the Worker participated in a Functional Capacity Evaluation (FCE) by her on November 3 and 4, 2010.

32. The FJA identified the critical demands of the Worker's job as follows:

Critical Demands:

Standing; static:	Occasionally to clean counters, sinks. Majority of cleaning tasks incorporate dynamic standing, short distances.
Sitting:	Rarely to occasionally. Higher amount of sitting occurs when undertaking sewing, labeling, repair of clothing garments, maintaining record in scribbler.
Walking:	Frequently to continuously. Distances traveled within the workplace.
Rotation in sitting:	Rarely.
Rotation in standing:	Occasionally, small range in cleaning activities.
Forward bend in sitting:	Rarely

Forward bend in standing:	Occasionally to frequently. Many aspects of cleaning incorporate this posture. May be lessened with use of squatting.
Climbing:	Rarely to occasionally (ladders, stairs). Ladders are used to access windows, to take down and put up curtains.
Balance:	Rarely to occasionally. Areas of kitchen, on ladder, accessing windows.
Gripping:	Light to medium frequently to occasionally respectively.
Lifting floor to waist:	Rarely 20 lbs heavy bags Occasionally 10 lbs linens, light supplies.
Horizontal lift:	Rarely to occasionally 10-20 lbs. Supplies, garbage, boxes.
Overhead lift:	Rarely to occasionally 10 lbs light goods, supplies.
Push/pull:	Rarely to occasionally. 10 lbs cart. Rarely 25 lbs dumbwaiter wagon Occasionally 8-10 lbs. mopping/bucket.
Kneeling:	Rarely when cleaning windows in kitchen, worker kneels on counter.
Carry unilateral:	Rarely to occasionally 15-20 lbs. Supplies, laundry, garbage bags.
Carry bilateral:	Rarely 20-30 lbs heavier bags, garbage to outside container. Occasionally 5-15 lbs. supplies, light garbage/laundry bags.
Squatting/crouching:	Occasionally to undertake cleaning lower surfaces, accessing stoves, supplies lower shelves.

33. The FJA also identified possible job modifications/accommodations as follows:

This Functional Job Analysis defines a position requiring light to medium physical weighted capabilities, significant ambulatory and positional tolerances. Cleaning tasks are repetitive in nature.

Job tasks are well outlined with some flexibility available.

The following recommendations may be found useful to ensure the workers efficiency and safety:

- Proper body mechanics should be used at all times; especially to access supplies on various shelf heights
- Step stools and ladders should be used to modify overhead reaching.

34. The FCE states:

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, she profiles herself with weighted capabilities that fall between the sedentary and light level overall, while identifying restrictions in her abilities to bend, reach, push/pull, particularly as it affects the right leg. While the restriction is identical, the Functional Capacity Evaluation would profile her with capabilities falling within the medium range overall.

PAIN BEHAVIOR:
During this assessment , signs that symptoms were present were noted with those activities which required maximum weight bearing or resisted work through the right leg; maximum extension range or force through the lumbar spine, (particularly right side); maximum sustained forward flexion in standing; maximum lumbar rotation to the right.

SIGNIFICANT ABILITIES:

1. Horizontal lift and bilateral carry attain maximums of 30 and 25 respectively; first and second day respectively. Both activities are restricted by the decreased control noted particularly with rotation to the right. The increased lumbar extension at the maximum weight contributes to the presence of groin pain.

2. Push/pull forces attain maximums of 58 and 62 lbs.

Push is noted as demonstrating an equal ability both legs with a decreased lunge.
Pull attains maximums using the left leg and decreased by approximately 20% when the right leg is used as the dominant leg. The client demonstrates a considerable amount of apprehension with pull and there is not a significant difference in force achieved over push. In dynamic fashion, pull demonstrates a significant amount of asymmetry with the decreased force through the right leg with a decreased stride length.

3. Unilateral carry on the left attains a maximum of 20 lbs. Restricted by the decreased weight bearing through the right leg and gait deterioration.

4. Grip bilaterally falls within normal values and is virtually identical, dominant and non-dominant.

5. Elevated work is tolerated on a continuous basis. The client demonstrates slight decreased weight bearing on the right leg within a 5 minute tolerance of the sustained position.

6. Forward bend in sitting is tolerated on a frequent basis with increased tone present in the paravertebrals at 4 minutes.

7. Rotation in sitting to the right and left is tolerated on a frequent basis with the client reporting increasing discomfort with repetition within good range bilaterally.

8. Rotation in standing to the right is tolerated on a frequent basis with the client demonstrating avoidance of pelvis rotation to accompany lumbar rotation in this activity.

9. Rotation in standing to the left is tolerated on a continuous basis with no restrictive factors identified.

10. Crawling is tolerated on a frequent basis with the client demonstrating decreased ability to demonstrate extension through right leg and lumbar spine.

11. Kneeling is tolerated on a continuous basis with no restrictive factors identified.

12. Crouching, deep static, is tolerated on a continuous basis with the client demonstrating excellent flexibility while reporting tightness over the right lumbar spine.

13. Repetitive squatting is tolerated on a frequent basis, restricted by the decreased use of the right leg with repetition.

14. Sitting tolerance is noted as continuous with no restrictive factors identified.

15. Standing tolerance is noted as continuous. The client does demonstrate a tendency to bend the right knee.
16. Walking is tolerated on a continuous basis with no restrictive factors identified on level surfaces. Restrictions will exist with elevated work as well as uneven surfaces.
17. Stair climbing is tolerated on a frequent basis. There is some decreased use of the right leg in going up the stairs with repetition.

18. Balance is tolerated on a frequent basis. The decreased control is noted through the right leg with extension and rotation forces.

19. Fine hand coordination skills are above average bilaterally with the right non-dominant hand demonstrating increased speed over the left.

SIGNIFICANT DEFICITS:

1. Floor to waist lift achieves maximums of 15 lbs. This activity is undertaken initially using a modified squat with the right leg kept behind. Maintaining a symmetrical squat, decreased use of the right leg becomes the restrictive factor.

2. Waist to overhead lift attains maximums of 15 lbs. Decreased use of the right leg in extension is the restrictive factor.

3. Unilateral carry on the right attain maximums of 15 lbs. This activity is restricted by the decreased weight bearing on the right leg with definite change in gait pattern, and the avoidance of right rotation and right hip extension.

4. Forward bend in standing is tolerated on an occasional basis in the presence of distal pain after 2 minute timeframes.

5. Step ladder climbing is tolerated on an occasional basis. Decreased control through the right leg is noted primarily down, such that double time is necessary.

RECOMMENDATIONS:

This Functional Capacity Evaluation profiles an individual with essentially light to low medium weighted capabilities, good ambulatory skills, and good positional tolerances overall. There are a couple of activities that are not as well tolerated as noted on the grid sheets - forward bend in standing and step ladder climbing.

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

35. A Job Match Review provided a comparison between the Worker's critical job demands and her physical work strengths as follows:

CRITICAL JOB DEMANDS	**PHYSICAL WORK STRENGTHS**	**JOB MATCH YES /NO**
Standing static occasionally	Standing continuously	YES
Sitting rarely to occasionally	Sitting continuously	YES
Walking frequently to continuously	Walking continuously	YES
Rotation in sitting rarely	Rotation in sitting frequently	YES
Rotation in standing occasionally	Rotation in standing frequently to continuously	YES
Forward bend in sitting rarely	Forward bend in sitting frequently	YES
Forward bend in standing occasionally to frequently	Forward bend in standing occasionally	NO
Squatting/crouching occasionally	Squatting frequently	YES
Lifting floor to waist rarely 20 lbs. Occasionally 10-20 lbs.	Lifting floor to waist rarely 15 lbs. Occasionally 12.5 lbs.	N0 NO
Horizontal lift rarely 10-20 lbs. Occasionally 10-20 lbs.	Horizontal lift rarely 25 lbs. Occasionally 20 lbs.	NO YES
Lifting waist to overhead rarely 10 lbs. Occasionally 10 lbs.	Lifting waist to shoulder rarely 15 lbs. Occasionally 12.5 lbs.	YES YES
Carry unilateral rarely to occasionally 15-20 lbs	Carry unilateral right 15/12.5 lbs left 20/15 lbs.	NO YES
Carry bilateral rarely 20-30 lbs. Occasionally 5-15 lbs.	Carry bilateral rarely 25 lbs. Occasionally 20 lbs.	NO YES

Push/pull rarely 25 lbs. Occasionally 8-10 lbs.	Push/pull rarely 58-62 lbs. Occasionally 44-46 lbs.	YES
Elevated work occasionally	Elevated work continuously	YES
Climbing rarely to occasionally	Climbing (ladder) occasionally Climbing (stairs) frequently	YES
Handling continuously	Handling continuously	YES
Gripping light frequently to medium occasionally	Gripping continuously within normal limits (equal)	YES
Balance rarely to occasionally	Balance frequently	YES

RECOMMENDATIONS:
This constitutes a job match with the exception of the heavier weights and the amounts of forward bend. A safe job exists where these can be modified.

36. The Job Match Review indicates that there is a job match for all of the critical job demands save only the lifting of heavier weights (identified as "rarely" or "occasionally" which would have to be modified to a somewhat lighter weight and forward bending in standing ("occasionally to frequently") which would have to be modified from frequently to occasionally.

37. On December 2, 2010, the Worker and her spouse met with Ms. Gauthier (Occupational Therapist), Samantha Allen (Case Coordinator) and two Employer representatives to review the results of the FCE and FJA as reported by Ms. Handren.

38. On December 7, 2010, the Worker met with the two Employer representatives to assist in the development of the necessary job modifications for her position but only stayed a few minutes and then left abruptly without giving a reason (as apparently the Worker became upset during the meeting and may have been in some pain or discomfort.)

39. The Worker saw Dr. Magennis later that day and he placed the Worker off work until January 15, 2011, and reports, "ongoing chronic pain right hip region" and "patient is becoming more depressed due to pain and fear of returning to work".

40. The job modifications developed by the Employer's representatives were received by the Board on December 10, 2010.

41. The Employer's job modifications provided for the following:

    (a) the Worker would not be responsible for lifting compost bags;

    (b) the Worker would not be responsible for lifting anything over 12.5 lbs. with one hand, she would use two hands for any tasks that require lifting of that weight or above;

    (c) the Worker would not be responsible for cleaning the ovens;

    (d) the Worker would use a squeegee to eliminate the need to climb up on counters when cleaning windows;

    (e) the Worker would not be responsible to put away the grocery order;

    (f) the Worker would not be responsible to lift a full case of frozen vegetables.

42. On December 15, 2010 these job modifications were forwarded by Ms. Allen to Ms. Handren for review.

43. On December 16, 2010, the Worker was seen by Dr. D. R. Moore, a Psychiatrist, as recommended by Dr. Magennis.

44. Dr. Moore's report to Dr. Magennis dated January 23, 2011 states:

> She has been on various "pain killers" but since the re-injury she has been on light duties and for the last ten days has been off work completely with plans to be off for the next month. She has been on WCB coverage since

> Aug. 2010. I understand Dr. Magennis prescribed Lyrica for her in May 2010 which has improved her pain.
>
> In addition to the pain and limitations physically, she has been demoralized and depressed over her situation. She has felt somewhat better with the time off but when she refers to work in any way, she becomes tearful and upset as she recounts her difficulties in getting along with her supervisor and some of her co-workers due to their lack of concern for her well-being and snide comments about her injury. It seems that as long as she is not at work her mood is good.
>
> ...
>
> Her pain is worsened by her tendency to be sensitive to the comments and criticism of others at [the workplace]. At home she doesn't have pain which speaks for itself and may indicate some degree of secondary gain on her behalf. She is mildly depressed in mood but suffers from a high degree of anxiety.

45. Dr. Moore's letter to the Board of the same date further states:

> ... while the Worker appears to be much improved when out of the workplace and at home in terms of pain, she is still emotionally handicapped by her anxiety over the attitude of others towards her when she is there. The injury and re-injury of her back have set a series of events in motion that have prevented her from returning to work- these events include not only the physical injury she sustained but also the re-emergence of all sorts of childhood conflicts, fears and behaviours she had beforehand coped with prior to the injury. Her anxiety, as well as the back pain, in my opinion is all part of the injury and should be considered in the compensation package.

46. The Worker saw Dr. Magennis on December 22, 2010, and he reports, "chronic groin pain, improving since off work past 2 weeks; may require extended period off work; and, that he would like to speak to Dr. Steve O'Brien, the Board's Medical Advisor, regarding the Worker.

47. On December 30, 2010, Ms. Handren sent a letter to Dr. Magennis, which states:

> As you know, the Worker has recently participated in a Functional Capacity Evaluation here on November 3rd and 4th, 2010. A Functional Job Analysis of her existing position was also undertaken at that time so that a Job Match could be completed. The Job Match identified that a safe match existed with the exception of the heavier weights and the degree of forward bending required. As well, climbing was identified as problematic in particular to the job circumstances accessing kitchen windows and higher shelves.
>
> Following a Case Conference meeting, the specific modifications were undertaken by the employer to accommodate for these restrictions. With these modifications to the job tasks, a safe match is now identified to the position the Worker is currently working.

48. On January 5, 2011, Dr. O'Brien, (Board's Medical Advisor), provided the following medical opinion to Ms. Allen:

> As requested in your memo of December 22, 2010, I did speak to Dr. Terry Magennis, Family Physician, today, January 4, 2011, regarding the Worker. Dr. Magennis stated that when he initially made the request for me to discuss the Worker's case, he was concerned about her poor improvement, but on the last visit of December 22, 2010, he did notice that she was " a lot better" and hoped that this improvement would continue for his next assessment in mid-January.
>
> Dr. Magennis and I did discuss other treatment options available that may facilitate the Worker's functional improvement and did discuss a possible appointment with Dr. Edvin Koshi, Physiatrist in Halifax with special

> expertise in fluoroscopic injection techniques. I did note on the Functional Capacity Evaluation (FCE) form, page 3, date stamped received December 3, 2010, Valerie Handren, Physiotherapist, states, "On palpitation, the client has slight discomfort over the L5-S1 facet on the right, and slight discomfort on the ischial tuberosity on the right, with maximum pressure. S1 stress test positive for maximum flexion and compression forces." The facet and S1 joints would be areas that Dr. Koshi could consider treating if he felt on clinical examination that they were causally related to the Worker's pain state and restricted functionality.
>
> Dr. Magennis stated that he would review the Worker carefully at his next visit and if he felt she needed referral to Dr. Koshi, he would discuss this with her at that time.

49. The Worker saw Dr. Magennis on January 17, 2011, and he reports "chronic hip/pelvic pain" and requests facilitation of the Worker's referral to Dr. Koshi.

50. On January 21, 2011, a decision letter was sent by Ms. Allen (Case Coordinator) advising the Worker her claim would close for temporary wage loss benefits effective January 4, 2011, based on the determination that the she was a safe match for her pre-injury position with the modifications put in place by her employer.

51. The Worker saw Dr. Magennis on February 3, 2011, and he reports the Worker's condition as "chronic hip, pelvic pain, Lyrica not helping. "

52. Dr. Koshi saw the Worker on February 15, 2010, for assessment of her pain.

53. Dr. Koshi states:

> The Worker had difficulties explaining the location of her pain... The only pain location that was constant during the history and physical examination was the pain over the spinous processes of the lower lumbar and upper sacral vertebra.

...

At present, her pain is localized in the lower back area. She points to the spinous processes of the lower lumbar and the upper sacral vertebra. This pain is mostly in the center, although there is some pain spread to the side.

...
As the Worker was in a standing position, I asked her to show me where her pain was localized. She pointed to the spinous processes of the lower lumbar and the upper sacral vertebra. She pointed to the right Dimple of Venus. I told her that in the pain diagram, her pain was much more lateral, closer to the greater trochanter. She touched that area, but she could not identify any pain.

The lumbar spine range of motion was full in all directions. The movements were done very smoothly and without any significant pain distress. She touched the ground with ease. The passive hip and knee range of motion were full and pain free.

I performed the palpitation with the Worker in the left lateral decubitus position. I was unable to identify any tenderness in the lumbar paraspinal muscles or the muscles of the right gluteal area. There was no tenderness with palpitation of the Dimple of Venus, greater trochanter or the ischial tuberosity. There was a very mild tenderness with palpitation over the spinous processes of the lumbar and sacral vertebra. Once again, I asked the Worker to describe where the pain was localized as I was unable to find any areas of tenderness. She pointed to the attachment of the quadratus lumborum muscle at the posterior iliac crest. Again, I drew her attention to the fact that this was not the pain that she drew in the pain diagram or the pain she described when I examined her while she was standing. Then, she told me that she did not have any right buttock/groin pain today.

...

Based on today's history and physical examination, and the medical information available for my review, in my opinion the Worker's diagnosis as relates to the injury in question (May of 2010) is:

Temporary exacerbation of pre-existing mechanical low back pain

...

In general, the very high level of subjective complaints of pain and disability seem disproportionate to the physical examination findings, to the smoothness of the spontaneous movements, to the pain tolerance that she showed during today's encounter and to what I usually see in individuals with the same condition and with the same injuries.

Prognosis
The prognosis for returning to her pre-injury level is "good", if the Worker decides to do so. (my emphasis)
The majority of individuals with mechanical low back pain are able to return to their pre-injury occupation.
Temporary exacerbation of mechanical low back pain is common in both working and non working populations.
This is in keeping with the natural history of this condition.
Moreover the Functional Capacity Evaluation Testing showed that the Worker was able to perform her work activities. Literature tells us that Functional Capacity Testing does not measure the "real capacity" (what an individual can really do), but rather the "performance" (what an individual tells us that he or she can do). The research shows that the performance is lower than the real capacity/capability.

Finally, there are no medical restrictions based on risk that apply to the Worker's activities of daily living or work related activities. In other words, there is no literature to support the view that individuals with mechanical low back pain are going to harm themselves or put themselves at risk of tissue damage if they returned to work at any level. In fact, the literature shows that work is healthy for the spine and for the regeneration of the discs. The literature also shows that the majority of individuals with mechanical low back pain are able to return to work at least at a medium level full-time.

Treatment Recommendations
I do not suggest spinal injections for the Worker.

> I do not have any further recommendations for her pharmacological treatment. Her family physician has done a wonderful job trying her on all the reasonable medications we use for this type of pain. ...
>
> I do not suggest any ongoing physical therapy. The activities of daily living and work activities are the best physical therapy for the Worker.
> In my opinion she does not need any psychological treatment. A frank discussion, regarding the nature of her pain and the prognosis in individuals with mechanical low back pain, which is best done by her family physician, would suffice.
>
> ...
>
> Education is the best treatment intervention. I gave the Worker the good news that I could not find signs and symptoms in keeping with any nerve impingement, spinal stenosis, or any other sinister diagnosis that she should worry about. I told her that she has ordinary/mechanical low back pain, common in both working and non working populations. I told her that the majority of individuals with mechanical low back pain live a good and productive life and are able to return to a gainful activity at least at medium level. I told her that mechanical low back pain is a condition characterized by a baseline pain and periods of pain flare-ups, which occur despite an individuals' work status. I told her that in most cases the flare-ups get better in a matter of months, often without any specific treatment. I frankly told her that I do not have a medical explanation why she would be an exception to this rule.
>
> Finally, I explained to her the importance of keeping strong muscles in her back as one of the best treatments for her condition. I told her that 35 years of research has shown that movement is the best treatment for the condition that she has. I told her that at this stage of recovery hurt does not mean harm. I encouraged her to go back to work.

54. The Worker filed a Request for Internal Reconsideration on March 10, 2011, requesting reconsideration of the Board's decision of January 21, 2011, to close her claim.

55. This request was dismissed by the Board's IRO on March 22, 2011, as she determined that there was new evidence on the file that had not been previously considered by the Case Coordinator (Ms. Allen).

56. The new evidence consisted of Dr. Moore's consultation letter dated January 23, 2011, Dr. O'Brien's medical opinion dated February 3, 2011, and, Dr. Koshi's consultation letter dated February 15, 2011.

57. On March 30, 2011, Ms. Allen sent a decision letter to the Worker stating that the new evidence did not change her original decision to close the claim for temporary wage loss benefits effective January 4, 2011.

58. On May 12, 2011, the Worker filed a second Request for Reconsideration, requesting reconsideration of the March 30, 2011, decision of the Board.

59. On August 10, 2011, the Board's IRO issued a decision denying the Worker's reconsideration request, finding no evidence connecting the Worker's current hip and pelvic symptoms to the back injury which initiated the claim and that in weighing the evidence on file versus the Worker's subjective view that she is not a safe job match, that the evidence weighs more in favour that the Worker is a safe job match for her pre-injury position with the modifications provided by her employer.

60. The Worker subsequently filed a Notice of Appeal with the Workers Compensation Appeal Tribunal (WCAT) on September 8, 2011, of the IRO's decision of August 10, 2011.

ISSUE

61. The issue is whether the Worker is entitled to temporary wage loss benefits beyond January 4, 2011?

ANALYSIS AND DECISION

62. WCAT is bound by the *Workers Compensation Act* (the "Act") and Board Policy.

63. Pursuant to section 6(1) of the Act, the Board shall pay compensation to any worker who suffers "personal injury by accident arising out of and in the course of employment".

64. Section 40 of the Act states that wage loss benefits are payable where injury to a worker results in a loss of earning capacity.

65. In this case, there is no dispute that the Worker was injured by an accident arising out of and in the course of her employment, and that the injury resulted in a loss of earning capacity.

66. The issue arising in this appeal is whether or not the Worker's loss of earning capacity has ended?

67. It is the Worker's position that when all of the relevant evidence is weighed, the evidence supports the conclusion that the loss of her earning capacity continued beyond January 4, 2011.

68. Board Policy POL 68,Weighing of Evidence, states in part:

3. The standard of proof for decisions made under the Act is the balance of probabilities- a degree of proof which is more probable than not.

4. Decision makers must assess and weigh all relevant evidence. Conflicting evidence must be weighed to determine whether it weighs more toward one possibility than another. Where the evidence weighs more in one direction then that shall determine the issue.

69. After considering the evidence and the submissions of the Worker's Advisor and the Board's solicitor, this Panel finds, on the balance of probabilities, that the Worker's condition/injury whether medically described by Dr. Magennis as back, groin, leg, hip or pelvic pain/symptoms or a combination thereof was a recurrence of the Worker's earlier work related injury.

70. This Panel also finds, on the balance of probabilities, that the Worker's loss of earning capacity has ended and that the Worker is not entitled to temporary wage loss benefits beyond January 4, 2011.

71. The Functional Capacity Evaluation (FCE) completed by Ms. Handren, a physiotherapist trained in the area, indicated that the Worker's pre-injury position was a safe job match for the Worker with the exception of making certain modifications to her job duties relating to heavier weights, the degree of forward bending, and climbing.

72. These job modifications were developed by the Worker's Employer and approved by Ms. Handren.

73. It is unfortunate that the Worker left the meeting when the job modifications were discussed and developed by the Employer's representatives.

74. Presumably, the Worker could have assisted the Employer representatives to a greater extent in this regard, if she had stayed for the entire meeting.

75. The specific job modifications submitted by the Employer should not be viewed as rigid or close ended.

76. If further modifications/restrictions were proven necessary, they could/would probably be made by the Employer.

77. Further, the Panel finds Dr. Koshi's assessment of the Worker's condition "ordinary/mechanical low back pain", his good prognosis "for her returning to her pre-injury level", and his encouragement for her "to go back to work," persuasive.

78. Accordingly, the Worker's appeal is dismissed.

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

Dated this 28th day of May, 2012.

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

Concurred:

Donald Turner, Employer Representative

Libba Mobbs, Worker Representative