2016 ONWSIAT 3235
Ontario Workplace Safety and Insurance Appeals Tribunal

Decision No. 2870/16

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DECISION NO. 2870/16

S. Netten V-Chair

Heard: November 3, 2016
Judgment: November 28, 2016
Docket: 2870/16

Counsel: H.K., for Worker
No one for Employer

Subject: Employment; Occupational Health and Safety; Public

Headnote
Labour and employment law

***S. Netten V-Chair*:**

(i) Issue

1 The issue under appeal is the worker's entitlement to a redetermination of the non-economic loss (NEL) award for her left knee, rated at 17% in 2001.

(ii) Overview

2 On August 18, 1998, the worker, who was an airline services representative, caught her foot in a blue box and fell off her chair, twisting her left knee and hurting her left forearm. While the initial diagnosis was a left medial collateral ligament (MCL) strain, subsequent diagnoses included a torn or damaged meniscus and chondromalacia/patellofemoral syndrome. The Board recognized a permanent impairment, with maximum medical recovery on February 18, 1999, and referred the worker for a NEL assessment. The 17% NEL award of January 23, 2001 recognized a torn or degenerated meniscus, chondromalacia patella, collateral ligament loss with moderate instability, and loss of range of motion.

3 In the meantime, on May 15, 2000, an Adjudicator had denied entitlement to the right leg, hip or knee as secondary conditions in this claim. The worker advised on June 28, 2000 that she would be considering an appeal of that decision but no further action was taken at the time. Following the submission of a medical opinion in December 2009, a Case Manager confirmed the denial of entitlement for the right hip and right knee, as well as the low back, on October 5, 2010. The worker completed Intent to Appeal and Access Request forms in August 2011. She was sent the file and an Objection Form on August 31, 2011, but it appears that the Objection Form was never submitted and as such the appeal did not proceed.

4 The worker requested a NEL redetermination for her left knee in February 2012; this was denied in March 2012. Another request, in September 2014, led to a confirmation of the denial of entitlement to a NEL redetermination, in December 2014. The worker's objection was referred to the appeals branch. On February 27, 2015 a Secondary Entitlement Case Manager confirmed the NEL redetermination decision and also stated, "Regarding the other areas of

entitlement which you have raised, you are directed to contact the Case Manager directly." The worker does not appear to have done so.

5 On July 6, 2015, an Appeals Resolution Officer (ARO) wrote, "the issue of secondary entitlement has not been referred to the Appeals Services Division, and therefore, I will make no finding regarding this issue." On the sole issue of entitlement to a NEL redetermination, the ARO denied the worker's objection, due to a lack of evidence placing the worker below her 17% NEL rating.

6 The worker now appeals the ARO decision to the Tribunal. This appeal was selected for a written hearing pursuant to the Tribunal's *Practice Direction: Written Appeals*. The worker's representative provided written submissions and updated medical reports on July 17, 2016.

(iii) Law and policy

7 The *Workplace Safety and Insurance Act*, 1997 ("WSIA") applies to this appeal. All statutory references in this decision are to the WSIA, as amended, unless otherwise stated.

8 Section 46 grants compensation for non-economic loss when a worker suffers permanent impairment as a result of a compensable injury. The amount of the NEL award is calculated based upon the degree of the worker's permanent impairment, expressed as a percentage of total impairment. The degree of permanent impairment is determined in accordance with the prescribed rating schedule, which is the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 3rd edition (revised) ("the AMA Guides").

9 Pursuant to section 47(9), a worker may request a redetermination of the degree of permanent impairment if, at least one year later, he or she has suffered a significant deterioration of the permanent condition.

10 Section 126 requires the Tribunal to apply Board policy when making its decisions. Board policy on NEL redeterminations (*Operational Policy Manual* (OPM) Document No. 18-05-09) defines significant deterioration as "a marked degree of deterioration in the work-related impairment that is demonstrated by a measurable change in the clinical findings." Decision-makers are directed to compare the most recent medical findings with the clinical condition at the time of the last NEL determination. Once a significant deterioration is confirmed, decision-makers must confirm that it is work-related. If a "non-work-related factor is found to have caused the deterioration, there is no entitlement to a NEL redetermination."

11 The standard of proof applicable in workers' compensation proceedings is the balance of probabilities. Pursuant to section 124(2), the benefit of the doubt is given to the claimant in resolving an issue where the evidence for and against is approximately equal in weight.

(iv) Entitlement to conditions other than the left knee

12 Pursuant to section 123 of the WSIA, the Tribunal's jurisdiction is limited to deciding appeals from final, *i.e.*, appeals branch or ARO, decisions of the Board. Accordingly, the sole issue presently within my jurisdiction is the worker's entitlement to a NEL redetermination for the left knee impairment. I cannot consider any other areas of injury, or non-organic conditions, in this appeal.

13 The worker's objection to the operating-level decisions which denied entitlement to the right knee, right hip and back, remains outstanding at the Board. If the worker wishes to pursue such entitlement, she (or her representative) should contact the Board to reactivate her appeal to the Board's appeals branch.

14 In September 2014, the worker wrote to the Board about her additional impairments, noting depression and other psychological concerns. In the present appeal to the Tribunal, the worker's representative's submissions make reference to the categories of impairment found in Board policy titled "Assessing Permanent Impairment Due to Mental

and Behavioural Disorders" (OPM Document No. 18-05-11); this policy contains a NEL rating scale for non-organic conditions such as chronic pain disability and psychological impairments. If the worker wishes to pursue entitlement to a non-organic condition, she (or her representative) must request such entitlement from the Board in the first instance.

(v) Entitlement to a NEL redetermination for the left knee

15 As indicated, this decision addresses only the worker's entitlement to a NEL redetermination; this requires a marked degree of deterioration in the compensable left knee condition, demonstrated by a measurable change in the clinical findings.

16 Under the AMA Guides, the degree of knee impairment is primarily based upon reduced range of motion, as representative of knee function. In addition, ratings are provided for specific knee disorders if applicable, including patellectomy or patella replacement (5-15%); torn meniscus, meniscectomy or partial meniscectomy (0-10%); knee replacement (20%); arthritis or chondromalacia (0-20% according to deformity); cruciate ligament loss (0-15%); collateral ligament loss (10% moderate instability, 20% marked instability); and post-traumatic deformities (10%).

17 The worker was assessed for NEL purposes by Dr. O. Mandel on September 1, 2000. At that time, the worker had pain and stiffness in the left knee, required medications including Tylenol #2 and Celebrex, and reported constant "squeezing/pull pain" ranging in intensity from mild to severe. She was able to flex the knee to 80° and extend to neutral (0°).

18 The worker's 17% NEL rating of January 23, 2001, consisted of the following:

- 25% for reduced range of motion: flexion to 80°, extension to 0°
- 5% for torn medial meniscus or meniscal degeneration in the left knee
- 10% for Grade 2 chondromalacia
- 10% for collateral ligament loss with moderate instability

19 As required by the AMA Guides, the above four percentage ratings were combined (not added) using the Combined Values Chart, resulting in a 43% impairment of the left lower extremity. Pursuant to Table 46 of the AMA Guides ("Relationship of Impairment of the Lower Extremity to Impairment of the Whole Person"), a 43% knee impairment is equivalent to a 17% impairment of the whole person. The worker was granted a 17% NEL award on January 25, 2001.

20 The worker first requested a NEL redetermination in February 2012.

21 On February 15, 2012, orthopedic surgeon Dr. H. Nourhosseini assessed worsening symptoms in the worker's *right* knee, which had required arthroscopic surgery in 2010, as well as the low back. While Dr. Nourhosseini indicated that the worker would eventually require surgery on the left knee, he did not provide any change of diagnosis, referring only to the previous meniscal tear. The worker's knee flexion at that time, to 130°, reflected an improvement in comparison to the NEL rating of 2001.

22 Similarly, family physician Dr. S. Dammerman's report of February 17, 2012 outlined left knee flexion to 130°, full extension, stable ligaments, meniscal instability due to the tear and degeneration, and chronic chondromalacia patella (damage to the cartilage behind the kneecap). These objective findings are all consistent with the findings upon which the 17% NEL rating was based in 2001, with improved range of motion. While Dr. Dammerman stated that there had been progression of the left knee meniscal disease, the imaging of the medial meniscus on MRI was virtually identical in August 2011 and November 1998: both MRIs illustrate "intrasubstance degeneration of the medial meniscus" without a meniscal tear. Moreover, the worker has already received a 5% NEL rating for the medial meniscus, consistent with a meniscal tear without a meniscectomy.

23 I note that there was the possibility of a tiny radial tear of the lateral meniscus in the 2011 MRI (apparently confirmed as a small tear in 2016). However, the worker did not injure the lateral meniscus in the 1998 injury, and I find no evidence to suggest the small lateral meniscus tear was associated with the initial injury or the medical meniscus tear. The Medical Discussion Paper titled *Knee Conditions and Disability* [1] indicates that degenerative meniscal tears are "found on a high percentage (up to 90%) of MRIs in people with known osteoarthritis of the knee", and are unrelated to a history of trauma.

24 Subsequently, on October 16, 2014, Dr. Dammerman wrote:

> From an objective perspective her right knee continues to show mild to moderate effusion, and she favours it when she walks. Gait is antalgic, and loss of cartilage in both knees makes her bow legged... There is extensive bone on bone crepitation from the kneecaps bilaterally with squatting.
>
> Subjectively [the worker] reports a progressive decline in all aspects of mobility, as well as a steady worsening of her arthritic and non-arthritic pain... Based on her relatively young age and lack of any significant family history of degenerative arthritis I feel this condition is all related to her original workplace injury, not age-related deterioration.

25 Following a specific request from the Board, Dr. Dammerman provided range of motion measurements on December 9, 2014: 88° of flexion and 2° of extension. While considerably worse than in 2012, this level of mobility is still better than the range of motion when last assessed for NEL purposes, in 2000.

26 Most recently, Dr. Dammerman provided a detailed report on April 19, 2016 which again discussed the relationship between the left knee injury and other areas of concern. As emphasized above, I can only consider deterioration of the left knee in this appeal. Dr. Dammerman summarized the recent MRI findings, which included mild degenerative changes in 2011 and tricompartmental osteoarthritic changes in 2016. He wrote that the MRI findings in 2011 and 2016 were essentially the same as in 1998, "with expected, age-related arthritic changes." He was unable to say "whether this progression is simply due to the passage of time or as a direct result of her accident." The worker was 48 in 2011 and 54 in 2016.

27 On July 8, 2016, Dr. Nourhosseini diagnosed "significant arthrosis" of the left knee and a meniscal tear and chondrosis of the right knee; it is unclear whether his other findings related to the left or right knee. Dr. Nourhosseini also indicated that the worker would eventually require a total knee replacement due to the severity of arthritis. Dr. Nourhosseini wrote, "because of the injury she has extensive progress [sic] of osteoarthritis", without any further explanation. The worker had been his patient only since 2011.

28 In the above-cited Medical Discussion Paper, Dr. Cameron describes primary knee osteoarthritis as age-related with a slow progression of symptoms. Secondary osteoarthritis can occur secondary to trauma such as a joint fracture or recurrent ligament instability, generally associated with a ligament tear. Here, while the worker was initially diagnosed with a ligament sprain, there was no ligament tear nor was a substantial ligament injury confirmed, and there was no joint fracture. The worker had "tricompartmental osteoarthritic change" in 2016, at the age of 54 when osteoarthritis is common and expected.

29 On the evidence before me, it appears that the worker now has overlapping diagnoses of chronic chondromalacia patella and, more generally, tricompartmental osteoarthritis, both of which may involve breakdown of cartilage. To the extent that the osteoarthritis throughout the left knee can be distinguished from the chondromalacia, I find this to be, on a balance of probabilities, non-compensable primary osteoarthritis. In this respect, I note the worker's age, bilateral pathology, the absence of a joint fracture or major ligament injury, and the lack of a fulsome medical explanation to support post-traumatic osteoarthritis generally.

30 However, while the worker does not have entitlement for osteoarthritis throughout the left knee, the Board previously determined that the compensable permanent impairment included chondromalacia patella. In February 1999,

orthopedic surgeon Dr. R. Bull diagnosed second degree chondromalacia and orthopedic surgeon Dr. M. Ford provided a similar diagnosis of patellofemoral syndrome. Dr. Dammerman reiterated the diagnosis of chronic chondromalacia patella in 2012 and, in 2014, he described loss of cartilage and bone on bone crepitation from the kneecap. On the basis of this recent clinical description, specific to the kneecap area, I find it more likely than not that the worker has experienced a progression of her compensable chondromalacia patella. There is, in my view, a measurable change in the clinical findings with respect to the worker's chondromalacia patella and a significant deterioration in that aspect of her compensable condition. On this basis, the worker is entitled to a NEL redetermination of the left knee.

31 As outlined above, the evidence does not establish a deterioration in the other aspects of the worker's compensable knee condition.

32 For the worker's information, the NEL redetermination will be conducted by the Board, within the constraints of the AMA Guides (see paragraph 16, above). An impairment rating within one of the classes of the Mental and Behavioural Disorders Rating Scale, proposed by the worker's representative, cannot be considered for an organic knee impairment.

DISPOSITION

33 The appeal is allowed. The worker is entitled to a NEL redetermination for the left knee, on the basis of deterioration of her compensable chondromalacia patella.

Footnotes

1 Prepared by orthopedic surgeon Dr. J. Cameron in August 2013, and included in the case materials for this appeal

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