WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 3163/16

BEFORE:	K. Iima	: Vice-Chair
	J. Blogg	: Member Representative of Employers
	K. Hoskin	: Member Representative of Workers

HEARING: December 5, 2016 at Toronto
Oral

DATE OF DECISION: March 8, 2017

NEUTRAL CITATION: 2017 ONWSIAT 710

DECISION(S) UNDER APPEAL: WSIB Appeals Resolution Officer (ARO) decision dated September 27, 2013

APPEARANCES:

For the worker:	M.S. Grossman, Lawyer
For the employer:	Not participating
Interpreter:	Not applicable

REASONS

(i) Issues

[1] The issues arising from the worker's appeal of an Appeals Resolution Officer (ARO) decision, dated September 27, 2013, are as follows:

- ongoing entitlement for organic injuries as a result of the workplace accident on November 19, 2008;
- entitlement for the October 11, 2010 motor vehicle accident (MVA) as related to the compensable work injury;
- entitlement to benefits for chronic pain disability (CPD); and,
- entitlement to loss of earnings (LOE) benefits beyond April 30, 2010.

(ii) Background

[2] The following are the basic facts.

[3] The worker was employed as a screening officer at an airport. On November 19, 2008, she slipped on ice and fell. The Workplace Safety and Insurance Board (WSIB or the Board) allowed entitlement for soft tissue injuries to the head, left elbow, and a low back and neck strain. The worker returned to modified work duties at reduced hours on February 23, 2009, starting at two days per week. She was unable to increase her work hours beyond three days a week, eight hours per day.

[4] In June 2009, the worker was assessed at a Regional Evaluation Centre (REC) by a physiatrist and chiropractor. The diagnosis was a cervical and lumbar spine strain/sprain; the worker was considered to be partially recovered at that time, with a full recovery anticipated in four to six weeks. The REC assessment team recommended a work conditioning program for four to six weeks depending on the worker's progress, following which she would be considered able to reintegrate to full duties.

[5] Due to the worker's limited improvement and preference for passive massage therapy, Board Medical Consultant, Dr. R. Preobrazenski, recommended participation in a Progressive Goal Attainment Program (PGAP). The worker attended the program from January to April 2010. As part of the PGAP, the occupational therapist conducted a worksite visit and concluded that the worker demonstrated the physical ability to return to work full-time and would benefit from a graduated return to work plan. The worker declined to participate in the plan and continued to work three days per week.

[6] On October 10, 2010, the worker reportedly became dizzy while driving and struck a parked car and hydro box. The worker's family doctor reported that the worker had sustained a number of injuries as a result of the single car motor vehicle accident (MVA) including multiple soft tissue injuries to the neck and low back, and an exacerbation of anxiety and depression. The worker has not returned to work in any capacity since that time.

[7] In the ARO decision under appeal, the ARO concluded that: the worker had no remaining organic impairments or entitlement for CPD; the MVA was not related to the work accident; and

there was no further entitlement to LOE benefits beyond April 30, 2010. The worker now appeals these issues to the Tribunal.

(iii) Law and policy

[8] Since the worker was injured in 2008, the *Workplace Safety and Insurance Act, 1997* (the WSIA) is applicable to this appeal. All statutory references in this decision are to the WSIA, as amended, unless otherwise stated.

[9] Tribunal jurisprudence applies the test of significant contribution to questions of causation. A significant contributing factor is one of considerable effect or importance. It need not be the sole contributing factor. See, for example, *Decision No. 280*. The standard of proof in workers' compensation proceedings is the balance of probabilities.

[10] Pursuant to section 126 of the WSIA, the Board has identified certain policies as applicable to this appeal. We have considered these policies as necessary in deciding the issues in this appeal, as set out in the analysis below.

(iv) Analysis

(a) Ongoing entitlement for the head, neck, left shoulder, arm and elbow, left leg and low back

[11] As noted above, the Board accepted entitlement for soft tissue injuries to the head, left elbow, low back and neck. In a decision dated November 10, 2010, the Case Manager clarified that entitlement to the areas of the left shoulder and arm, left hip, right wrist, foot problems, leg length, panic attacks, and depression had not been accepted by the Board. At the appeals level of the Board, the ARO noted that the worker was seeking entitlement to ongoing problems with her head, left elbow, low back, neck, left shoulder/arm and legs, as a result of her slip and fall at work on November 19, 2008. The ARO found that there was "no pathology in the back, the neck or the head that would suggest an organic deficit in any way" and concluded that the worker did not have any remaining organic impairments. Thus, there is no indication before us that the worker's entitlement in this claim had been extended to include the left shoulder and arm or left leg, or that the ARO had considered initial entitlement to these areas. Accordingly, the Panel's jurisdiction on this issue is limited to a determination of ongoing entitlement for the specific areas of the head, neck, left elbow, and low back.

[12] Following the worker's accident on November 19, 2008, the worker had two CT scans of her head which revealed normal findings. The worker was subsequently referred to a neurologist who confirmed that her CT scans were "unremarkable." Although Dr. S.W. McKenzie observed some pupillary asymmetry, the neurologist opined that it was a benign form of anisocoria. The neurologic exam showed normal findings and there was no evidence to suggest intracranial pressure or damage to the 3rd cranial nerve.

[13] The medical record indicates the worker continued to complain of intermittent headaches and some dizziness. However, we note there are no organic findings or objective medical opinions before us to support a conclusion that these complaints were causally related to the workplace accident on November 19, 2008. Indeed, the only medical opinion which directly links the worker's various complaints to her accident in November 2008 is the worker's family physician, Dr. S. Gideon. However, the Panel does not place significant weight on the opinion

of Dr. Gideon due to our concerns regarding the objectivity and reliability of her reports. In reaching this conclusion, we have taken the following into account:

- As documented in Dr. Gideon's clinical note of September 27, 2010, the worker had sought medical attention due to symptoms of illness, including a cough and increased fatigue. In a subsequent entry dated October 12, 2010, Dr. Gideon noted the worker had been in a MVA when she hit a car parked in a driveway and a hydro box; both air bags had been deployed and it was thought the worker might have pressed the gas pedal instead of the brakes. On examination of the worker, Dr. Gideon noted that the worker's left ear was "red + +." In an entry dated October 25, 2010, Dr. Gideon wrote "note re MVA 2nd to (L) inner ear infec.; (L) ear still red, finished Cefzil[1] on Sat., 80% better;"
- Dr. Gideon later appeared to retract her statement that the worker's MVA was secondary to her left inner ear infection in correspondence dated December 20, 2011, indicating:

  > [The worker] complained of dizziness and fatigue post-fall but the dizziness became clarified as vertigo + her repetitive neck movements. She did see Dr. Wade – ENT – notes enclosed. I am uncertain if her MVA was related to ear infection or her vertigo from head injury. She was unaware of any cold symptoms then.

- The report of Dr. P.S. Wade, otolaryngologist, dated February 14, 2011, confirms however that the worker did not have vertigo. The vestibular test report, auditory brainstem evoked potentials report, and audiological assessment all reported normal findings.
- The case materials also contain two medical forms completed by Dr. Gideon in support of the worker's application for accident benefits as a result of the MVA. In Part 5 of the Treatment Confirmation Form (OCF-23) dated November 11, 2010, Dr. Gideon listed the following as "injuries and sequelae that are the direct result of the automobile accident:"
  - Chemical burns to (L) side of face and chin
  - Bruising to (L) breast
  - Multiple soft tissue injuries to neck and low back
  - Exacerbation of anxiety and depression

  In response to the question of whether the worker had any disease, condition or injury prior to the accident that could affect her response to treatment for injuries identified in Part 5, Dr. Gideon clearly indicated "No."
- The Disability Certificate (OCF-3) completed by Dr. Gideon on December 16, 2011 provided the following list of injuries and sequelae that were the direct result of the automobile accident:
  - Severe bilateral trap. spasms + bil. paracervical + bil. periscapular; whiplash → headaches
  - Vertigo – improving + her [what appears to read "comtions"]
  - Bilateral paralumbar strain
  - Fibromyalgia
  - Aggravation of anxiety and depression

[1] An antibiotic commonly prescribed to treat bacterial infections, including inner ear infections.

Under Part 6 of the form, Dr. Gideon reported that the symptoms first appeared on October 11, 2010. According to the family doctor, the worker:

- was substantially unable to perform the essential tasks of her employment as a result of the accident and within 104 weeks of the accident;
- was unable to return to work on modified hours and/or duties;
- had suffered a complete inability to carry on a normal life;
- had suffered a substantial inability to engage in caregiving activities in which she was engaged at the time of the accident; and
- had suffered a substantial inability to perform the housekeeping and home maintenance services that she normally performed before the accident.

No explanation was provided as to why the worker was likely to be completely disabled for more than 12 weeks.

- In Part 8 of the Disability Certificate, Dr. Gideon again unequivocally indicated that prior to the accident, the worker did not have any disease, condition or injury that affected her ability to perform the activities listed in Part 6 (above). Dr. Gideon noted that the worker had been "working 3 days/wk due to a WSIB injury – no problems + home chores, etc."

[14] Thus, based on the medical forms completed by Dr. Gideon for the purposes of the worker's application for accident benefits, it would appear that the doctor considered the worker to have recovered from her compensable head, neck, and low back soft tissue injuries. This is evidenced by her statements that prior to the MVA, the worker did not have any disease, condition or injury that could affect her response to treatment for soft tissue injuries to neck and low back, and exacerbation of anxiety and depression, or that had affected her ability to perform the essential duties of her job, caregiving duties, housekeeping and home maintenance activities. As reported by Dr. Gideon, prior to the MVA, the worker had no problems working three days per week or performing home chores. However, following the MVA, the worker had suffered a complete inability to carry on a normal life, and was substantially unable to perform the essential tasks of her employment, engage in caregiving activities, and perform housekeeping and home maintenance activities.

[15] The Panel also finds it concerning that Dr. Gideon reported the worker had developed vertigo and fibromyalgia as direct results of the automobile accident. In that regard, we note there is no persuasive evidence before us that the worker has or had vertigo. As discussed above, Dr. Wade, a specialist in otolaryngology, confirmed that the worker did not have vertigo. There are no other medical reports on file (i.e., other than references made by Dr. Gideon) which indicate otherwise. Given Dr. Wade's specialized expertise in otolaryngology, we prefer his opinion and accept that the worker did not have vertigo. We also note that in other medical reports on file (i.e., those not pertaining to MVA benefits) Dr. Gideon suggests that the worker's alleged vertigo was causally related to her workplace accident. In a report solicited by the worker's representative dated April 15, 2014, Dr. Gideon stated:

> Since that [workplace] injury, [the worker] has suffered from vertigo, headaches, neck pains, back pains, increasing depression and anxiety due to her delayed recovery and continued disability and pains. As a result of her vertigo made worse by an ear infection, she was involved in an accident on October 10, 2010. This made her regress in her recovery and aggravated her symptoms of neck, low back pains and vertigo as well as the depressive elements. She was diffusely achy and was diagnosed with fibromyalgia.

[16] In our view, there is also no persuasive evidence before us that the worker has or had fibromyalgia. In clinical notes dated May 26, 2010 and July 7, 2010, Dr. Gideon queried whether the worker has fibromyalgia and indicated "consider Dr. Prutis." However, no medical reports from Dr. Prutis appear in the case materials before us. In addition to the fact that these clinical notes predate the MVA, the Panel notes that there is no objective medical opinion on file which indicates the worker has fibromyalgia. Notably, the Independent Medical Examination report of physiatrist Dr. J.D. Heitzner, dated April 18, 2012, provided physical examination findings, which included:

> On palpation, [the worker] had tenderness to her hips, knees, elbows and wrists while sitting, but in lying position, no pain was reported. She initially had 18/18 Fibromyalgia tender points but it was not consistent upon retesting with distraction.
>
> [The worker] had a high perceived level of disability, pain behavior, self-restricted range of motion and inconsistency on physical examination.
>
> **ANSWERS TO SPECIFIC QUESTIONS:**
>
> **1. What (if any) impairments did [the worker] suffer as a result of the motor vehicle accident?**
>
> ….
>
> She currently has only mild decreased range of motion to her cervical, thoracic and lumbar spine as well as her bilateral shoulders but it must be pointed out that she has a high perceived level of disability, pain behavior and self-restricted range of motion which affects her true level of functioning. She did have 18/18 Fibromyalgia tender points but upon distraction and retesting this was not the case. It is hard to determine if she does in fact have a diagnosis Fibromyalgia given her inconsistency and symptom magnification.
>
> ….

[17] Thus, based on the preponderance of medical evidence, the Panel finds that there is no ongoing entitlement for the head, left elbow, neck and low back. The worker had sustained soft tissue injuries, as confirmed by diagnostic imaging and treating health care practitioners. By April 2009, the worker had reported an improvement in the severity of her headaches, although she continued to complain of low back pain. At the REC assessment in June 2009, the worker reported constant pain in her low back and left side of her neck, and intermittent left elbow pain which she felt came from her neck. The work-related diagnoses were cervical spine strain and lumbar spine strain. While the Panel accepts that the worker experienced some pain, we find it significant that medical reports from various assessors and health practitioners (other than the family doctor) had noted the presence of significant pain behaviours, symptom magnification, and the worker's self-perception of being severely disabled. For reasons we have described above, the Panel places little weight on the reports of Dr. Gideon. We also find it significant that in the initial assessment of the worker's condition following her MVA, the worker had reported that the onset of her symptoms and their progression, including headaches, neck and low back pain, began after her car accident. The assessment report noted that according to the worker, she had been active in recreational activities prior to the accident, but was unable to participate in these activities after the accident. The worker's past history in respect of her reported symptoms resulting from the MVA was noted to be "unremarkable" and the worker had denied any prior similar musculoskeletal injuries. Given the apparent inconsistencies in the worker's reported onset of headaches, neck and low back pain, and the lack of objective medical evidence to

support ongoing organic injuries to the head, neck, left elbow, and low back, the Panel concludes the worker does not have ongoing entitlement for any compensable organic injuries.

(b) Entitlement for the October 11, 2010 MVA as related to the compensable work injury

[18] The clinical notes of Dr. Gideon contemporaneous to the worker's MVA clearly indicate that the car accident was secondary to her left inner ear infection. In our view, this would be consistent with the fact that the worker had sought medical treatment due to illness approximately two weeks before the accident. While Dr. Gideon reported over a year later in December 2011 that she was no longer certain whether the worker's MVA was related to the ear infection or to vertigo from the head injury, the Panel prefers the doctor's initial assessment as it was made contemporaneous to the accident and was not solicited by the worker's representative or by the worker in support of her claim for accident benefits. Moreover, given the Panel's earlier finding that the worker did not have vertigo, as confirmed by Dr. Wade, we find that the worker's MVA was more likely than not related to the ear infection. We are not persuaded that the worker was "unaware of any cold symptoms then," as suggested by Dr. Gideon, since the worker had recently sought medical treatment for cold or flu-type symptoms. Accordingly, the Panel finds that the workplace accident was not a significant contributing factor to the worker's October 11, 2010 motor vehicle accident.

(c) Entitlement for chronic pain disability

[19] *Operational Policy Manual* (OPM) Document No. 15-04-03 "Chronic Pain Disability" sets out five criteria to assist adjudicators in determining entitlement for CPD. For a worker to qualify for compensation for CPD, all of the following conditions must exist, and must be supported by the evidence:

Condition	Evidence
A work-related injury occurred.	A claim for compensation for an injury has been submitted and accepted.
Chronic pain is caused by the injury.	Subjective or objective medical or non-medical evidence of the worker's continuous, consistent and genuine pain since the time of the injury, AND a medical opinion that the characteristics of the worker's pain (except for its persistence and/or its severity) are compatible with the worker's injury, and are such that the physician concludes that the pain resulted from the injury.
The pain persists 6 or more months beyond the usual healing time of the injury.	Medical opinion of the usual healing time of the injury, the worker's pre-accident health status, and the treatments received, AND subjective or objective medical or non-medical evidence of the worker's continuous, consistent and genuine pain for 6 or more months beyond the usual healing time for the injury.

Condition	**Evidence**
The degree of pain is inconsistent with organic findings.	Medical opinion which indicates the inconsistency.
The chronic pain impairs earning capacity.	Subjective evidence supported by medical or other substantial objective evidence that shows the persistent effects of the chronic pain in terms of consistent and marked life disruption.

[20] In this case, the Panel is unable to conclude that the worker has entitlement for CPD because in our view, the evidence does not support a finding that the worker's pain has been continuous, consistent and genuine. As described above, the various medical reports on file from health practitioners who examined and/or treated the worker, and assessments commissioned by the automobile insurance company noted the presence of significant pain behaviours, symptom magnification, and the worker's self-perception of being severely disabled. These reports include:

- the REC report which noted the worker's significant pain behaviours;
- the reports of physiotherapist, J. Sheridan, documented the worker's chronic pain behaviours, inconsistencies between her subjective reporting and objective measurements, and the worker's effort during the active rehabilitation program was described as "sub-maximal at best;"
- the PGAP's assessment of the worker as perceiving herself to be severely restricted in social and recreational activities, although somewhat less disabled with respect to occupational activities;
- the Functional Abilities Evaluation in February 2012, requested by the insurance company, revealed "a guarded and self-limited individual;" the results of the functional testing were not believed to be representative of the worker's true functional tolerance;
- the Independent Medical Examination by physiatrist, Dr. Heitzner, in April 2012 reported that the worker had a high perceived level of disability, pain behaviour, symptom magnification, self-restricted range of motion which affects her true level of functioning, and inconsistency on physical examination.

[21] We also note that the consensus among these health/medical professionals, including the REC physiatrist, treating physiotherapist, PGAP occupational therapist, and specialists commissioned by the insurance company to examine the worker (such as a physiatrist, orthopaedic surgeon, neurologist, and psychologist) was that the worker had the ability to return to her pre-injury job as a screening officer.

[22] As stipulated in Board policy on CPD, all five conditions set out therein must exist and be supported by evidence in order for entitlement to be allowed. Since the worker does not meet all of the criteria set out in the applicable Board policy, the Panel concludes that the worker does not have entitlement for chronic pain disability.

(d) Entitlement to LOE benefits beyond April 30, 2010

[23] Pursuant to section 43 of the WSIA, a worker is entitled to LOE benefits when there is a loss of earnings that result from the injury. In this case, the Panel has found the MVA was not causally related to the compensable work injury, and that the worker does not have ongoing entitlement for organic injuries or entitlement for CPD. Moreover, with the exception of the worker's family doctor, there is consensus among the health/medical professionals who have examined and/or treated the worker both prior to and following the MVA that she has the ability to return to her pre-injury job on a full-time basis.

[24] As part of the PGAP, the occupational therapist conducted a worksite visit on April 8, 2010 and concluded that the worker demonstrated the physical ability to return to full-time hours as a screening officer. While the occupational therapist recommended at the time that the worker avoid the screening position of scanning passengers due to a reported increase in low back pain with bending and low level positions, the employer had confirmed that the worker was not required to rotate to all positions and was allowed to complete only those she felt comfortable completing. In a report dated April 25, 2010, the occupation therapist provided her worksite observations, including the following:

> While observing the worker during the work visit, details were obtained regarding the various job positions that she is responsible for and through which she is scheduled to alternate/rotate very 15-20 minutes. There are 5 positions available to the workers including: 1) standing and checking boarding passes; 2) scanning passengers as they walk through the scanner; 3) sitting/standing at the x-ray machine and analyzing contents of bags; 4) standing at the EDT machine and taking swabs of bags as required; and 5) searching bags that are coming off the conveyor belt. [The worker] is currently not completing the scanning position as a result of restrictions with bending due to reports of increased pain with this position. According to her employer and Ms. P. of WSIB, [the worker] is not required to rotate to all positions and has been allowed to complete only those that she feels comfortable completing.
>
> During the worksite visit, [the worker] was observed to be checking boarding passes and searching bags, without difficulty. She was noted to be able to stand against the wall during the less busy times to rest as required.
>
> ….

[25] The Panel accepts the opinion of the PGAP occupational therapist that the worker had the ability to return to her pre-injury job on a full-time basis. We find this assessment to be a reliable indicator of the worker's functional ability, noting that it was made following the worker's completion of the PGAP over the course of 10 separate sessions and the occupational therapist's worksite visit and job demands analysis. We are also satisfied that the employer was able to accommodate the recommendations of the occupational therapist for a graduated return to full-time duties at no wage loss. As discussed above, the Panel is not persuaded by Dr. Gideon's view that the worker was only capable of part-time employment following completion of the PGAP in April 2010. The medical notes provided by Dr. Gideon do not provide any objective findings to support her opinion and the worker's absences from work are indicated as "due to/for medical reasons" only.

[26] As a result, for the reasons set out above, the Panel finds that the worker's loss of earnings beyond April 30, 2010 flowed from the worker's self-perceived inability to return to work full-time rather than her work-related injuries. Accordingly, we find that the worker is not entitled to LOE benefits beyond April 30, 2010.

DISPOSITION

[27] The appeal is denied. The worker does not have ongoing entitlement for any compensable organic injuries, or entitlement for the October 11, 2010 motor vehicle accident benefits under the Board's CPD policy, or LOE benefits beyond April 30, 2010.

DATED: March 8, 2017

SIGNED: K. Iima, J. Blogg, K. Hoskin