

WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 291/04

- [1] This appeal was heard in Toronto on February 17, 2004, by Vice-Chair R. McClellan.

THE APPEAL PROCEEDINGS

- [2] The worker appeals the decision of the Appeals Resolution Officer (“ARO”), S. Marangoni, dated March 28, 2002. That decision concluded that the worker was not entitled to a reassessment of her permanent disability award of 12% awarded for right upper extremity repetitive strain injury dated from March 13, 1989. The decision also concluded that the worker was not entitled to a permanent impairment award or ongoing compensation benefits under a separate claim for a left cervical condition arising from a disablement injury in the summer of 1999.
- [3] The worker appeared and was represented by Mr. M. Kelly. The employer was represented by Ms A. Eagle, assisted by Ms. J. McInerney.

THE RECORD

- [4] The Panel considered the material included in the Case Record prepared by the Office of the Vice-Chair Registrar (Exhibit #1). In addition, we considered:
- Exhibit #2: Addendum #1;
 - Exhibit #3: Addendum #2;
 - Exhibit #4: The Hearing Ready Letter;
 - Exhibit #5: Addendum #3;
 - Exhibit #6: The MLO Paper on Cervical Disc Disease;
 - Exhibit #7: The WSIB letter of February 11, 2004;
 - Exhibit #8: Post-Hearing Addendum #1, dated April 26, 2004;
 - Exhibit #9: Post-Hearing submissions dated May 18, 2004.
- [5] The Panel also heard oral evidence from the worker. Submissions were made by Mr. Kelly and Ms Eagle.

THE ISSUES

- [6] The issues before the Panel are;

1. Whether the worker is entitled to a re-assessment of her permanent partial disability award of 12% awarded on August 22, 1997 for an impairment in the right upper extremity, and
2. Whether the worker is entitled to a permanent impairment award and ongoing benefits for an injury to the neck and left upper extremity arising from a disablement accident in the summer of 1999.

THE FEBRUARY 11, 2004 LETTER

[7] In the course of the worker's testimony, the worker stated that in a recent telephone conversation with her Claims Adjudicator, the Claims Adjudicator had advised her that the Board had granted entitlement for bilateral wrist carpal tunnel syndrome on the basis of a review of the file by a Board medical consultant. Further, she stated that the Claims Adjudicator advised her that the Board medical consultant supported entitlement for the right shoulder tendon tear but that because this issue was before the Tribunal, the ARO decision could not be changed.

[8] In response to direction from the Vice-Chair, the accident employer produced and submitted in evidence a letter from the Claims Adjudicator to the worker, dated February 11, 2004. Neither the worker nor the Tribunal had received a copy of this letter. Letter was marked as Exhibit #7.

[9] It needs to be stated at this point, that the accident employer in this case is the WSIB.

[10] The letter reads in part:

A review of your file indicates that on December 5, 2001, entitlement for the tear in the right shoulder was denied at the Operations Level. This decision, dated March 28, 2002, was confirmed by the Appeals Branch.

In view of the above, I am unable to reconsider a decision that has already been determined at the Appeals Branch level. According to information on file this issue is currently with the Workplace Safety and Insurance Appeals Tribunal and a hearing has been scheduled for February 11, 2004. Therefore I am unable to take any further action regarding this issue.

(...)

I have also reviewed your file in its entirety regarding additional entitlement for bilateral carpal tunnel syndrome

(...)

A review of your file indicates that there is continuous mention of pain, coldness and sweaty right hand symptoms which doctors attributed to carpal tunnel syndrome. Although most of the complaints were for the right hand and wrist, there is also mention of left hand symptoms as early as September 1989. A review of the job duties performed in 1989, Group Leader Data Entry Clerk, determined that the duties of this position were repetitive in nature and could have brought on the symptoms

(...)

Both myself and a member of the Medical Branch reviewed your file in its entirety. It was the opinion of the medical consultant that the diagnosis of Bilateral Clinical or Dynamic Carpal Tunnel of the wrist is in order under this claim, noting that the symptoms of this condition had been present since early 1989. It is also the opinion of the Medical Consultant that this condition has been mild and is still considered mild, to date, especially the left side.

I have accepted the opinion of the Medical Consultant and therefore, this letter is to advise you that the condition of Bilateral Clinical or Dynamic Carpal Tunnel of the wrist, will be accepted. A pension assessment under this claim will be conducted after the Workplace Safety and Insurance Appeals Tribunal has dealt with the issue regarding the tear in your right shoulder.

[11] The Vice-Chair advised the parties that the Tribunal would obtain the complete updated WSIB file, including all memos and Board medical consultant opinions with respect to the worker's 1989 claim, which had been excluded from the Case Record prior to the appeal.

[12] Following the receipt of the updated WSIB file, the parties were given a three-week period to make any additional submissions in writing based on the new material.

THE REASONS

(i) Background

[13] The worker is a forty seven year old woman, who was employed as a data entry worker by a large public insurance company. She suffered an upper right extremity injury to the right shoulder, right elbow and right wrist, on a disablement basis with an accident date of March 13, 1989. Her condition was diagnosed as reflex sympathetic dystrophy.

[14] On August 3, 1990, the worker was awarded a 5% partial disability benefit pension for the right shoulder. On October 20, 1991 the award was increased to 7.5% for the upper extremity with elements of reflex sympathetic dystrophy

[15] On August 22, 1997 the award was increased to 12%, broken down by 7% for the right shoulder and 5% for the right elbow, with no award for the wrist or hand.

[16] In 1999, the worker's workstation was re-organised, after which she claimed to experience a gradual onset of pain and discomfort in the left shoulder, left arm and neck. An ergonomic assessment found inadequacies in the worker's workstation and made recommendations for change in November 1999, but according to notations in the Case Record, as of July 7, 2001 not all those changes had been carried out.

[17] The worker made a claim for cervical strain with an accident date of February 1, 2000. The claim was allowed on March 28, 2000 on a disablement basis, with no lost time. Entitlement was terminated on July 12, 2000.

[18] In Board Memo #40, dated February 14, 2002, Board medical consultant Dr. Kanalec advised that the worker had a chronic C7 radiculopathy resulting from age related degenerative disc disease which was not related to her job.

[19] In Board Memo #29 dated May 11, 2001, Board medical consultant Dr. Ho confirmed his view previously expressed in Board Memo #12, July 5, 2000, that the worker's neck strain had fully resolved by April 28, 2000, according to the report of Dr. Harvey and that the underlying condition of degenerative disc disease at C4-6, C5-6 and radiculopathy at C6 were not related to the nature of her work.

(ii) The medical evidence

[20] The doctor's first report from the 1989 accident is dated August 10, 1989 from the family physician Dr. Rabideau. He reported gradual onset of right arm pain, and swelling from repetitive use of the arm at keyboard data entry. He diagnosed multiple soft tissue injuries of the right arm, right rotator cuff tendonitis and medial epicondylitis in the right arm.

[21] The worker was first seen by the rheumatologist, Dr. Gary Craig, on August 23, 1989. His initial diagnosis was mild carpal tunnel syndrome, but subsequent tests ruled this out. He also found very mild right rotator cuff tendonitis.

[22] The neurologist, Dr. Ian Kirby, reported work-related tendonitis in the right forearm flexor and extensor compartments since March 1989, together with tingling of the right arm and fingers. His view was that the tendonitis affected the median nerve in the carpal tunnel. A wrist splint had been provided.

[23] On September 21, 1989, Dr. Rabideau reported that the worker's condition had worsened in the right wrist/hand and that she had had developed pain in the left wrist and hand as well. He advised her to stop work.

[24] On October 5, 1989, Dr. Craig diagnosed reflex sympathetic dystrophy rather than CTS, with totally diffuse arm pain, restricted range of shoulder motion to 50 % and puffiness and diffuse tenderness in all parts of the hand, wrist, forearm and upper arm.

[25] The physiatrist Dr. David Harvey examined the worker on October 27, 1989 and found reflex sympathetic dystrophy in the right arm; 20% decreased range of movement of the right shoulder consistent with adhesive capsulitis; probable carpal tunnel syndrome with Tinels' sign at the wrist and numbness and tingling in the median innervated fingers; tendonitis of the flexor tendons started at the medial epicondyle, and through the forearm and into the fingers, "which is probably the initiating event for the whole problem". Range of motion in the right shoulder was restricted by 20% in all directions and that there was a lot of pain in the medial epicondyle with pain down into the wrist. He concluded that her diffuse pain pattern was consistent with sympathetic mediated pain. He added that the worker could not overuse her right arm, could do modified work only on a part-time basis until recovery, which he thought would take eight to 12 weeks.

[26] The worker was cleared to return to work part-time with no keyboard or typing work on October 30, 1989 by Dr. Rabideau.

[27] A bone scan taken November 27, 1989, reported nothing abnormal in the cervical spine or upper limbs and "no evidence for reflex sympathetic dystrophy."

[28] However, on December 1, 1989, Dr. Harvey acknowledged the bone scan findings but stated that:

I think that she still has vasomotor and trophic changes suggesting the diagnosis of reflex sympathetic dystrophy and I would recommend treatment with local steroid injection into the shoulder and at the painful area at the medial epicondyle as well as a diagnostic sympathetic blockade.

[29] The record shows that the worker declined to have these injections.

[30] In January 9, 1990, Dr. Harvey reported that he had agreed with the worker's request to return to regular duties. On January 15, 1990, Dr. Harvey reported:

Clinically I believe this lady has reflex sympathetic dystrophy. She has diffuse pain, episodes of coldness and heat and the therapist reports she has colour change.

[31] On June 11, 1990 Dr. Harvey wrote that there was an increased risk of recurrence if the worker returned to her previous work at data entry

[32] On August 30, 1990, the worker was assessed by Board medical adviser Dr. Mede for pension purposes. He found functional weakness of all activities of the right hand, and restricted abduction of the right arm. Dr. Mede did not reference the reports from Dr. Harvey, or his diagnosis of RSD.

[33] On October 22, 1991, Board medical coordinator Dr. Baichwal reassessed the worker for pension purposes and reported overuse syndrome of the dominant right upper extremity with some features of reflex sympathetic dystrophy.

[34] On July 4, 1997, the worker was seen again by Dr. Harvey, who reported pain throughout the right upper extremity at the base of the neck, as well as swelling in the right hand and some discoloration in the right hand, restricted range of motion in the neck and shoulder. He had no new treatment to offer.

[35] On August 20, 1997, Board medical consultant Dr. Little examined the worker for a permanent pension rating. He found restricted range of motion in the right shoulder and tenderness on the right side of the neck and in the right trapezius and the right anterior aspect of the right shoulder. His diagnosis was overuse syndrome of the right upper extremity, rotator cuff tendonitis with possible adhesive capsulitis, medial epicondylitis of the elbow, insignificant triggering of the middle finger and thumb of the right hand, and "functional overlay".

[36] Dr. Harvey saw the worker again on April 28, 2000. He reported as follows:

On physical examination today I find her cranial nerves to be normal. Reflexes are normal in the upper and lower extremities. No Hoffmans. No clonus. Both hands are a little cool to touch but they are symmetrical today.

She has very diffuse tenderness including dermal and sub dermal pain through the neck and shoulder blade region.

She has limited range of movement of the shoulder which was limited with both passive and active range of movement. Again there is subcutaneous stress pain all through the right and left upper extremity.

I saw no wasting or fasciculation in any of the muscles.

I could see no soft tissue swelling or a fusion in any of the joints.

Once again I would say that she has a chronic pain syndrome with diffuse skin rolling tenderness. There is some coolness which is now symmetrical in the hands which might suggest a little bit of automatic disturbance. This can also be seen with disuse with venous pooling.... I cannot think of any new treatments to offer this lady.

[37] On September 20, 2001, Dr. Harvey reviewed the worker again, reporting similar symptoms as in 1997 and April 2000.

In summary then, this lady has a very diffuse pain syndrome in the right upper extremity with dermal and subcutaneous stress pain as well as stress pain on all of the joints of the right upper extremity. There is no sign of synovitis at the present time. Given that her right shoulder is quite stiff, it might be worthwhile doing an ultrasound to see if there is any sign of a rotator cuff tear.

[38] On February 14, 2002, Dr. Harvey reported following an ultrasound taken October 13, 2001 (which found that there was a full thickness tear of the anterior and mid-supraspinatous tendon of approximately 1.7 by 2.0 centimetres.)

Based on the history then it would appear that this lady injured her right upper extremity back in 1989 and has had continuous pain through the whole arm ever since then. It has been very difficult to localise because her whole arm has been painful. Ultrasound recently shows the tear in the shoulder. As far as I know there has been no intercurrent injury between 1989 and now. Therefore I think it is reasonable to suspect that the tear that is currently seen in the rotator cuff is related to the original injury since I am not aware of any other injury that occurred between 1989 and now.

[39] On September 19, 2000, Dr. Rabideau reported:

There is evidence of prior cervical degenerative disc disease i.e. osteophytes or 'bone spurs' which likely developed over a number of years. However, until there had been changes in her workstation and the malfunction of her hands-free telephone device, she had been free of neck pain and left radicular arm pain. The worker has been under my care since 1985 and she has never complained of neck pain or pain referred into her left arm prior to October 1999. In summary I believe quite strongly that the changes in the worker's work environment which began in or around October 1999 aggravated her degenerative changes in her neck and likely caused acute disc protrusion as well on the left C7 nerve root causing her severe arm pain and hand numbness.

[40] The worker was seen by neurologist, Dr. Susan Fawcett in April 27, 2000 and June 5, 2000. She reported that EMG studies showed degenerative changes suggestive of chronic denervation and a C7 radiculopathy as the most likely diagnosis.

[41] MRI taken May 25, 2000 showed normal alignment of the cervical and upper thoracic vertebral column. Moderate disc space narrowing was present at the C4-5 and C5-6 disc levels. There were associated discophytes at these levels. On the left side, osteophytes arose from both levels (C4-5 and C5-6), causing moderate narrowing of the exit foramina from both the left C5 and C6 nerve roots. There were no other abnormalities. The conclusion was discogenic degenerative disease at the C4-5 and C5-6 disc levels with consequent narrowing of neural exit foramina for the left C5 and C6 nerve roots and right C6 nerve root.

[42] The worker was referred to the Hamilton Pain Management Centre where she was seen by the psychiatrist and specialist in pain medicine, Dr. Larry Kahn, beginning in January 2001. On January 23, 2001, Dr. Kahn reported that the worker's pain problem began in October 1999 following changes at her workstation, and featured pain over both shoulders, at this time more on the left than on the right, and pain through the left upper extremity. Dr. Khan wrote:

MRI of her cervical spine was performed in May 2000 and showed some degenerative changes at C5-C6 and C4-C5 as well as some narrowing of the neural exit foramina on

the left at C5 and C6 and C6 on the right. An EMG study was performed in April 2000 and showed some chronic denervation in a C6 supplied muscle on the left.

This lady appears to have non-specific cervical pain with a fairly classic description of cervicogenic headaches and probably somatic referred pain down her left arm. There are some features suggestive of a complex regional pain syndrome as well or possibly sympathetic mediated pain.

(iii) The worker's testimony

[43] The worker testified as follows. She started working for the accident employer in September 1986 as a data entry operator. She stated that she had no prior health problems of any kind. Her right arm/shoulder problems developed in 1999, starting with pain in the right shoulder and swollen biceps. She was treated by Drs. Richards and Harvey, and was off work for about five weeks. She stated that she returned to work at modified duties as an assessor coder and never returned to her old data entry job. She testified that she was able to cope with her work by taking prescription medications and she did the assessor coder job until 1998, when she was given a new job as a health care payment processor.

[44] The worker testified that her new job was a newly created position for which she and one other worker were specially trained. When she finished her training in September 1999, she stated, her co-trainee booked off work on disability and she was required to do double duty because no one else in the organisation was trained for the work.

[45] She also testified that at this time, September 1999, she was given a new workstation which was not ergonomically set up and that she requested that an ergonomist be provided to set up the workstation correctly, but that this was not done until late February 2000. She stated that when the ergonomist did arrive, in February 2000, the ergonomist made changes to the height of her chair, the configuration of the desk and advised the use of a phone headset. During this interval, between September 1999 and February 2000, the worker testified that she developed pain in her neck, at the base of the neck, not just in the right side as before, and pain in the left shoulder. She testified that the pain got progressively worse on her right side as well at this time.

[46] The worker testified that the pain worsened to the point that it affected her ability to do house work and other household chores. She was no longer able to reach overhead, or behind her back, and she was no longer able to offset her right arm disability by compensating with her left arm. At the time, she was living in her own home with her two sons, being a widow, and she found it necessary to sell her house and move to a smaller home. She stated that she was no longer able to do gardening, snow removal, cleaning and laundry and other home maintenance tasks and a housekeeper had to be hired.

[47] The worker testified that in January 2001, she was promoted to customer service representative. Her work still involved computer use and extensive phone work. Since September 1999, she said that she had only taken two or three days off from work, to take physiotherapy.

[48] In reply to questions from the employer's representative, the worker testified that in addition to new pain in the back of the neck, she started to get severe headaches after September 1999, one of which required emergency treatment in hospital and the administration of morphine. Previously, she said, the pain had been at the right side of the neck. She said that the headaches began to occur weekly, as opposed to monthly or even less frequently prior to 1999.

[49] In her testimony, the worker informed the Panel that she had been advised by her Claims Adjudicator in a very recent telephone conversation that the Board was going to allow entitlement for bilateral wrist carpal tunnel syndrome, back to 1989, and that this decision was based on a Board medical consultant's review of Dr. Harvey's reports. She also recalled the Claims Adjudicator telling her that the Board medical consultant had recommended approving the shoulder tendon tear as well but that because it was an issue before the Tribunal in this appeal, it could not be granted by the Claims Adjudicator.

[50] The employer's representative stated at this point that her information from the Board contradicted the worker's testimony, and referred to a letter in her possession from the Claims Adjudicator. At this point in the proceedings, the Vice-Chair instructed the employer's representative to produce the letter, which was introduced as evidence and marked as Exhibit #7.

(iv) Submission of the worker's representative

[51] Mr. Kelly submitted that this long-time employee developed a compensable repetitive strain injury in 1989 but continued to work with her disability, which she managed with heavy prescription medications.

[52] In 1999, he argued, as a result of improperly configured workstation and an increased workload, the worker developed a second repetitive strain injury affecting her neck and left upper extremity, for which she required additional medical treatment.

[53] Mr. Kelly reviewed the reports of Dr. Fawcett, Dr. Rabideau and Dr. Harvey and submitted that the medical evidence established that there was a new accident in 1999. The worker was diagnosed with cervical degenerative disc disease but this condition was clearly asymptomatic prior to the commencement of the health care payment processor job in September 1999. The new injury had a dramatic impact, he argued, affecting the worker's home life and leading to a deterioration in her compensable right upper extremity disability as well as creating a new impairment in the left upper extremity.

[54] Mr. Kelly claimed that there were errors in the report of the Board medical consultant, Dr. Ho, who had advised against entitlement. He stated that Dr. Ho's claim that Dr. Harvey had reported on April 28, 2000 that the worker's neck problem had resolved was completely inaccurate. Mr. Kelly cited the report of Dr. Harvey in support of a relationship between the right shoulder tendon tear and the 1989 work accident.

[55] Mr. Kelly submitted that, in view of the Claims Adjudicator's letter of February 11, 2004, which established additional entitlement for right upper extremity impairment, he requested the opportunity to make further written submissions once the complete WSIB file is received, which will include any new opinions from Board medical consultants.

(v) Submissions of the employer's representative

[56] Ms Eagle submitted that the ARO decision should be confirmed. She reviewed the medical evidence in detail, and argued that, with respect to the 1989 claim, there was no evidence that the worker's condition was below her permanent partial disability level of 12%, established in 1997. She also submitted that the medical evidence of Drs. Ho and Kanalec was preferable to that of Drs. Rabideau, Fawcett and Harvey with respect to the tendon tear in the shoulder, which she argued should be discounted and that a temporal correlation was not sufficient proof of causation.

[57] With respect to the neck and left upper extremity, Ms Eagle submitted that the evidence does not support a finding that the worker's work duties were a significant contributing factor. Entitlement was granted to the worker for an acute cervical strain but Dr. Ho's evidence is that the strain had resolved by April 2000. She argued that the worker's cervical problem was related to age-based degenerative disc disease which was not work-related, according to the evidence from the EMG and MRI. Her position was that the worker's cervical/left shoulder condition "just happened" as a result of the normal aging process.

[58] Ms Eagle submitted that there was nothing in the nature of the worker's job duties, which were so strenuous as to lead to a conclusion that they were a significant contributing factor in the development of the worker's condition.

[59] She cited passages from the MLO paper, "Neck Pain and Related Symptoms Cervical Disc Disease" by Dr. Fleming, found in the Case Record, in support of her arguments.

[60] Ms Eagle contended that neither Dr. Fawcett nor Dr. Rabideau had an accurate understanding of the worker's job duties, in contrast to Drs. Ho and Kanalec. She stressed again that the ergonomic changes made in February 2000 were very minor.

(vi) Evidence received post-hearing

[61] Additional evidence was requested and received from the Board following the hearing, and is found in Post-Hearing Addendum #1 (Exhibit #8). The material includes documents, including Board memos and medical reports in the Board medical file, which were essential to the adjudication of the issues before the Tribunal and which had not been made available prior to the hearing.

[62] Board Memo #81, dated November 10, 2003, from Dr. McKenna-Boot, reports that the worker had right carpal tunnel syndrome symptoms dating back to the 1989 compensable injury, under the "3" claim. Under the "9" claim, which was established for the 1999 disablement injury, Dr. McKenna-Boot advised that the rotator cuff tear suggested possible deterioration. He suggested additional information with respect to ongoing symptoms from the worker's treating physicians.

[63] Board Memo #86, dated December 2, 2003, documents that Dr. Harvey reported on November 28, 2003 that the recent ultrasound test found a full thickness tear of the right supraspinatous tendon and that the worker's ongoing pain and symptoms were related to the tear. In the same memo, the Claims Adjudicator recommended entitlement for bilateral carpal tunnel syndrome under the "3" claim established for the accident of 1989, on the following grounds.

From a claims point of view it appears that the condition of bilateral carpal tunnel syndrome of wrists, was a result of the disablement injuries sustained in March 1989. Right hand symptoms had been present since 1989. The symptoms have always been related to the right upper extremity as a whole, including the shoulder and medial epicondylitis. However, carpal tunnel syndrome has always been questioned as early as August 1989. Although tests had been negative, noting the EMG of October 3, 2003, the worker has a clinical or dynamic CTS. Mention is made of the left hand, this is always when comparing the two hands. Worker is right-handed and therefore, it can be assumed that she would feel the effects of this condition on her dominant hand more so than the left.

[64] In Board Memo #87, dated January 9, 2004, Board medical consultant Dr. Kanalec reviewed the entire medical file and advised as follows:

Right shoulder tear likely responsibility of claim based on original diagnosis of rotator cuff tendonitis. Tear more likely with history of tendonitis and impingement.
Impression: accept pension reassessment.

[65] Dr. Kanalec also advised that entitlement for bilateral carpal tunnel syndrome under the "3" claim should be denied.

[66] Further discussions with Dr. Kanalec are recorded in Board Memo #88, dated January 14, 2004. The memo records that the issue of right rotator cuff tear was before the Tribunal and therefore the ARO's denial decision could not be changed. It was also agreed by the Claims Adjudicator and Dr. Kanalec to allow entitlement for bilateral carpal tunnel syndrome as related to the accident of 1999 on the grounds of continuous symptoms. A pension assessment was ordered.

[67] New medical evidence obtained post-hearing includes the following.

[68] An ultrasound test of the worker's left and right shoulders dated September 30, 2003 confirmed a full thickness tear of the supraspinatous tendon. It also identified pathology in the left shoulder. The summary reads as follows:

1. Persistent finding of full thickness tear right supraspinatous tendon. Increased fluid within proximal longhead biceps tendon sheath as well as probable loculated collection with subdeltoid bursa. Additional evidence of synovial thickening with the bursal lining.

2. Heterogeneous thickened left supraspinatous tendon, indicating tendonopathy. No evidence of tear.

[69] A report from the physiatrist, Dr. Ghose, with EMG data, on October 8, 2003, gave a diagnosis of bilateral carpal tunnel syndrome. A wrist splint was prescribed.

[70] A report from Dr. Harvey, dated November 28, 2003, records both right and left shoulder pain, with more pain on the right. He wrote, "The pain in the shoulder limits the mobility of the shoulder... We know the diagnosis, it has been confirmed by ultrasound now on two occasions." He advised medical restrictions against using the shoulders above the chest level, repetitive rotation or repetitive or frequent lifting. His diagnosis was "chronic tendonopathy in the shoulders."

(vii) Law and policy

[71] On January 1, 1998, the *Workplace Safety and Insurance Act, 1997* ("WSIA") took effect. However, pursuant to section 102 of the WSIA, the *Workers' Compensation Act* continues to apply to pre-1998 injuries. Thus the pre-1989 Act and pre-1997 Act continue to apply, as amended by the WSIA.

[72] The relevant section of the pre-1989 Act states as follows:

45(1) Where permanent disability results from the injury, the impairment of earning capacity of the worker shall be estimated from the nature and degree of the injury, and the compensation shall be a weekly or other periodic payment during the lifetime of the worker, or such other period as the Board may fix, of a sum proportionate to such impairment not exceeding in any case the like proportion of 90 per cent of the worker's net average earnings.

(...)

(3) The Board may compile a rating schedule of percentages of impairment of earning capacity for specified injuries or mutilations that may be used as a guide in determining the compensation payable in permanent disability cases.

(4) Where the impairment of the earning capacity of the worker does not exceed 10 per cent of the worker's earning capacity and the worker does not elect to receive compensation by a weekly or other periodic payment, the Board shall, unless the Board decides that it would not be to the advantage of the worker to do so, direct that such lump sum as may be considered to be the equivalent of the periodic payment shall be paid to the worker.

[73] In *Decision No. 776/93*, (43WCATR, p. 51) the Tribunal found that: "Prior to the 1989 amendments it was accepted that the word "disability" referred to the physical or functional abnormality or loss resulting from the injury."

[74] Compensation for non-economic loss is provided at section 46 of the *Workplace Safety & Insurance Act*

46(1) If a worker's injury results in permanent impairment, the worker is entitled to compensation under this section for his or her non-economic loss.

(...)

[75] Section 1 of the *Act* defines Impairment:

1(1) In this Act

"impairment", in relation to an injured worker, means any physical or functional abnormality or loss including disfigurement which results from an injury and any psychological damage arising from the abnormality or loss ("déficiency")

"permanent impairment", in relation to an injured worker, means impairment that continues to exist after maximum medical rehabilitation of the worker has been achieved ("déficience permanente")

[76] Pursuant to sections 112 and 126 of WSIA, the Appeals Tribunal is required to apply any applicable Board policy when making decisions. Pursuant to WSIA section 126, the Board has identified certain policies applicable to this appeal. We have considered these policies as necessary in deciding this appeal.

(viii) Findings and conclusion

[77] The issues in this case are whether the worker has entitlement to a re-assessment of her permanent partial disability award of 12% which was granted on August 20, 1997 for disability in the right upper extremity, resulting from a repetitive strain injury in 1989, and secondly, whether the worker has entitlement to an award for a permanent impairment in the neck and left upper extremity arising from the disablement injury in 1999.

[78] In this case, I find the worker to be a credible witness, whose testimony was given in a straightforward manner without exaggeration and which was corroborated by the evidence in the Case Record.

[79] Dealing with the first issue, I find that the medical evidence does establish that the worker is entitled to an increase in her 12% permanent partial disability pension for her right shoulder condition, based on the medical evidence that the underlying condition was a previously unacknowledged right rotator cuff tear directly attributable to the 1989 accident.

[80] The medical evidence in support of a relationship between the rotator cuff tear and the work injury comes from two of the worker's treating physicians: Dr. Harvey, in his report of February 14, 2002 and Dr. Rabideau, in the report of September 19, 2000. The relationship between this injury and the 1989 accident is also supported in the report of the Board medical consultant, Dr. Kanalec, in Board Memo #87 dated January 9, 2004.

[81] I find that the employer's submission, that this combined medical evidence of the worker's treating physicians should be dismissed, to be without merit.

[82] I find that the worker is below the level of her permanent disability award of 12%, because the presence and effects of the rotator cuff tear have not been factored into this award. She is entitled to an increase in her permanent partial disability award for her right upper extremity disability, taking into account the fact of her rotator cuff tear and permanent shoulder tendonopathy, dating from the accident of 1989.

[83] With respect to the issue of entitlement for left shoulder/neck impairment as a result of the 1999 disablement injury, the facts are as follows. The worker's job duties were changed in September 1999 and she was assigned to a new workstation, where her duties involved processing health claims data by computer. The workstation was not configured in an ergonomically adequate manner, according to the worker's testimony, which was corroborated by the letter dated November 19, 2002 from the Nurse Case Manager. The nurse wrote:

I am aware that [the worker] was experiencing difficulty with her neck and left shoulder as a result of her workstation being changed and I noticed on several occasions that she would hold her neck in a very guarded manner because of pain, as corrections to her workstation were not implemented until the winter of 2000.

As promoters of accident prevention in the business that we do, I was disappointed that it took as long as it did for [the worker's] workstation to be ergonomically corrected.

[84] Initial entitlement was allowed for cervical/left shoulder injury as an accident arising on a disablement basis. In a letter dated July 12, 2000, the worker was advised by the Claims Adjudicator that this was a strain injury which had resolved without evidence of permanent impairment and that degenerative changes in the cervical spine accounted for the worker's ongoing discomfort.

[85] The family physician, Dr. Rabideau, reported on September 19, 2000 that he had treated the worker since 1985 and that she had never complained of neck pain or left arm pain prior to October 1999. He stated that it was his opinion that the changes in the worker's work environment around October 1999 had aggravated her pre-existing degenerative changes and caused her severe pain.

[86] Pre-existing degenerative changes in the cervical spine had been identified in April 2000 by Dr. Fawcett.

[87] The ultra-sound tests of September 20, 2003 found tendonopathy in the left shoulder. Dr. Harvey has given his diagnosis of chronic bilateral tendonopathy.

[88] On the basis of the medical evidence, together with the worker's testimony, I find that the worker's left shoulder/neck were symptom-free prior to her assignment to an ergonomically incorrect workstation in September 1999. I find that in the course of working at this improperly configured workstation between September 1999 and February 2000, the worker developed a disablement injury in the neck and left shoulder. While there is evidence of pre-existing degenerative change in the cervical spine, there is also evidence that the condition was completely symptom-free prior to the disablement injury caused by the unsuitable workstation. The preponderance of medical evidence is that the worker's neck/shoulder injury did not resolve as of July 2000, and that it has become a chronic condition which includes a diagnosis of chronic left tendonopathy.

[89] The worker is therefore entitled to receive an NEL award for a permanent impairment to the neck and left shoulder arising from the disablement injury of 1999.

[90] On the issue of the workers bilateral carpal tunnel syndrome, which could be considered an aspect of the worker's upper extremity condition, I note that entitlement has been accepted by the Board on the basis of the medical evidence in the file. This issue is now before the ARO on appeal by the employer and is not currently before the Tribunal.

THE DECISION

[91] The worker appeal is allowed.

[92] The worker is entitled to an increase in her permanent partial disability award for her right upper extremity disability based upon the finding of a torn right supraspinatous tendon resulting from the accident of 1989. The Board is directed to reassess the worker's permanent pension award accordingly.

[93] The worker is entitled to an NEL award for a permanent impairment in the neck/left shoulder arising from the disablement injury of 1999.

DATED: This 27th day of July, 2004.

SIGNED: R. McClellan.