Workers’ Compensation Appeal Tribunal

Decision #157

Claim No.: 2002-1479

Date of Notice of Appeal: June 23, 2009

Date Notice of Appeal Received at Tribunal: June 25, 2009

Date of Oral Hearing: August 11, 2009

Date Hearing Closed: August 11, 2009

Date of Decision: September 3, 2009

Appeal Committee Members appointed under s. 64 (1) of the *Workers’ Compensation Act*, S.Y. 2008, c. 12

Committee Chair: H. Leenders
Member representative of employers: C. Alexander
Member representative of workers: M. McCullough

In attendance: The Worker
The worker’s representative – Julie Docherty
Observer – Joshua Paddon
Recorder - Vernna Johanson

Location: Room #201, 419 Range Road
Whitehorse, Yukon Territory

Introduction

The worker was employed as a mechanic. On November 7, 2002 he sustained a hyperextension injury to his knee when he stepped on a drain cover at work, causing it to give way. The worker fell into the resulting hole and twisted his left knee. Yukon Workers' Compensation Health and Safety Board (the board) accepted his claim for a left knee sprain on January 30, 2003.

The worker was provided with compensation benefits, medical management and rehabilitation assistance. He returned to work on April 1, 2004. On January 11, 2005 the worker was notified that his claim was being closed; he was awarded a 1% permanent partial award.

In May of 2008, the worker contacted the board requesting that they reopen his claim as he had increasing pain in his knee and was having difficulty standing or walking for any length of time. On August 14, 2008, the adjudicator notified the worker she would not reopen his claim for compensation. The worker provided the board with additional medical evidence on November 10, 2008, requesting that his claim for compensation be reopened. The adjudicator denied this request in a letter dated December 3, 2008.

The worker appealed the adjudicator's decisions to a board hearing officer. The hearing officer agreed with the adjudicator in his March 31, 2009 decision. He concluded the worker's ongoing left knee problems where due to a pre-existing degenerative non-compensable condition. The worker asks the tribunal to reverse the hearing officer's decision and is seeking ongoing compensation from the date his benefits were terminated.

Jurisdiction

[1] On June 25, 2009 the workers' advocate office, representing the worker, filed an appeal of the hearing officer's decision with the tribunal under s. 53 of the *Workers' Compensation Act,* S.Y. 2008 (the "Act"). The review (appeal) should be determined according to the *Workers' Compensation Act,* S.Y. 2008, c. 12. Section 65(1) of the *Act* gives the appeal tribunal jurisdiction to hear and decide this appeal.

[2] The worker filed a claim for an injury which occurred on November 7, 2002. Compensation entitlement decisions are made pursuant to legislation in place at the time of injury. In this instance the *Workers' Compensation Act*, S.Y. 1992 as amended to the date of injury, should be used to determine the issues of entitlement.

[3] The board provided the following policies to the tribunal as relevant to this appeal under the authority of section 64 (4) of the 2008 *Act*:

- Policy CL-47, Pre-existing Conditions, effective 94-04-01
- Policy AP-03, New Evidence at Reviews and Appeals

[4] The worker attended the hearing and testified by affirmation. He was represented by the acting workers' advocate. The deputy worker's advocate attended as an observer. The proceedings were recorded. The employer was notified of the appeal but did not participate.

[5] The acting workers' advocate submitted two documents with the Notice of Appeal. One was an April 23, 2009 report by Dr. P. Anderson; the other was a May 19, 2009 report by Dr. M. Penner. The tribunal determined the reports did not meet the basic criteria to be considered as new or additional evidence as outlined in Policy AP-03. Specifically, the reports did not provide new information that was not previously available to the decision-maker. They simply repeated existing information that had already been considered.

Evidence

[6] The appeal committee considered the following:

- the worker's testimony
- the acting workers' advocates' submission
- the aforementioned policies
- the entire claim record no. 2002-1479 as provided by the board

Hearing Officer's Decision

[7] The worker is appealing the hearing officer's March 31, 2009 decision. He is seeking ongoing compensation from the date his benefits were terminated. He disagrees with the hearing officer's decision because, he claims, "the specialist concludes the injury and ongoing problems are work-related." The hearing officer found the worker's ongoing problems with his left knee were due to a pre-existing non-compensable degenerative condition.

Evidence from the Record

[8] The worker filed a Worker's Report of Injury/Illness dated December 10, 2002 stating that he injured his left knee when he stepped on a floor drain cover plate that gave way, which caused him to fall in the hole. At the time of injury, he was employed as a mechanic on a permanent basis.

[9] The Employer's Report of Injury/Illness also dated December 10, 2002 notes the same information. The report notes the worker has been employed with the company since 1987.

[10] The worker attended Dr. P. Anderson on November 18, 2002. Dr. Anderson's First WCB Report states the worker reported that immediately following the accident his knee felt fine but the next day it was swollen; there was no redness, locking or giving way. Dr. Anderson reports the worker had a full range of motion, there was some pain with hyper-extension but cruciate ligaments, medial and collateral ligaments were all intact. An x-ray obtained of the knee indicated minimal medial joint osteoarthritis.

[11] An x-ray undertaken on November 21, 2002 of the left knee reveals the following findings:

> There is mild reduction of medical knee joint spacing. Minimal marginal osteophyte formation is noted. No significant bone or soft tissue abnormalities can be appreciated otherwise.

Impression: Minimal osteoarthritic change.

[12] Dr. Tadepalli reports on December 10, 2002 that the worker attended with complaints of pain in his left knee. On examination, Dr. Tadepalli could not detect any swelling or bony tenderness. Ligaments were intact; there was normal range of movement and no neurological defect was evident. The diagnosis is "left knee sprain". Dr. Tadepalli states "I would expect him to recover with conservative treatment".

[13] The worker begins physiotherapy on December 18, 2002. Physiotherapist Catherine Fussell's impression on the initial assessment report states, "MCL [medial collateral ligament] grade 1, possibly ACL [anterior cruciate ligament]. Likely damage to capsule and/or meniscus due to nature of injury."

[14] Dr. Anderson's December 19, 2002 progress report notes the worker attended for follow-up. The worker reports he "re-injured" it at work. On examination, Dr. Anderson could not see any significant effusion; however, the worker says that effusion develops as the day goes on. He complains of pain on the medial side of the joint. Dr. Anderson states, "I expect he has a sprain".

[15] A January 9, 2003 progress report by Dr. Anderson states the worker continues to have recurrent swelling of his knee. Dr. Anderson is concerned that the worker may have some internal derangement. The worker is put on a list to be seen by an orthopaedic surgeon.

[16] Physiotherapist C. Fussell's progress report of January 13, 2003 notes the worker's hamstring strain should have healed by now if it was the primary injury. Due to the "(+) quadrant test" and slow healing, she suspects the worker may have a medial meniscus tear. Ms. Fussell recommends further investigation "MRI/arthroscopy and a knee brace".

[17] The worker attends Dr. Anderson on January 22, 2003 with complaints of ongoing episodes of swelling. Objective information reveals a mild effusion and pain on stressing the medial ligament. Dr. Anderson notes it will be many months before the worker can be seen by the visiting orthopaedic surgeon. He opines that although the worker's x-rays shows mild medial joint osteoarthritis, his knee never bothered him until the work injury. Dr. Anderson notes the physiotherapists are also of the opinion the worker has "more findings and symptoms than one would expect from a simple sprain."

[18] A physical therapy progress report of January 24, 2003 recommends the worker obtain a knee brace. Physiotherapist C. Fussell also recommends follow-up investigation by MRI or arthroscopy.

[19] A disability case manager notifies the worker by letter dated January 30, 2003 that his claim is accepted for a left knee sprain.

[20] The board's alternate medical consultant examines the worker on February 10 and issues a report on February 13, 2003. Following are excerpts from the report:

> Impression: This 45-year-old worker has probably torn his anterior cruciate ligament. My guess is that it is completely torn. I suspect it was partly torn with the first injury and it gave out completely with the second rather minor injury. It is also possible that he has damaged the medial meniscus.
>
> I would agree with Dr. P.J. Anderson that a MRI is the best way to get a definitive answer here. . . .
>
> At this worker's age and given how rapidly he is improving, I doubt that surgery to repair the damaged ACL would be a wise move. It may be that arthroscopic investigation would be helpful to trim up any damage to the injured menisci if the worker is not continuing to improve or if a large tear is found on MRI that may be responsible for further disruption inside the joint in time. . . .
>
> With an anterior cruciate deficient knee, we can expect to worker to be at increased risk for further damage usually to medial or collateral ligament or to the medial or lateral menisci with certain movements and motions that might once again cause hyperextension.
>
> . . . The medical and surgical evidence to-date does not indicate that surgical intervention would decrease the incidence of such long-term "arthritic" changes.

[21] The worker undergoes an MRI of his left knee on February 20, 2003. Findings indicate:

- A moderate joint effusion is present.
- Intrasubstance myxoid degeneration is present in the medial meniscus, with very subtle extension, suspected to the tibial articular surface.
- The lateral meniscus is intact.
- Cruciate ligaments are normal.
- The ACL is intact.
- PCL is also normal.
- Collateral ligaments are intact.
- There is early evidence of degenerative spurring.

The Impression is, "Degenerative tear suspected in the posterior horn medial meniscus, extension to the tibial articulate surface".

[22] The alternate medical consultant responds to several questions the adjudicator has posed. Following, in part, is his March 12, 2003 report:

> 1. It is my opinion that the accident in the workplace caused the meniscal tear. The degenerative changes that were seen on the MRI are secondary to this injury which happened some 3 months before the MRI was performed.

2. This question regarding aggravation of a pre-existing condition is negated by my answer to question number 1. My opinion is that this was not a pre-existing condition and that the meniscus tear happened as a result of the workplace injury.

3. The majority of the patient's symptoms can be explained by the meniscus tear. It is work related. It is unlikely that the medial meniscus tear is "a red herring".

4. Yes, the swelling in his knee is attributed to the workplace injury and the meniscus tear that happened as a result of that injury.

The medical consultant reports the worker indicated he would like to have the meniscus repaired. The consultant cautions that, although postoperatively there is relief, less pain and more mobility, often there is decreased stability. He states the worker must be encouraged to undertake aggressive quads and hamstring exercises to strengthen his quad muscles and avoid further re-injury. Further, "It is my opinion that surgery on the medial meniscus, if it occurs, should be considered a WCB responsibility".

[23] The worker undergoes surgery on his knee on June 3, 2003 by Dr. Bray, Orthopedic Surgeon. The operation performed is:

> Arthroscopy posterior horn medical meniscectomy, debridement anterior cruciate ligament tear, anterior compartment synovectomy with abrasion arthroplasty medial femoral condyle and femoral sulcus.

Dr. Bray reports that post-operative care should focus on ACL rehabilitation protocol with the possibility of a de-rotation brace if the worker experiences hyperextension-style instability. Dr Bray suggests conservative management of the worker's ACL over the next six months.

[24] Dr. Bray's follow-up report of July 3, 2003 states the worker needs to continue with therapy and rehabilitation. He is only fit for a desk job at this time. Dr. Bray states:

> Finally, I have been quite determined in reading "the riot act" with respect to his obesity. He needs to lose 50 lb. and this would be a substantial beneficial factor in the natural history of his osteoarthritis of the knee, as well as his cruciate ligament laxity.

[25] The worker is provided with a custom knee brace mid-August 2003. An August 19, 2003 progress report by Dr. Anderson states that the worker should attend physiotherapy to increase his activity, "with a plan to return [to work] on a graduated basis".

[26] A January 15, 2004 note to file by the adjudicator states the worker was reassessed at Riverfront Physiotherapy. The worker has lost strength and range of motion in his knee. The physiotherapist told the worker that "his knee will never be pain free due to many issues affecting it", although he can gain strength and range of motion again. The worker is provided

with four weeks in a work conditioning program.

[27] A March 8, 2004 physiotherapy work conditioning program Discharge Report by physiotherapist Mandy McClung has the following discharge recommendations:

1. Generation II knee brace returned to lab with new cast of leg for refitting.
2. [The adjudicator] to contact employer to plan return to work.
3. Return to work as auto mechanic once knee brace is refitted.

Complicating factors affecting recovery are noted as, "[The worker] has an unstable knee due to considerable laxity of his ACL (grade II) as well as medial joint degeneration."

[28] A Return to Work plan dated March 30, 2004 notes an initial return to work schedule is to begin on April 1, 2004. The worker and his supervisor will adjust his schedule as necessary during the first two weeks. The worker will be provided with re-employment benefits until April 15, 2004.

[29] On January 7, 2005, the medical consultant is asked by the adjudicator to calculate the worker's level of permanent impairment. The medical consultant notes that an x-ray of November 21, 2002 identified "minimal osteoarthritic change in the left knee". It is his clinical impression the osteoarthritis would have predated the work incident. He addresses Dr. Bray's July 2, 2003 report with respect to reading the "riot act" to the worker regarding his obesity. The medical consultant states:

> We know that obesity is a significant factor in the development of osteoarthritis and produces additional wear and tear on the knee joint. Dr. Bray's examination identified extensive osteoarthritis in the patellofemoral joint. This area is not directly damaged with a tear to the medial meniscus and I therefore could not attribute the finding of the extensive osteoarthritis to the work-related incident.

The medical consultant opines the worker has a 1% of total of permanent partial impairment of function as a result of the meniscal injury. He notes the worker has osteoarthritis which, he anticipates, will worsen over time, particularly if the worker continues to be obese. The consultant states, "I am unable to relate patellofemoral osteoarthritis to this type of incident."

[30] An adjudicator's January 11, 2005 letter notifies the worker of his permanent partial impairment award and that his file is now closed.

[31] The file does not contain further information until May 8, 2008. Dr. Anderson reports the worker continued to work as a mechanic, although it has become increasingly more difficult within the last two months. There is no reporting of further injury. Dr. Anderson states:

> [The worker] is having increasing pain and is not able to stand or walk for any significant length of time. There is no history of injury since 2002, although a review of the notes at that time indicates he had 2 injuries at

> work in succession on this knee.
>
> Given that he had subchondral injury related to the meniscal injury with grade 3 changes there is likely significant osteoarthritis present now; however, he has had relatively quickly worsening symptoms in 2 months and it is also possible he may have another meniscal tear.

[32] A May 15, 2008 x-ray of the left knee notes, “Mild joint space loss in the medial compartment of the left knee. Significant premature arthropathy is not visible.”

[Dorland’s Pocket Medical Dictionary, 25th ed. defines “arthropathy” as any joint disease.]

[33] Dr. Anderson reports on May 23, 2008 the worker attended to review the x-ray of his knee. The worker reports feelings of instability, with locking and clunking. “The radiologist reports only minor degenerative changes on standing x-rays”. Dr. Anderson opines that the worker’s symptoms are out of proportion to the x-ray findings. He will refer the worker to an orthopaedic surgeon and he also may require an MRI.

[34] On July 11, 2008 the medical consultant reviews the file and provides a report from Up-to-Date, an authoritative resource that regularly reviews (medical) literature. Following are excerpts from the medical consultant’s report:

> As the Website states, “obesity is perhaps the strongest modifiable risk factor for the development of osteoarthritis”. . . .
>
> Having a meniscectomy does increase the risk of developing osteoarthritis. For those whose meniscectomy occurred under age 35, arthritis started on average 25 years later. In people over age 35, osteoarthritis from the surgery occurred 9.8 years later.
>
> In this claim, there was evidence of degenerative changes immediately following the injury. Since these changes take some time to develop, these abnormalities would have been present prior to the incident at work. Age, weight and genetics are associated with that type of condition.
>
> I do note however that Dr. Anderson’s report of May 8, 2008 suggests relatively quick worsening symptoms in 2 months which raises the possibility of another meniscal tear. It is for this reason that Dr. Anderson is requesting another consultation and possibly and MR scan.
> Dr. Anderson reports “there is no history of injury since 2002.”
>
> Meniscal tears can occur as a result of the degenerative process and are not always traumatic. It is not clear from the reports whether or not [the worker] has followed Dr. Bray’s advice and lost 50 pounds. If obesity continues to be a factor, the possibility of degenerative changes in the menisci are increased. In the absence of a repeat injury, it is difficult to relate the sudden flare-up of symptoms to a process

related to the 2002 injury.

[35] The adjudicator writes to the worker on August 14, 2008 denying his request to reopen his claim. Based on the medical evidence, she can find no evidence establishing a direct link between the current condition of his left knee and the work-related injury of November 2002.

[36] On October 22, 2008, Dr. Murray Penner, Orthopedic Surgeon, provides his consultation report. The reason for assessment is "left knee pain and locking". Dr. Penner relates the worker's history of the present problem. He attributes the worker's current problems to the knee injury sustained in November 2002. Following are excerpts from Dr. Penner's report:

> Assessment: [The worker] has mechanical symptoms consistent with recurrent medial compartment pathology. This originated with a work-related medial meniscal tear in 2002.
>
> Currently, he likely has further fraying and degenerative tearing of the medial meniscus, as is commonly seen after the partial meniscectomy. Further, this has led to early medial compartment arthritis with joint space narrowing as is very typically seen following partial medial meniscectomy.
>
> Recommendations: I discussed this diagnosis with him. His current mechanical symptoms are likely related to a degenerative meniscal tear and possibly cartilage flaps within the articular cartilage.

Dr. Penner suggests repeat arthroscopy "however, such arthroscopy is unlikely to significantly alter his background aching pains". Dr. Penner further recommends anti-inflammatory medication, along with weight loss to deal with the worker's more chronic aching pains due to degenerative changes in his knee. He requests board authorization to carry out the procedure. He states, "It seems quite clear that his unilateral left knee medial compartment early arthritic change and persistent meniscal pathology originated with his left knee twisting injury in 2002".

[37] A November 4, 2008 MRI of the left knee reveals the following:

> Conclusion:
> 1. A previous arthroscopy
> 2. Almost complete tear of the posterior root of the medial meniscus.
> 3. Tricompartmental osteoarthritis most severe within the patellofemoral compartment.

[38] On November 10, 2008 the worker provided the board with Dr. Penner's consultation report and November 4, 2008 MRI. He requested that his claim be reconsidered based on the additional information. A December 3, 2008 adjudicator's letter explains her reasons for denying his request. Following are excerpts from her letter:

> Analysis: In my decision letter of August 14, 2008, I found that the most compelling objective medical evidence was the November 21, 2002 x-ray

> which showed pre-existing osteoarthritic changes, and the June 3, 2003 Operative Report by Dr. Bray. In his report, Dr. Bray noted that there was a posterior horn medial meniscal tear which was **complex (degenerative)** in nature. There was **extensive cartilage damage in the medial femoral condyle** *(the rounded articular surface of the thigh bone)*. There were areas where the bone beneath the cartilage was exposed *(subchondral).*
>
> Dr. Bray's report also noted that the patellofemoral joint (the joint between the thigh bone and the knee cap) showed extensive osteoarthritis of the femoral sulcus *(long narrow groove)* with extensive cartilage damage and patchy areas of exposed subchondral bone. [Bolding and italics added by the adjudicator.]
>
> . . . I prefer the objective evidence in the June 3, 2003 surgical report by Dr. Bray over the subjective conclusion made by Dr. Penner in his report of October 22, 2008.
>
> Conclusion: . . . You had extensive pre-existing non-compensable degenerative changes in your left knee at the time of the original Injury at work.
>
> The current condition of your knee was likely to occur even if there had been no initial work-related injury on November 7, 2002.

The adjudicator denies the worker's request to reopen his claim; the original decision of August 14, 2008 stands.

[39] The worker disagreed with the decision. He appealed it to the hearing officer. The hearing officer rendered his decision on March 31, 2009, also denying the appeal. He concluded that the ongoing problem the worker was experiencing in his left knee was due to a pre-existing non-compensable degenerative condition.

Medical Reporting received after the Hearing Officer's Decision

[40] Further medical reporting was received with the Notice of Appeal submitted by the workers' advocate office (see para. 5). Following are excerpts from Dr. Anderson's April 23, 2009 letter and Dr. Penner's May 19, 2009 report.

[41] Dr. Anderson's April 23, 2009 follows in part:

> I write regarding this man's left knee injury. . . . This documented significant intra-articular injury, including a complicated tear of the medial meniscus, a partial tear of the cruciate ligament and, not surprisingly, given the injury to the anterior cruciate ligament, there was associated significant chondral

damage. This latter problem, injury to the joint cartilage, is commonly associated with the appearance of osteoarthritis, which is, of course, a degenerative joint condition, but which, in this case, a major inciting factor is the injury to the joint surface itself.

It should be noted that [the worker], prior to his injury in 2002, did not have any significant knee complaints. He was able to run and use his knee without any significant symptoms.

[The worker] has suffered a further tear of his meniscus, which is commonly seen, according to Dr. Penner, following a previous tear of the meniscus. This, and the significant chondral injury, which he suffered in 2002, has led to the development of premature osteoarthritis and, in fact, the osteoarthritis, in my view, is not a pre-existing condition but rather was brought on by the original injury.

I should add that on Dr. Penner's consultation note of October 22, 2008, this view appears to be supported in Dr. Penner's assessment wherein he states that his injuries have led to early medial compartment arthritis.

Even if [the worker] did have a mild degree of osteoarthritis in 2002 at the time of the original injury, the original injury to his meniscus, anterior cruciate ligament and chondral surface is a much greater contributor to his current situation than he would otherwise have been in had he not injured his knee in 2002.

It does appear to me that the significant consequences of the original injury have not been taken into account and rather than his current situation being looked at as an isolated circumstance with a pre-existing condition, it is, in fact a direct consequence, although delayed in time, of the injury suffered in 2002.

[42] Dr. Penner's May 19, 2009 report states in part:

Investigations: Standing x-rays of both knees dated May 19, 2009 demonstrate obvious joint space narrowing of the left knee medial compartment. There is early osteophyte formation though there is still some cartilage space remaining. This is in contrast to the right knee which shows completely normal joint spaces both medially and laterally with no evidence of arthritic change.

Assessment and Recommendations: Left knee posttraumatic medial compartment arthritis.

The fact that the right knee is completely uninvolved, and the involved areas primarily the left medial compartment from which the majority

> of the medial meniscus was resected at the time of the surgery in 2003, strongly supports the contention that his left knee arthritis is post-traumatic in nature, secondary to meniscal injury and subsequent loss of the left medial meniscus. I have reviewed his operative report from June 3, 2003 which states "there was a posterior horn medial meniscal tear which was complex in nature and this was resected."
>
> I note that at no point in the operative report is the medial meniscus noted to have had a "degenerative tear." Rather, it appears that this was an acute complex tear of the medial meniscus. There is a note suggestive of some degenerative change within the patellofemoral joint, although it is clear that it is not his patellofemoral joint that is primarily symptomatic now. Indeed, his x-rays demonstrate focal medial joint space narrowing consistent with medial meniscal loss as secondary to trauma.
>
> I have reviewed the letters from the Workers' Compensation Board of the Yukon suggesting that the status of his left knee is not work-related. Unfortunately, this simply does not appear to be a reasonable conclusion.
>
> The unilateral nature with focal involvement of the medial compartment now approximately 7 years following a severe medial meniscal injury strongly would suggest otherwise.

[43] The morning of the hearing, August 11, 2009, the workers' advocate office provided an operative report dated May 20, 2009 by Dr. Penner. The worker underwent a left knee arthroscopy and partial medial meniscectomy with debridement. Post-operative diagnosis is "Post-traumatic left knee medial compartment arthritis with recurrent medial meniscus tear. Patellofemoral chondromalacia."

The Worker's Testimony

[44] The worker explained the initial accident as follows: His place of employment, an automotive shop, had a "sewer system" or water moat down the centre of the work area where water and waste would drain into and then run outside the building. It was covered by steel plates that ran the length of the shop. Because the plates were a make-shift set-up, they did not fit the holes that they covered properly and there were no retaining devices on the plates to hold them in place. These plates were knocked out position quite frequently. He said he was aware of these but the day of the accident, he was not paying attention while walking across the shop floor and not really paying attention to where he was placing his feet. He stepped on one of the plates and "down it went" and "down he went in with it". His leg went into the moat, he lost his balance completely and went forward down onto the concrete, but his leg stayed in the hole.

[45] The worker testified that he remained at work. When he did see the doctor he was told he had a sprain and did not need to miss work. He continued to work after the accident. He said that

it took 3 or 4 days for the swelling to go down; his leg was painful and his knee hurt continuously afterwards.

[46] He explained that he re-injured himself within a few weeks of the original injury. He believed that it was in November while adjusting the forks on a forklift. The worker said the forks are made of heavy steel. He said in order to get the forks into the right position, you have to push or kick the forks with your leg to make them move. He said he pushed the fork with his left leg and it felt as if his whole knee had come apart. The pain was worse than the first injury. The worker said he almost lost consciousness, he fell to the ground, and "saw little stars". His doctor said he had a sprain, it was not necessary for him to miss work. He was advised to attend physiotherapy.

[47] The worker testified that he attended physiotherapy for 6 to 8 weeks. The physiotherapist realized that they "weren't gaining any ground", his injury was not improving and his pain level was steadily getting worse – he lost feeling in his lower leg. The worker said his physiotherapist finally spoke to his doctor and the board; everyone agreed that his knee should be investigated further. He saw the board's medical consultant and was put off work.

[48] The worker testified that he had surgery on his knee on June 3, 2003. He was off work for approximately 10 months following the surgery and was provided with compensation benefits.

[49] He said that he returned to work on April 4, 2004 but he felt that it was too soon. His knee was still painful; he could not squat, kneel, or lift heavy weights. Activities that would put any stress on his knee, he did not have the stamina to do. The worker said to date he still cannot kneel, squat or do any heavy lifting.

[50] The worker testified that once he returned to his accident employer, he was having difficulty maintaining his production levels compared to before the injury. He had worked for the same company for 18 years. The way employees were paid had changed also. Previously he had been on an 8-hour wage system which was changed to a production-based system. He said he could not cope because of his knee. The company was interested in how fast their employees could work not how well they performed. He said he worked until that Fall but could not keep up with the production that his employer expected. The worker left the accident employer but continued to work for other automotive repair companies.

[51] The worker said that he expected his knee to hurt after it was injured and had surgery. He never complained or attended the doctor for 4 years because of this. He understood that certain parts of his knee had been damaged and they had been removed. That is the way it was going to be. He stated, "you just put up, shut up, eat your pills, go to work and hopefully it will get better." He said he never had a bad knee before so he did not know what was normal. When the pain got to the point where he could not handle it anymore, he went to the doctor.

[52] He testified that during the years 2004-2008 there is no medical reporting on his claim file. Although he attended the doctor for other issues, he said that he was unaware that he could return to the board and he was hoping he would get better. His knee was constantly painful and it kept getting worse. His doctor prescribed anti-inflammatories and Advil. The worker did not want to take narcotics. In 2008, after speaking with his family doctor, he approached the

board to inquire whether they would reopen his claim.

[53] The worker said he had surgery on his knee. His doctor told him that his knee is going to get worse. Ultimately, he will need to get a total knee replacement, probably within the next 2 years. He said that prior to the accident, he had no problems with his left knee. His right knee is fine; he has no problems with it.

[54] The worker said his knee is constantly painful. It does not go away. He said before the injury, he used to take his cameras and his dog and walk along the many trails in his neighbourhood. He would be gone for half a day. He can no longer go for a walk although he is hopeful that one day he will be able to return to walking long distances.

[55] The worker testified Dr. Anderson, his family doctor, has advised that he attend physiotherapy. He said he cannot afford it right now. Currently he is checking into attending a gym in his neighbourhood by purchasing a monthly pass. This would allow him to use a rowing machine and stationary bicycles in order to gain strength in his leg.

[56] The worker said no one has prescribed exercises for him. He was told to find a physiotherapist, inquire about a program and then undertake whatever recommendations they suggest. He said none of that has happened yet.

[57] When questioned about Dr. Bray "reading him the riot act", he said the riot act part of that reference was about his smoking. He said he has since quit. The other part, the worker said, was he was told to lose 50 lbs. The worker said he is 6 lbs. lighter than one year ago. He said it is difficult to lose weight when he has no mobility; it is painful to go for a walk.

[58] When questioned why he stopped wearing his brace at work, the worker said that although it is a great piece of equipment, he kept getting stuck in places when he wore it. He said that when working on big motors, he had to get right in the motor cavity. The brace was too big to move around and he would get stuck. He said that after a day's work, wearing the brace, he was just as sore as if he had not worn it.

The Workers' Advocate Submission

[59] The workers' advocate submits that the ongoing problems the worker is experiencing in his left knee are due to the 2002 work-related injury. The advocate also submits the ongoing recent symptoms are due solely to the work-related condition.

[60] The advocate references the November 8, 2002 x-ray which notes "minimal osteoarthritic change." She contends that for a man of the claimant's age, it is normal to see arthritic changes.

[61] The advocate addresses Dr. Anderson's January 22, 2003 report which states, "some very mild medial joint osteoarthritis". Dr. Anderson notes the worker's knees have never bothered him before and have been asymptomatic until the injury. The advocate asks the committee to review these documents because, she says, the claim was originally accepted for a mild strain which actually turned out to be a complex tear in the ACL joint and the meniscus.

[62] The advocate asks the committee's special attention to the board's alternate medical consultant's February 13, 2003 report because, she maintains, "it is pivotal" and clearly articulates what happened to the worker. She says this medical consultant examined the worker whereas the chief medical consultant has provided 3 reports on the file without examining or meeting the worker.

[63] She says the alternate medical consultant's March 13, 2003 report [see para. 22] is compelling evidence. The medical consultant attributes the results of the MRI imaging i.e., degenerative changes as secondary to the injury. He further opines that the meniscus tear resulted because of the workplace injury and the worker's symptoms are a result of the injury.

[64] The advocate referenced Dr. Bray's post-operative report of June 3, 2003 which showed the worker's patellofemoral joint showed extensive osteoarthritis of the femoral sulcus. The advocate maintains the "extensive osteoarthritis" was not evident on the November 8, 2002 x-ray, rather minimal osteoarthritic change was identified. She says that between November 18 [should have said November 8], 2002 and June 3, 2003 there has been a progression of osteoarthritis. The advocate says both Drs. Penner and Bray say the worker's osteoarthritis was traumatically induced osteoarthritis; it was not a pre-existing condition.

[65] The workers' advocate says Dr. Bray's follow-up report of July 2, 2003 recommends the worker should continue with therapy and rehabilitation but he would only be fit for a desk job.

[66] The advocate notes the physiotherapist report of September 24, 2003 states the worker is fit for pre-accident work with restrictions and/or modification. She submits that common sense dictates that it is pretty hard to send a heavy duty diesel mechanic back to work on light duty. She says it just does not happen. However, the worker did return to work on full duties. The advocate says the worker "was not able to cut it" because of the ongoing pain in his knee.

[67] She says the worker did not understand that he could return to the board with complaints of ongoing pain after completion of the graduated return to work. He found alternate employment of his own volition and continued with it until July of 2008, when he could no longer carry on with the pain.

[68] The advocate says that not seeking medical attention for a period of time while trying to continue working through the years is not a bar to compensation. She says the hearing officer and adjudicator have used this 4 year gap to deny the worker compensation. She submits that the worker possibly could have sought further medical treatment sooner but the worker cannot be blamed for trying to work through the pain and carry on to try and earn a living.

[69] The advocate takes particular exception to the medical consultant's statement, "it is my clinical opinion that the osteoarthritis would have predated the incident at work." She maintains "the medical evidence on file clearly indicates the worker's injury was traumatically induced, there was no osteoarthritis in the knee previously, the x-ray says minimal osteoarthritis and now it is deemed to be a pre-existing, non-compensable condition". She continues that the statement made by the medical consultant regarding no further medical reporting being received since discharge from the work conditioning program is where the claim "really got derailed". The

advocate says these comments are made outside of meeting with the worker, examining him and having a discussion with him. She says it is reports like these which lend a prejudicial effect to the adjudicator's conclusion. This kind of reporting tends to stop adjudicators from carrying out a proper investigation. This medical consultant's report suggests there was a pre-existing condition and the worker had recovered.

[70] The workers' advocate addresses internet information contained on the file which she states as "reams and reams of internet research" which they maintain "flies in the face" of the important principle that each case must be based on its own justice and merits. Again, she notes "reams" of risk factors for possible causes of osteoarthritis. She says this strays from this case being about the worker specifically.

[71] The advocate notes the medical consultant's report of July 11, 2008 states that having a meniscectomy does increase the risk of developing osteoarthritis. She says that it should have been investigated but all the other non-meritorious comments out shadows it and it is not looked into. The advocate says this report is directly contradictory to the alternate medical consultant's opinion that the accident in the workplace caused the meniscal tear and the degenerative changes seen in the MRI were secondary to this injury. These, she says, are conflicting medical opinions.

[72] The workers' advocate maintains the board denied this worker's claim because the x-rays showed degeneration in his knee. She reminds the committee the x-rays showed minimal arthritic changes. She submits that none of the medical evidence said it was a degenerative tear and the reporting to date addresses that issue. An x-ray taken 7 months post-injury notes extensive osteoarthritic changes in the worker's left knee. The advocate maintains it is traumatically induced arthritis.

[73] She says the hearing officer denied the worker's claim because he found that Dr. Penner relied on subjective background history and did not have the medical documentation from the original injury to form his assessment. The advocate says Dr. Penner is an orthopaedic surgeon who has probably spent 15 years in medical school and the hearing officer is calling his reporting subjective. She submits it is for this reason and the 4 year gap in medical reporting that the board used to deny the worker's claim for compensation.

[74] The advocate contends the opinions of the specialists, especially the orthopaedic surgeon who performed the knee operation, exceeds the board medical consultant's opinion who has not met nor examined the worker. To say that it is merely subjective medical reporting is absurd.

[75] The advocate references Dr. Penner's May 19, 2009 consultation report [see para. 42] in which he notes "left knee post-traumatic medial compartment arthritis". She says that diagnosis reveals traumatically induced arthritis. There is no internet article that can usurp this specialist's diagnosis. The medical specialist's opinion, that examined the worker and operated on him, must stand. In this instance Policy CL-54, Merits and Justice of the Case applies.

[76] The advocate addresses Dr. Anderson, the worker's family doctor's April 23, 2009 report

[see para 41]. She contends this report sums up the case and most significantly the statement by Dr. Anderson that says, "It does appear to me that the significant consequences of the original injury have not been taken into account and rather than his current situation being looked at as an isolated circumstance with a pre-existing condition, it is, in fact, a direct consequence, although delayed in time, of the injury suffered in 2002."

The advocate says they find it hard to believe that decisions have been rendered saying all of the worker's problems are related to something outside of what happened in 2002. She says, the damage, significant intra-articular injury and associated significant chondral damage, is what the board is saying has nothing to do with the work-related injury. The workers' advocate says Dr. Anderson is the treating physician; he relies on Drs. Penner and Bray's reports.

[77] She says the board did not base their decisions on the individual justice and merits of this worker's case. The board medical consultant did not meet nor examine the worker. She contends this caused a problem on this worker's claim.

[78] The advocate provided the following excerpts from Terence G. Ison's, *Workers' Compensation in Canada,* 2nd ed.:

- Pgs 58 & 59 – Multiple Causes of Disability
  section 3.7.1, Eligibility principles and
  section 3.7.2, Pre-existing conditions
- Pg. 217 & 219 – Problems of Medico-legal Interaction
  section 9.8.6, Deciding the general issue; section 9.8.9,
  section 9.8.9, Attitudinal problems
  section 9.8.10, Negative assumptions

[79] The advocate says sections 3(1), 6, 32, of the 2002 *Act* should be used in this worker's case. Policy CL-54, Merits and Justice of the Case and CL-47, Pre-existing Conditions should be applied.

[80] The worker asks the appeal committee to reverse the hearing officer's decision and reinstate his compensation benefits from the date they were terminated and when the worker left his employment, including any periods of time when he was not employed due to his knee injury and consequent surgery.

Issue: Are the worker's ongoing symptoms due to a work-related condition?

Answer: Yes

[81] Compensation entitlement decisions are made pursuant to legislation in place at the time of injury. In this instance the *Workers' Compensation Act*, S.Y. 1992 as amended to the date of injury should be used to determine the issues of entitlement.

[82] Section 3 (1) of the 1992 *Act* provides compensation entitlement to workers who suffer a work-related disability unless the disability is attributable to conduct deliberately undertaken for

purpose of receiving compensation.

[83] Section 5 states "if a disability arises out of or in the course of a worker's employment, the disability is presumed to be work-related unless the contrary is shown."

[84] Section 19.5 notes that decisions, orders and rulings of an adjudicator, the hearing officer or the appeal tribunal shall always be based on the merits and justice of the case and in accordance with the Act and policies.

[85] Section 19.6 provides a worker the benefit of the doubt on any application for compensation when there is doubt on an issue with respect to the application and the disputed possibilities are evenly balanced, the issue shall be resolved in favour of the worker.

[86] Policy CL-47, Pre-existing Conditions, effective April 1, 1994 states in part:

> A pre-existing condition means a known or unknown abnormal physical and/or psychological state of health that existed prior to the compensable disability.
>
> An aggravation means the temporary or permanent effect of a compensable condition on a pre-existing condition.
>
> A non-compensable pre-existing condition is a condition that did not arise out of and in the course of employment. It is not work-related.

[87] Policy CL-54, Merits and Justice of the Case states, in part:

> Evidence and the Decision-making Process
> Decision-makers must assess and weigh all relevant evidence. This necessarily involves making judgements about the credibility, nature and quality of that evidence as they determine the weight of evidence on either side of an issue. The decision-maker cannot ignore or fail to evaluate relevant evidence in the written decisions.
>
> Conflicting Medical Evidence
> The following general principles shall be applied by decision-makers in situations where conflicting medical evidence must be weighed for the determination of entitlement:
>
> 1. When addressing conflicting medical evidence, decision-makers will not automatically prefer the medical evidence of one category of physicians or practitioners to that of another. However, the opinion of a specialist concerning his/her area of specialty should generally be preferred to the opinion of a general practitioner.

2. Subject to paragraph 1. above, decision-makers shall consider all of the following criteria in deciding what weight to give to medical evidence:

   (a) the expertise of the individual providing the opinion,

   (b) the opportunity of the individual providing the opinion to examine the worker,

   (c) the timeliness of the examination and report relative to the issue,

   (d) the correctness of the facts and assumptions relied upon by the provider of the opinion,

   (e) any issues of bias or objectivity with the opinion,

   (f) objective versus subjective medical evidence, and

   (g) the findings of any relevant scientific studies referenced by a medical practitioner, as defined by the Act.

Analysis

<u>The Worker's Testimony</u>

[88] He noted that his knees were pain free before the incident at work, but since that time his left knee has constantly bothered him. He continued working but his knee kept him from being able to work at the level he used to do before his injury. He claims he "just toughed it out".

[89] The worker also stated that around December 11, 2002 he tried adjusting a fork-lift by kicking the forks in with his left leg. His knee buckled and he fell to the floor in pain.

[90] He went through a succession of jobs after working for one employer for 18 years. This was due in part to him being unable to work at the same pace as before because of his knee.

[91] The worker had been fitted for a knee brace and when the appeal committee questioned him how it was working, he stated that it kept him from the more confined spaces in vehicles which he needed to access. He would take it off and that would make work go faster, but the knee would pay the price.

[92] The evidence of the worker's testimony may be viewed as subjective, and perhaps even exaggerated to elicit sympathy from the committee; however, successive knee surgeries corroborate the reason for the continuing pain experienced by the worker.

The Medical Evidence

[93] A number of medical people were involved with the worker. We will examine statements by the worker's personal physician, his physiotherapist, his surgeon, as well as the board chief medical consultant and the alternate medical consultant.

[94] The initial prognosis was a sprain of the left knee made by his personal physician, Dr. Anderson as well as Dr. Tadepalli. An x-ray taken on November 18, 2002 showed minimal osteoarthritis in the worker's left knee. It is important to note the presence of arthritis because both the adjudicator and the hearing officer used that in their decisions to terminate compensation benefits.

[95] Initial treatment was for the diagnosed knee sprain, however, when the worker continued to complain of pain after a number of weeks, the attending doctors state:

- January 9, 2003 - Dr. Anderson – "This man continues to have recurrent swelling of his knee. Because of this I am concerned he may have some internal derangement although he doesn't have other symptoms at this point".
- January 13, 2003 - Catherine Fussell, of Riverfront Physiotherapy – "Grade I MCL or hamstring strain should have healed by now if that was the primary injury. Quadrant test and slow healing make me suspect medial meniscus tear".
- January 23, 2003 - Dr. Anderson – "I think that he has more swelling than one would expect from a simple sprain and it is my view that he should be either seen in consultation by an orthopaedic surgeon for an opinion and possibly arthroscopy or he should have an MRI scan of his knee to help sort this out".
- February 13, 2003 - Dr. Henderson – "This worker has probably torn his anterior cruciate ligament. . . . It is also possible that he has damaged the medial meniscus."

[96] The MRI taken on February 20, 2003 states, "Impression: Degenerative tear suspected in the posterior horn medial meniscus, extension to the tibial articular surface." Dr. Henderson, commenting on those findings on March 12, states it is his opinion that "this was not a pre-existing condition and that the meniscus tear happened as a result of the workplace injury."

[97] On June 3, 2003 Dr. Bray, orthopaedic surgeon, performs surgery on the worker's left knee. The complex medial meniscus tear is resected, grade 3 chondral damage is abraded and abrasion arthroplasty is performed on exposed subchondral bone. The procedure also notes that the patellofemoral joint showed rather extensive OA (osteoarthritis) of the femoral sulcus. The committee brings this up, because the x-ray at the time of the incident showed minimal OA, whereas, seven months later extensive OA is noted.

[98] July 2, 2003, the worker in a post operation follow-up report is advised to obtain a derotation brace for his return to work in three to six months. Dr. Bray also requires reassessment for knee laxity if ACL deficiency becomes symptomatic for the left knee. This orthopaedic surgeon recognizes the fact that the worker's knee may get worse over time.

[99] The following is from the August 28, 2003 physiotherapist's report: "Currently, the worker states the knee is fine 90% of the time but it flares up every few days when he 'steps wrong'".

[100] On March 8, 2004 physiotherapist Mandy McLung reports that complicating factors affecting recovery are "[The worker] has an unstable knee due to considerable laxity of his ACL (grade II) as well as medial joint degeneration." The laxity of his ACL was noted by other medical people as well and was attributed to the worker's accident.

[101] The medical consultant, on January 7, 2005, writes that in his opinion the main cause for the formation of the worker's arthritis is due to the worker's obesity. He further states the extensive arthritis was found in the patellofemoral joint, an area which is not directly damaged with a tear to the medial meniscus. On the basis of the foregoing he could not attribute the finding of the extensive osteoarthritis to the work-related incident.

[102] The worker's file was closed after the 1% payment for permanent impairment in January 2005; the board considered the worker fit to return to work. The evidence contradicts that assessment as the worker continued to have considerable difficulty with his knee resulting in several job changes over the next few years.

[103] In May 2008, the worker's knee is to the point where working becomes extremely difficult; he attends Dr. Anderson. The doctor states that the worker's symptoms are out of proportion to the x-ray taken at that time, which showed only minor degenerative changes and suggests a referral to an orthopaedic surgeon. The worker then applies to have his file reopened. His request is denied by his adjudicator stating that his present condition is due to the pre-existing arthritis in his knee.

[104] Dr. Penner, orthopaedic surgeon, in his October 22, 2008 report, assesses the worker's mechanical symptoms as consistent with recurrent medial compartment pathology. He makes the following statements:

- This originated with a work related medial meniscus tear in 2002.
- Currently, he likely has further fraying and degenerative tearing of the medial meniscus, as is commonly seen after the partial menisectomy. Further, this has led to early medial compartment arthritis with joint space narrowing as is very typically seen following a partial medial menisectomy.
- It seems quite clear that his unilateral left knee medial compartment early arthritic change and persistent meniscal pathology originated with his left knee twisting injury in 2002.

[105] The medical consultant reports to the hearing officer on March 18, 2009 and basically echoes his earlier diagnosis that the worker's present condition is due to the pre-existing arthritis, the age and the obesity of the worker.

[106] Dr. Anderson writes on April 23, 2009:

> Even if [the worker] did have a mild degree of osteoarthritis in 2002 at the time of the original injury, the original injury to his meniscus, anterior cruciate

> ligament and chondral surface is a much greater contributor to his current situation than he would otherwise have been in had he not injured his knee in 2002.
>
> It does appear to me that the significant consequences of the original injury have not been taken into account and rather than his current situation being looked at as an isolated circumstance with a pre-existing condition, it is, in fact a direct consequence, although delayed in time, of the injury suffered in 2002.

[107] The foregoing information is presented again to point out the progression of the medical findings since the worker's accident in October 2002, from the diagnosis of a knee sprain to surgeries for medial meniscus tears and the final prognosis of possible knee-replacement. It also points out the different views of the medical people involved.

[108] We consider the progressive nature of the worker's knee deterioration to be due mainly to the impact of his accident and the subsequent meniscus surgery. The worker's weight, according to medical literature, made him a prime candidate for early onset of arthritis; however, the committee agrees that the incidents at work were the main contributors to his present condition.

<u>The Requirements of the Act</u>

[109] Policy CL 54, Merits and Justice of the Case, requires the panel to assess and weigh all relevant evidence.

[110] In June, 2003 Dr. Bray operates on the worker on the basis of a work-related injury involving hyperextension to the left knee. After the operation he does not change his mind as to the cause of the knee damage and tells the worker that he may have subsequent meniscus tears in the future. The committee views this as compelling evidence that this expert considered the worker's condition to be work-related.

[111] The committee considers the findings of Dr. Penner to be important evidence as well. Here is a surgeon who has seen many knees during his years in practice and from that experience he draws a conclusion that the worker's left knee problem is work-related. He does not dampen his assessment by suggesting that it may also be due to the ravages of progressive osteoarthritis in the knee. If anything he suggests that the arthritic changes that have occurred are due to the 2002 injury.

[112] The medical consultant is the only physician who presumes that the worker's present condition is due to pre-existent arthritis brought on by the age and weight of the worker. The acting worker's advocate reminded the committee that his opinion was based on the medical reports available to him and not on a personal examination of the worker.

[113] In this case, the committee gives more weight to findings of those medical professionals who

had direct contact with the worker, especially those specialists who performed surgery on the worker's knee.

[114] Policy CL 47, Pre-Existing Conditions, requires the committee to assess whether there was a pre-existing condition or an aggravation of a pre-existing condition that became the major contributor to the worker's present condition.

[115] Dr. Bray, after operating on the worker's knee, noted extensive osteoarthritis almost seven months after the worker's injury. At the time of the injury an x-ray showed only minimal arthritic changes. Dr. Penner contends the level of left knee arthritis is post-traumatic in nature.

[116] In the committee's opinion, the presence of advanced osteoarthritis in the worker's left knee, just a few months after his injury, points to aggravation of a pre-existing condition. The policy states:

> If it can be shown that the pre-existing condition is worsened by the compensable condition, the pre-existing condition shall be considered compensable to the extent that the pre-existing condition has deteriorated as a result of the compensable condition.

[117] We did consider the medical consultant's view that the extensive osteoarthritis in the patellofemoral joint could not be attributed to the work-related incident since that area is not directly damaged with a tear to the medial meniscus. The committee finds that this did not answer the question of the rapid progression of the arthritis from minimal to extensive in such a short period of time and gives greater weight to the opinion of Dr. Penner.

[118] We also considered the 1% PPI and viewed the amount too small to be of any serious consequence in the outcome of this appeal.

Conclusion

[119] We conclude the worker suffered a compensable injury in November 2002 to his left knee. The hyperextension and twisting of his knee caused a severe sprain as well as a medial meniscus tear. This made the worker vulnerable to further meniscus tears with accompanying surgery and the possibility of eventual knee-replacement. Thus the subsequent deterioration of his knee was mainly due to the compensable injury.

[120] We also conclude the injury aggravated a pre-existing condition which deteriorated as a result of the compensable condition.

[121] We further conclude the worker is eligible for compensation benefits in the form of loss of earnings benefits and/or vocational rehabilitation if the worker can no longer work in his chosen occupation.

Decision

The worker's appeal is allowed. The hearing officer's decision of March 31, 2009 is reversed.

The board shall provide compensation benefits to the worker for time lost due to his injury and provide any necessary vocational rehabilitation.

Dated this **3rd day** of **September 2009** in the City of Whitehorse, Yukon Territory.

This decision is made with the concurrence of the appeal committee.

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H. Leenders, Committee Chair

Committee Members:

H. Leenders	Committee Chair
C. Alexander	Member
M. McCullough	Member