

# Workers' Compensation Appeal Tribunal

## Decision #173

**Claim Nos.: 2006-0453**

Date of Notice of Appeal: November 2, 2009

Date of Oral Hearing: June 24, 2010

Date of Decision: August 23, 2010

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

Committee Chair:	E. Sumner
Member representative of employers:	H. Hermanson
Member representative of workers:	M. McCullough

**In attendance:** The Worker  
The worker's representative – Rebecca Anderson  
Recorder - Vernna Johanson

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

## Introduction

This 51-year-old woman was employed as a licensed practical nurse. On April 6, 2006 she filed a claim for compensation stating that in approximately May of 2003 she suffered an injury to her shins due to working at a continuing care facility, walking on hard surfaces. Originally the claim was not accepted; however a hearing officer found that the worker had a work-related disability. She was provided loss of earnings and medical benefits. The worker underwent several medical investigations and a work-conditioning program. Recommendations from the work-conditioning program indicated the worker was able to participate in a graduated return to work; the employer was willing to accommodate this. The worker's benefits were suspended because the adjudicator found the worker was not willing to participate in a return to work.

The worker asks the appeal tribunal to reverse the adjudicator's July 31, and October 1, 2008 decisions to suspend her benefits because she has not recovered from her work-related injury. She requests entitlement for compensation and provision of rehabilitation services as provided by the legislation.

## Jurisdiction

- [1] On November 2, 2009 the workers' advocate office representing the worker, filed an appeal of the adjudicator's decision with the tribunal under s. 14 (3) of the *Workers' Compensation Act*, S.Y. 2008 (the "Act"). The review (appeal) must 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. The earliest date the workers' advocate office provided for hearing of the appeal was May of 2010, resulting in a delay in scheduling the hearing until June 2010.
- [2] Compensation entitlement decisions are made pursuant to legislation in place at the time of injury. The worker filed a claim for an injury/condition which occurred in 2003. In this instance the *Workers' Compensation Act*, R.S.Y. 2002 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 RE-01, Return to Work - Overview
  - Policy RE-02-1, Duty to Co-operate, Part 1 of 4: Early and Safe Return to Work
  - Policy RE-02-2, Duty to Co-operate, Part 2 of 4: Roles and Responsibilities
  - Policy RE-02-3, Duty to Co-operate, Part 3 of 4: Functional Abilities
  - Policy RE-02-4, Duty to Co-operate, Part 4 of 4: Penalties for Non Co-operation
- [4] The worker attended the hearing and testified by affirmation. She was represented by the deputy workers' advocate. The proceedings were recorded. The employer was notified of the appeal but did not participate.

## Evidence

- [5] The appeal committee considered the following:
- the worker's testimony

- the workers' advocate's submission
- the aforementioned policies
- the entire claim record No. 2006-0453 as provided by the board.

### **Adjudicator's Decisions**

[6] The case manager (adjudicator) issued a decision on July 31, 2008 stating the worker had undergone a number of investigations to help diagnosis of shin symptoms. A functional capacity evaluation and discharge report from the work hardening program indicates the worker could safely return to work in a modified manner; her accident employer was willing to accommodate. The adjudicator advises the worker to contact him or her former supervisor to discuss a return to work. He notes that if she does not do so by August 15, 2008 it is an indication that she does not wish to participate/co-operate in the proposed return to work and her loss of earnings benefits will cease.

An October 1, 2008 letter from the adjudicator responds to new medical information received after his July 31, 2008 letter. He states that he has reviewed the information and cannot find any objective reporting which would prevent her from participating in a return to work. The adjudicator further concludes the worker is not 100% disabled; she fits the criteria for suspension of benefits pursuant to Policy RE-02.

### **Evidence from the Record**

[7] The Worker's Report of Injury/Illness, dated April 6, 2006, states she suffered an injury to shins "due to shin splints" beginning in approximately May of 2003 due to the floors of the continuing care facility that she works at as a Licensed Practical Nurse (LPN).

The Employer's Report of Injury/Illness, dated April 24, 2006 provides an attached memo noting the worker was employed at a different location (continuing care facility) when she experienced pain in her legs due to the flooring. The report notes that at the time the worker filed her claim with the board she was employed at a different continuing care facility.

[8] Dr. Stephanie Starks Doctor's First Report dated April 5, 2006 states the worker was diagnosed with shin splints "3 years ago" after starting work as a nursing home attendant. When she attended school for her LPN certificate, symptoms eased. The worker is advised to stay off work for one month.

[9] Dr. Starks April 24, 2006 progress report refers the worker for an MRI and orthopedic assessment. The worker is not fit for work.

[10] A Bone Scan completed on July 11, 2006 states "opinion – consistent with stress periostitis bilaterally (shin splints)."

[11] Dr. Newhouse reports to Dr. Starks on July 17, 2006. Following are excerpts from the report:

The above patient has a fairly classic history and confirmatory bone scan of a medial tibial stress syndrome that has progressed from a tibialis posterior tendonitis to a periostitis to most likely a bilateral stress fracture and is now reversing itself with the relative rest.

We have advised a program of wearing a tibial air cast all of the time for the next two months along with semi-rigid orthotics for pronation control. After another 6-8 weeks she may try coming back to work with the tibial air casts on and orthotics in place.

- [12] The worker sees Dr. R. Loomer, Orthopedic Surgeon at the Specialist Clinic on September 1, 2006. He reports the worker developed pain in the pretibial area and in her feet about 3 to 4 years ago while working extra shifts. She was treated by a chiropractor, wore neoprene casts and special shoes. She was also referred to a primary care sports medicine doctor, Dr. Newhouse, in Kamloops. Dr. Newhouse ordered a bone scan which resulted in a diagnosis of "stress periostitis". Dr. Loomer states that he cannot add much to the diagnosis. He explains to the worker that he is not an expert in this area and does not feel qualified to give her advice on diagnosis or treatment.
- [13] A September 5, 2006 letter to Dr. Starks from Dr. Newhouse states "the above patient had been suffering from a medial tibial stress syndrome which I feel is related to her work where 8 hour shifts were done walking on hard surfaces."
- [14] Dr. Starks writes to Sunlife Assurance Company on December 5, 2006, providing a medical update on the worker's condition. Following are excerpts from her report:
- When I saw [the worker] on October 16, 2006, she was continuing to experience a significant amount of foreleg pain. The combination of air casts and orthotics had reduced her pain from severe to moderate level, but at that point she seemed to plateau with no further improvement in her symptoms. A CT scan of her tibia was requested and I made a referral back to Dr. Newhouse for reassessment.
- On December 4, 2006, I again saw [the worker] in follow-up. Symptoms remain essentially unchanged. Her CT scan and follow-up with Dr. Newhouse is still pending. [The worker] continues to use her air casts and takes ibuprofen to control the pain symptoms. She is unable to return to her work duties because of her persistent pain. It is difficult to set an expected return to work date at this time, given that her symptoms seem to be at a plateau and we have not seen any improvement for several months. As mentioned, earlier, the goal is to have her symptom-free for a period of two to three months before attempting to return to work.
- [15] MRI reports of the left and right legs undertaken on February 3, 2007 reveal findings of "no abnormal signal in soft tissues, cortical or medullary bone is identified."

- [16] Dr. Newhouse reports to Dr. Starks on February 8, 2007. He believes the worker is currently suffering from a neuropathic pain. He states, "This sometimes is called chronic regional pain syndrome." Dr. Newhouse advised the worker to become more active by participating in water running or swimming up to 4-5 times per week as well as using an elliptical trainer. He states, "I feel she could be brought back on a graduated return-to-work plan if her pain control is adequate."
- [17] A hearing officer review is conducted on March 7, 2007. The hearing officer asks the board medical consultant to interpret Dr. Newhouse's February 8, 2007 report, particularly to explain what neuropathic pain and chronic regional pain syndrome mean.

The medical consultant responds on March 20, 2007 as follows:

Neuropathic pain is pain initiated or caused by a primary lesion or dysfunction in the nervous system. The pain is usually described as being burning, electrical or pins and needles type. The most common causes of neuropathic pain are diabetic or peripheral neuropathy or postherpetic neuralgia.

Chronic regional pain syndrome means ongoing pain in an extremity with no apparent cause.

There is a condition that is called complex regional pain syndrome, and I am not sure whether or not Dr. Newhouse is considering this as a diagnosis.

- [18] The hearing officer sends the worker to Viewpoint Medical Assessment Services Inc. for a medical examination. In a letter dated March 23, 2007 he asks Dr. McDougall to comment as follows:
1. how her work might have affected or caused her initial condition (when first diagnosed in 2006). (Would it have been walking on hard floors at work that caused the shin pain or could the problem have arisen from some other source?)
  2. how her work might have affected or caused her present condition. (She has not worked since April 2006 but is still suffering shin pain.)
- [19] A FAME-Functional Test was completed by Sherri Beauchamp, BScKin, Registered Kinesiologist and Functional Evaluator at Viewpoint Medical Services Assessment Services Inc. on April 17, 2007. Following are excerpts from the evaluation:

Overall, [the worker's] results suggest that she is capable of working at a MEDIUM strength level, handling up to 50 pounds occasionally from waist to shoulder only. Due to observed difficulties with lifting from floor level (involving more of her lower body), reported symptom increase, and changes in biomechanics, it is suggested [the worker] perform LIGHT

strength level tasks (up to 40 pounds occasionally) when lifting from the floor.

. . . [The worker] was observed to weight bear for approximately 2 hours in total with sustained standing up to 15 minutes. She reported symptom increase with standing and was observed to frequently shift her weight from one leg to another, “roll” her ankle (both sides) while standing on the opposite leg, take more frequent breaks to sit/rest towards the end of the assessment, and frequently use external support. It is the evaluator’s opinion that [the worker] should be limited to frequent weight bearing and sustained standing on an occasional basis at this time as she was observed to limp towards the end of the assessment with prolonged weight bearing.

[20] Dr. McDougall, Occupational Health Consultant, Viewpoint Medical Assessment Services Inc., reports on April 17, 2007 in part as follows:

The validity of the Functional Capacity Evaluation demonstrates a patient who is relatively deconditioned. The FCE results are generally consistent with what I would have expected. It is, therefore, my opinion, that the results of this Functional Capacity Evaluation are valid in that they are a reliable indicator of what this patient is currently able to do. I do not however, believe this patient is at maximum medical improvement, i.e. that she can be better than she is.

#### Summary and Conclusions

Based on the results of this history, physical examination and a review of the documentation submitted with this file, it is my opinion that [the worker] suffers from periostitis, i.e. an inflammation of the periosteum of both lower shins, specifically the periosteum of both tibia. In my opinion, the common vernacular diagnosis of shin splints is appropriate for this patient. This is a relatively protracted and severe case with positive bone scan findings. The patient is, however, getting better. I am pleased to see that there is a normal MRI showing no structural defects. In my opinion, this patient has also had a delayed recovery, i.e. it has taken longer to get better than would normally be anticipated. I note, however, that this patient has some mild osteoporosis and is 47 years old. . . . Dealing with the patient’s mood is, in my opinion, a medically necessary treatment recommendation. The patient will feel better. Her pain will be much more tolerable. In my opinion, it is premature and not yet applicable to diagnose this patient with chronic regional pain syndrome. There is however, that risk. Pain can be a “learned” phenomenon. . . .

It is also my opinion that the patient’s job description does include significant and prolonged weight bearing job demands. In my opinion, therefore, the causation model with respect to work relatedness has been met. This patient does not have, by job description review, a sedentary job. . . . It is also my

opinion, that this patient's delayed recovery has been as a result of the multiple stressors in the patient's life. . . . Medical follow up is suggested in June of 2007 and by September 2007. In my opinion, there is an increased risk this patient will relapse should the patient return to a job that is predominantly weight bearing. Again, there are many patients who can move forward after an episode of "shin splints" and become active in activities of daily living and occupational activities. I do not believe that after one workplace incident, it is reasonable to suggest a change of occupation or workplace removal. Should, however, the patient's symptoms return, it would then be reasonable to assume this patient should be precluded from that type of work experience and be counseled in her activities of daily living to decrease weight bearing.

With specific reference to the questions that you have asked of me in your intake letter of March 23, 2007, I will answer them in the order presented. In my opinion, this patient's periostitis has been effectively caused by prolonged weight bearing. You have asked whether it would have been walking on hard floors at work that caused the shin splints or could the problem have arisen from another source. The problem, in my opinion, is relevant for all weight bearing and not just activities at work. Therefore, the weight bearing at work as part of the job description of the Licensed Practical Nurse is a constant exacerbating factor. For practical purposes, the percentage of time the patient is weight bearing at work versus those of non-work-related activities is an appropriate measurement of apportionment. In any event, however, it is my opinion that weight bearing at work is at best part of the cause for the patient's shin splints. This also goes to your second question where you note that the patient has not worked for a year but is still suffering shin pain. This goes to the prolonged convalescence.

- [21] The worker's job description is contained on file. After the heading "Working Environment", sub-title "Physical Effort" states:

Position assists with transferring and repositioning residents weighing between 100-300 pounds 15-25% of the time, although there are lifts that can aid with the transfers. Position stands, stoops, bends, walks, sits, reaches, and pushes (wheelchairs, beds, lifts, gerichairs), approximately 75-80% of the day. Position lifts boxes (supplies) up to 25 pounds approximately 5% of the time.

- [22] On June 28, 2007 the hearing officer renders a decision reversing the adjudicator's June 15, 2006 decision. He determines the worker's condition is a work-related disability; the worker is entitled to loss of earnings benefits and medical benefits for the disability.
- [23] Dr. Starks diagnoses "periostitis" on July 20, 2007 with a treatment plan of "retraining to other type of duties" and notes the worker has a chronic condition with "reoccurrence most likely".

- [24] A case manager's July 24, 2007 note to file states he received a call from the worker advising that she was moving to Powell River, BC and inquiring how it would affect her claim. The adjudicator tells that he had contacted her employer to determine whether they would accommodate her disability although they had not gotten back to him at that time. He tells the worker if her employer could accommodate her disability and she moved away or would not participate, there would be ramifications.
- [25] On July 26, 2007 the case manager's note to file mentions he spoke to the worker and explained the process regarding medical management and "hierarchies" he must follow on her claim. The adjudicator notes he told the worker she is not at the point of retraining. He further explained that if she cannot return to work, the claim will go to vocational rehabilitation. The worker is set up with therapy when she moves to Powell River.
- [26] An August 23, 2007 report by physiotherapist Inge Tholen, On Track Physiotherapy, states, "It is this therapist's opinion that [the worker] is suffering from bilateral chronic shin splints. An aggressive course of 8-12 weeks of physiotherapy seems most appropriate at this time."
- [27] An October 3, 2007 progress report by Robin Roots, physiotherapist, states the worker noted an improvement in pain following the first few sessions but no improvement in functional ability. When treatment progressed to include weight bearing, the worker reported an increase in pain which she had difficulty controlling. She continued to note constant pain in her lower leg during the day. The physiotherapist proposes the worker participate in a work conditioning program to increase tolerance to walking, standing and to perform other activities during weight-bearing. Mr. Roots states:
- While it is too early to predict a return to work status and date, it is expected that when [the worker] returns to work it will be on a graduated basis over a long time frame (3 months or greater), as she has been away from the workplace for an extended period of time.
- [28] The adjudicator's November 6, 2007 note to file states he spoke to the worker. She asked whether the graduated return to work could be done in Powell River. The adjudicator explained that her employer is in Whitehorse but if she found an employer willing to accommodate her restrictions, it was up to her, but she would have to give up her position in Whitehorse.
- [29] The worker attends Dr. Jubb for acupuncture on December 4, 6, and 7, 2007.
- [30] On December 10, 2007 physiotherapist Tholen reports:
- Objectively, [the worker] demonstrates a full range of motion in her knee and ankle bilaterally. She walks without limping. There are no signs of inflammation or swelling. Functionally, [the worker] is able to execute all aspects of the work conditioning program. She is able to cycle/walk for 1 hour, attend 1 hour of stretching, execute 45 min. of core strengthening exercises, participate in a 1 hour pool session and execute 1 hour of strengthening exercises in a gym environment. During the

functional training, she has demonstrated that she is able to lift 12 lbs. from floor to waist and from waist to shoulder repetitively. She has demonstrated rolling over a weighted “dummy” bag repetitively without a problem.

After treating [the worker] since August, 2007, initially with physiotherapy and afterwards with a daily 4-hour work conditioning program, it is this therapist’s opinion that [the worker] should attempt to return to work to her position as an LPN on a gradual basis. I would suggest initially to start with 2 weeks of 2-4 hours per day without any restrictions and then gradually increase the number of hours.

[31] A draft Return to Work plan dated December 11, 2007 has the worker returning to work on a graduated basis with no job restrictions. The plan is to work full duties for the entire return to work plan beginning at 2 hours per day on week one and working up to 12 hours per day at week eight.

[32] Dr. Jubb refers the worker to Dr. David Mann, a sports medicine doctor. On December 14, 2007 he reports:

This lady has chronic difficulties and extensive investigations and consultations. A diagnosis is still elusive and while there is a degree of chronic periostitis, I do not feel this will account for her current symptomatology. Chronic ongoing periostitis can eventually result in chronic compartment syndrome and I have seen this many times. The investigations for this are relatively simple, particularly as it involves the anterior compartment and I strongly recommend that this diagnosis be considered, even in the absence of distal dorsal neurological findings with provocation. I am baffled however about her night time pain and I suppose a degree of restless leg syndrome will also have to be entertained.

[33] Dr. Mann refers the worker to Dr. A. Salvian, Vascular Surgeon, on December 14, 2007, asking whether or not Dr. Salvian agrees with the diagnosis of “chronic anterior compartment syndrome” as a viable differential.

[34] The case manager’s note to file dated December 18, 2007 states he met with the employer to discuss a graduated return to work. They are willing to accommodate her. The worker calls on December 19, 2007 stating that physiotherapy has aggravated her shin splints and her doctor is sending her for tests for compartment syndrome.

[35] The file contains the same draft Return to Work plan dated December 11, 2007 [ref. para. 31]. Functional Abilities state, “see attached updated physical abilities report” which includes the following:

- Full range of motion in ankles and knees
- Walks without a limp

- No signs of inflammation or swelling
- Able to full(y) participate in four hours of activity (**1 hour of cycling, 1 hour of stretching, 1 hour of pool sessions and 1 hour of strengthening exercises.**)
- Repetitive lifting floor to waist (12 lbs)
- Repetitive lifting waist to shoulder (12 lbs)
- Able to roll over a weighted dummy bag repetitively without a problem.

[Bolding on original document.]

- [36] February 14, 2008 compartment tests of the right and left legs indicate a negative test for compartment syndrome.
- [37] Dr. Salvian, Vascular Surgeon, reports on February 28, 2008 that he is not sure why the worker is suffering from pain symptoms in her legs. He will organize a CT scan of the lumbar spine and suggests the worker be seen by a neurologist.
- [38] Dr. Mann's progress report dated March 7, 2008 notes the worker's condition or treatment has changed. He provides a diagnosis of "chronic leg pain". After the heading "Return to Work Planning", Dr. Mann checks off the "no" box after the question "Is the worker now medically capable of working full duties, full time?"
- [39] An April 4, 2008 CT scan of the Lumbar Spine notes some degenerative disc space narrowing and degenerative changes which may compromise the L5 nerve roots laterally. There is no focal disc herniation, spinal stenosis or other abnormality noted.
- [40] Dr. Teal, Neurologist, reports on April 24, 2008:
- She does have some evidence for a peripheral neuropathy but the majority of her symptoms do not sound like neuropathic pain to me and I do not think she has a complex regional pain syndrome. . . .
- Unfortunately, I am not certain what is causing her rather persistent calf and shin pain provoked by walking very short distances on cement or her nocturnal pain.
- [41] The case manager's July 28, 2008 note to file states he called the worker to set up a meeting with the employer. There was no answer "again". He states he called last week and left a message for her to call him back. Also, "the employer is willing to accommodate".
- [42] The case manager's July 31, 2008 note to file states he received a call from the worker's supervisor to determine if anything had been done. The employer told him the worker was in Whitehorse as she had stopped by work to see some old colleagues. When the supervisor questioned whether she would be returning to work, she informed him she was diagnosed with a "complex region pain syndrome" and did not say when she would be returning to work. The case manager states, "I am going to suspend her benefits until she contacts the board. I need to set up the RTW [return to work] meeting".

[43] The adjudicator writes to the worker on July 31, 2008 stating that pursuant to Policy RE-02 and RE-03, the worker has a duty to co-operate with her employer with regards to return to work and she is responsible to mitigate her losses. Further, the adjudicator states that since the worker has been cleared to return to work and her employer is willing to accommodate the provided recommendations, she no longer suffers a loss of earnings and she is no longer entitled to this benefit. He directs the worker to contact him or her supervisor as soon as possible to discuss return to work. If he has not heard from her or her supervisor by August 15, 2008, he will take it as an indication that she does not wish to participate/co-operate in the proposed return to work recommendations.

[44] A Return to Work Plan dated July 31, 2008 states the following:

Case Management Team:

The case management team supporting [the worker's] recovery and return to work includes:

Worker: [Worker's name]

Employer Representative: [name]

Family Doctor: Dr. Watson

Physiotherapist: Inge Tholen

Disability Manager: [adjudicator/case manager's name]

Return to Work Action Plan

The recommendation from the treating physiotherapist are to have [the worker] return to work on a graduated basis. Initially starting at 2-4 hours per shift for the first two weeks without any job restrictions and then gradually increase the number of hours.

An accompanying chart indicates the worker is to begin week one for 2 hours and work her way up to 12 hours by week eight, completing full duties at every step.

[45] On September 2, 2008 the case manager writes a note to file stating the worker's supervisor called. The case manager explains he has sent a letter to the worker but has not heard back from her; he has suspended her benefits until he hears from her. The supervisor states he saw the worker at a local store "a week ago".

[46] Dr. Newhouse reports on September 8, 2008 that the worker's symptoms are in keeping with complex regional pain syndrome and peripheral neuropathy. At the worker's request, they are undertaking repeat vascular lab tests and a DEXA scan "due to the previous stress fractures".

[47] Dr. Watson reports on September 11, 2008:

[The worker] has been away all summer in the Yukon. Whilst there she saw her old Sports Medicine Dr. Newhouse. He has referred her for further evaluations – bone scan and vascular assessment I believe. [The worker's] pain in her shins is progressively worsening in that the burning sensation is now felt above the knees bilaterally. She feels the pain walking on a flat surface for example walking around the supermarket. I do not feel she is ready for a return to work plan yet. Given that her symptoms have not

significantly improved over the years further improvement in the near future is unlikely.

- [48] The case manager's September 15, 2008 note to file reports the worker called inquiring about her cheques. He explained he had sent a letter telling her to report back to him by August 15<sup>th</sup> or he would consider it an indication that she did not wish to return to work. The worker explained her doctors told her not to return to work because of "the extensive damage to her legs." The case manager indicated he needs objective medical reporting to substantiate this claim.
- [49] Dr. Watson reports on September 18, 2008 the worker is not fit to return to work "despite the recommendation by the physiotherapist in December 2007". The worker reports worsening of her symptoms over the last 12 months including some new symptoms.
- [50] Three reports dated October 14, 2008 from Royal Inland Hospital Diagnostic Laboratory contain:
1. "Entrapment Testing" final impression: "The above results are negative for popliteal artery entrapment."
  2. "Compartment Syndrome Testing" final impression: "The patient is positive for compartment syndrome in the left anterolateral compartment".
  3. "Doppler Arterial Assessment" final impression: "The above results indicate patent arterial flow proximally and distally to both lower limbs with minimal to no disease proximally or distally."

Note: "This document has been dictated and authenticized by Dr. A. Azad" (vascular surgeon).

- [51] The adjudicator writes to the worker on October 31, 2008. He states that the new medical information contains no objective reporting which would prevent her from returning to work. He notes that Dr. Newhouse reported she provides care for her disabled son, performs household duties and travelled from Powell River to the Yukon and back in a truck and camper. These activities, in addition to the functional information provided by the physiotherapist, indicate she has the ability to return to work. His July 31, 2008 decision stands.

- [52] Dr. Quong's follow-up of chronic lower limb pain report of October 17, 2008 states:

She does get features of common peroneal nerve entrapment with burning pain over the lateral aspect of the calf and paresthesia into the dorsum of the right and left feet. She also has hyperesthesia over the lateral aspect of both lower calves.

We have therefore referred her to Dr. Azad for consideration of definitive surgical therapy for the chronic compartment syndrome diagnosed on these recent vascular tests.

[53] The medical consultant reports on November 20, 2008:

I must say that the reports do not suggest that she meets the criteria for complex regional pain syndrome but an assessment at a facility such as Orion Health would be clinically appropriate.

At the present time, I would strongly advise against surgical therapy for compartment syndrome. At the very least, the previous reports should be supplied to the treating physician, as these reports clearly demonstrate that compartment syndrome was not previously present. One might be able to make a case for compartment syndrome developing if she were hiking while camping but it is not reasonable nor probable from a medical perspective to relate the current findings of increased compartment pressure to her work activities in 2003 especially when the previous testing was normal.

[54] A May 4, 2009 report by Dr. A. Azad, Vascular Surgeon states:

She was seen in the vascular lab where she was found to be positive for compartment syndrome on her left side. Anti lateral compartment was quite high. This patient has also been experiencing complex regional pain syndrome problems. . . . Before we go ahead and do a compartment release I think one thing I will check her for is sympathetic dystrophy in the vascular lab. I will make arrangements for that to be done tomorrow. I'm also going to get a series of sympathetic blocks on her before she makes any decision as to carry out release or have her return back to work. I am just not convinced that the compartment syndrome is causing her that much discomfort just at rest. If it is just a complex regional pain syndrome it may respond to the sympathetic blocks, but we have to prove that there is sympathetic abnormalities to begin with.

[55] "Sympathetic Testing" is undertaken on May 5, 2009. The final impression by Dr. Azad is "moderately abnormal sympathetic tone, both lower limbs."

[56] On June 4, 2010 the deputy workers' advocate provided further medical reporting to the tribunal via e-mail attachment. The documents were reviewed pursuant to Policy AP-03. The committee found that they did not meet the criteria for new or additional evidence as set out in Policy AP-03, "New Evidence at Reviews & Appeals". We have set out excerpts from the documents below.

[57] A September 2, 2009 Consultation Report by Dr. M. Kowbel, an anesthesiologist and pain management physician, states he believes the worker suffers from a chronic pain syndrome which started in 2003 when the worker developed shin splints and fractures. He reports, "The chronic pain syndrome is likely from a myofascial problem and not a complex regional pain syndrome or compartment syndrome." He lists the reasons why he believes it is a myofascial problem and not a complex regional pain syndrome or compartment syndrome:

Summary: I think this lady suffers from a chronic myofascial pain syndrome affecting below the knees bilaterally. She requires a specialized team to deal with the problem including tertiary specialists in the field of physiotherapy and massage therapy. Ideally she would be best handled by a multidisciplinary approach and a multidisciplinary pain management team. There is a relatively good chance that with her motivation that she may return to work or may feel better enough to work given the appropriate treatment and appropriate length of treatment. It will be a lengthy process of 2 years if not longer.

[58] Dr. May reports to Dr. Watson on November 3, 2009 that he saw the worker approximately 2 weeks after her right-sided lumbar sympathetic block. This resulted in a warming of her leg and almost eliminated her right-sided pain for 24 hours. “Unfortunately the pain and coldness returned after that.” Dr. May states:

It seems to me that these findings and my previous examination are all consistent with a diagnosis of CRPS [complex regional pain syndrome] in both legs and I have explained this to [the worker] today. I have explained that the major treatment for CRPS is gentle regular mobilization rather than “exercising through the pain”.

She tells me that WSBC [WorkSafe BC] will want some objective testing for CRPS. I have explained to her that here is no one objective test. However, if WSBC are adamant they can probably arrange some thermography testing.

### **The Worker’s Testimony**

[59] The worker explained the symptoms she experienced on April 4, 2006 which caused her to first miss work due to the injury. She said her shins were totally on fire; deep, deep burning. It felt like the shin muscle was “getting ripped off of” her bone. She experienced severe, sharp, stabbing pains and muscle cramps in both legs, more severe in the left leg than the right.

[60] From April 2006 to the present her symptoms have changed in the following ways. She now suffers deep, deep, aching and burning. Her feet are ice-cold all the time. She needs to sleep with her socks on, a quilt folded in half on top of that and a down-filled quilt folded in half over top of her feet. Her tendons from the knee down are shrinking drastically. She said that most of the shrinking occurs at night when she is sleeping; she can feel the tenseness. She said she tries to “stretch it out” and when she does, it creates a severe muscle spasm in her calves. This causes her to lose sleep.

[61] The worker testified that presently she will be walking across a floor and her toes on her left foot “trip” her. This also happens when she is going up stairs. She testified the doctors have classified these occurrences as “foot drop”. Within the last year, her big toe gets a deep ache that really hurts. She said doctors have diagnosed this as gout.

- [62] She said she suffers severe, sharp, stabbing pain in her legs which she referred to as the “nerve damage pain” which is why she was prescribed Gabapentin. She is also taking quinine to help stop the muscle cramping. The worker asked her doctor for a higher dose of quinine because the cramping has become more frequent and severe. She was told they could not increase it as she is on the highest dose possible.
- [63] The worker testified that she did not experience similar pain in her legs prior to 2003 when she started to work at the continuing care facility.
- [64] She said she manages her symptoms with medication. Previously, she received rehabilitation from a work-conditioning program. When she first moved to Powell River, she attended a physiotherapist. The worker said the physiotherapist would massage her legs, finding trigger spots. The first one she found, the worker said, hurt “extremely” when she pressed on it. When the original physiotherapist was not available, the one that replaced her, “had a different outlook” leading to problems for the worker. It was this physiotherapist that put her into the work-conditioning program which led to a suggested return-to-work.
- [65] The worker testified that since she stopped the work-conditioning program, she feels that she has regressed. She said that when she was attending the program, when the others went outside for a walk, she had to stay inside and use a recumbent bicycle, with zero tension on the pedals. The tension was never increased. When she attempted to ride the normal stationary bikes, it caused too much pressure on her shins and created more pain.
- [66] When questioned why the worker sought treatment on her own, she said that many of the doctors said there was nothing more they could do for her. She said she does not want to give up. She does not like to be on Gabapentin and quinine all the time. She believes that her doctors were trying to refer her to “people who knew”. She said some of the testing increased the pressure in her legs and so it was stopped.
- [67] She said was diagnosed by Dr. Newhouse in February of 2007 with complex regional pain syndrome(CRPS) but no one would agree with that diagnoses. The worker said recently the more doctors she has attended have agreed that she does have CRPS. She says she feels “tied”; she does not know what to do or how to fix her legs. On one hand, if she has CRPS and compartment release is undertaken, it will make the syndrome worse. When she had the sympathetic blocks last August, the doctors said if it did not work, then she should undergo a sympathectomy. This involved killing the nerves. She said some doctors say this does work; some say it does not. She is getting conflicting medical information and does not know where to go.
- [68] She said she asked the board to send her to a pain centre in Toronto staffed by people who deal with these issues all the time; they are located in the same building and would naturally come to the same conclusions about her condition and how to handle it. She needs answers and definite direction on what to do.
- [69] The worker testified that she has not and does not do anything away from work that could produce the severity of symptoms she is experiencing. She cannot stay in the kitchen and

cook a full meal; she has to do it in sections. Climbing stairs and standing for prolonged periods, such as cooking, creates pressure and weakness in her legs.

- [70] The worker said that she was not made aware of a return to work plan developed by the board until she returned home from Whitehorse to Powell River in September of 2008. The letter from the board arrived in August; it was post-stamped August 8<sup>th</sup> and was to be in effect by August 15<sup>th</sup>.
- [71] She said when she left Powell River to come to Whitehorse, the treatment plan concentrated on pain management only. No one knew what to do to manage the pain. She tried to attend Dr. Newhouse before leaving but he was on holidays. On her way back, she did see Dr. Newhouse who suggested getting the compartment syndrome testing redone. This was scheduled for October 14<sup>th</sup>. The worker said her case manager agreed to wait until the testing was done but he went ahead on October 1, 2008 and made a final decision.
- [72] She testified she was not involved in the creation of the return-to-work plan in any form. She said she cannot figure out any of "this mess". When she was in Whitehorse, she went to both previous places of employment and spoke to her former colleagues and manager. The manager had changed since she had last been employed. She said she introduced herself to the new manager but he did not say anything to her about a return-to-work. She called her case manager when she returned home and that is when he told her she needed to submit objective medical reporting.
- [73] The worker attended her family doctor but was advised not to return to work. Documentation from her doctor was submitted to her case manager. When he received it, he informed her it was not good enough; he needed objective information. The worker feels that by not accepting her doctor's recommendations, it makes her look like a fool. She has to continue to attend her doctor and relate that the doctor's word is not good enough; WCB will not accept it.
- [74] When questioned who was responsible for the worker's medical management she said that her family physician, Dr. Starks, referred to her an orthopaedic surgeon in Kamloops who in turn referred her to Dr. Newhouse. The bone scan was ordered. She said that no one knew how to deal with her issues or direct her to the correct doctor/specialist. She believes it is the sports injury doctors, Dr. Newhouse and Dr. Mann, which are directing her care with specialists. Dr. Starks was her physician in Whitehorse and Dr. Watson is her physician in Powell River.
- [75] The worker testified that once she returned home in September and received the letter from the case manager notifying her that she was expected to return to work in the Yukon, she contacted him and asked that she be sent to Toronto for treatment rather than having her "jumping all around the provinces of BC and Alberta". She said the place in Toronto deals with her type of condition all the time. This would allow her to get some answers and she would get direction of what to do. She said her next step is Dr. Azad for sympathectomy; a very invasive procedure.

## The Workers' Advocate's Submission

[76] The worker disagrees with the July 31, 2008 decision letter and subsequent confirmation letter of October 1, 2008 which resulted in a suspension of benefits effective August 15, 2008. She submits it was wrong for the case manager to terminate benefits because the worker continues to suffer a loss of earnings directly related to bilateral leg pain as a result of the work-related injury suffered in 2003.

[77] The advocate says the following policies apply to this worker's appeal. These policies were in effect at the time of injury and should be used for entitlement purposes:

- Policy CL-54, Merits & Justice of the Case
- Policy CS-08, Suitable Employment and Earnings Capacity Loss
- Policy CS-11, Rehabilitation

For appeal purposes:

- Policy RE-02 – Duty to Co-operate, Parts 1 to 4
- Policy RE-10 – Vocational Rehabilitation

The advocate also provided the following excerpts from Terence G. Ison's, *Workers' Compensation in Canada*, 2<sup>nd</sup> ed.:

Pg. 21, section 3.2.7, Pain

Pg. 58, section 3.7.1, Eligibility principles

Pg. 60, section 3.8.1, General principle

Pg. 61, section 3.8.3, Disablement from drugs

[78] The advocate says there are two issues to address:

1. The worker continues to experience significant bilateral leg pain which has been diagnosed as chronic pain.

The advocate submits the worker has not recovered to her pre-injury status, nor has she reached medical stability. She is still unable to work due to pain and medication effects as a direct result of her work-related injury which she sustained in April 2006.

2. The board, without neither input nor consultation with the worker or her treating physician, developed a graduated return to work plan for her to return to her pre-injury employment in the Yukon.

The advocate says the board is aware the worker relocated to Powell River, BC in 2007. She submits that relocation cannot be a bar to compensation; however, the board has used this as grounds to suspend the worker's wage loss benefits.

[79] The advocate submits the board medical consultant was questioning compartment syndrome as early as December 29, 2006, noting it as one of the disorders that can mimic the symptoms of shin splints. On February 14, 2008 the worker underwent tests for compartment syndrome. The advocate submits the tests at that time were essentially negative; however on the

accompanying report by Dr. Salvian, Vascular Surgeon, he notes the worker's history is consistent with chronic anterior and lateral compartment syndrome. The advocate says although the tests were negative at that time, it was at Dr. Salvian's recommendation the worker be retested; it was not at the worker's request. The advocate points this out because the case manager later uses this information to suspend the worker's benefits. The advocate says on October 15, 2008 when the tests were repeated, as suggested by Dr. Salvian, they did show positive for compartment syndrome.

- [80] She points out that Dr. Mann's December 13, 2007 report states chronic periostitis or shin splints can eventually result in chronic compartment syndrome. She contends it is possible and probable that the shin splints have resulted in, or at the very least, contributed to the confirmed compartment syndrome.
- [81] The advocate maintains the worker was not fit to return to her pre-injury job after being discharged from the work-conditioning program on December 17, 2007. She references Dr. McDougall's Independent Medical Examination conducted on April 17, 2007 [ref. para. 20] noting that he advises the worker's job as an LPN "is a constant exacerbating factor" that carries "an increased risk this patient will relapse should the patient return to a job that is predominantly weight bearing". The advocate uses Policy CS-11, Rehabilitation, to strengthen her argument.
- [82] The advocate contends that if the worker would have returned to work in August of 2008 as a LPN, it would not have only jeopardized her own health and well-being, it would have affected the health and well-being of the patients she was caring for.
- [83] She references Dr. Azad's October 14, 2008 report in which he notes the worker is positive for compartment syndrome in the left anterolateral compartment. A further May 4, 2009 report by Dr. Azad states the worker is positive for compartment syndrome on her left side, in addition to experiencing complex regional pain symptom problems.
- [84] The advocate asks the committee to review Dr. Kowbel's November 2, 2009 [should be September 2, 2009 ] report wherein he opines the worker suffers from a chronic pain syndrome which started in 2003 when she developed shin splints and stress fractures. He further states that the chronic pain syndrome is "likely from a myofascial problem and not a complex regional pain syndrome or compartment syndrome."
- [85] The advocate submits the aforementioned medical reports speak for themselves and although the physiotherapist did recommend an attempted graduated return to work there is considerable medical evidence on file to the contrary. The worker was specifically told by several doctors, including her family doctor and specialists, not to return to work. She contends that Policy CL-54, Merits and Justice of the Case, applies; in particular, 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. The opinion of a specialist concerning her or his area of specialty should generally be preferred to the opinion of a general practitioner.

- [86] She says the medical evidence on file shows this worker is still struggling and suffering with both recovery and rehabilitation. The worker would not be presenting with the ongoing pain but for the work-related incident. This worker has recently been diagnosed with chronic pain. In spite of this, she has continually shown both a willing and a co-operative nature to all potential treatments from physiotherapy to painful and intrusive injections for the sole purpose of her recovery and return to work.
- [87] The advocate submits the worker had no previous history of chronic pain. It is clear from the medical reporting on file it developed directly as a result of the work-related accepted injury of April 2006. As confirmed in the medical reports, and no time since the date of injury, has the worker been fit to work in her pre-injury occupation. They believe the board is compelled by legislation to deem the worker, allowing her some dignity to focus her efforts on dealing with the chronic pain on a daily basis, to seek out the treatments she needs and to get on with her life.
- [88] She contends that as a direct result of the board's lack of support, this worker's medical condition has regressed to the point where it would be very difficult, if not impossible, for the worker to recover to a medical plateau where she is able to return to work.
- [89] The advocate says the board developed a rehabilitation plan for return to work in the Yukon when the worker has been residing in Powell River, BC since August of 2007. She notified the board that she had relocated and was assured that it would not be a problem. There was no consultation or involvement with the worker or her treating physicians in developing the graduated return to work plan. Additionally, there was no consideration given to the fact that the worker had been living away from the Yukon for a year at the time of the graduated return to work plan. She contends from documentation contained on file, there is no meaningful or adequate consultation between the board and worker. The worker was not involved whatsoever in the return to work process nor was she listened to when she said she was still in a great deal of pain.
- [90] The advocate submits the worker was specifically told by her physician she was not ready to return to work. The work conditioning program ended in December 2007; the graduated return to work was being arranged for August 2008 – a significant period of time without any kind of treatment plan in place. They believe a lot of regression happened during that period. Since reporting in 2006, the worker's symptoms never significantly decreased or were manageable for her. She was terrified to have her symptoms increase as she was already in a great deal of pain. The worker was left with the impression that she had no control over her personal life or her treatment.
- [91] She maintains the worker first experienced symptoms of bilateral leg pain in 2003 after commencing work as an LPN at the continuing care facility. The symptoms grew steadily worse until April 4, 2006 when she was forced to stop work due to the pain. The symptoms were persistent and did not subside or reach any medical plateau prior to the claim being suspended in August of 2008. Doctor and specialists reports consistently state the worker was not fit to return to work.

## **Relief Being Sought**

[92] The worker asks that the tribunal reverse the case manager's July 31, 2008 decision and subsequent confirmation letters. She asks for reinstatement of her benefits from August 15, 2008 to the present, including loss of wages, medical treatment costs and any other related expenses on an ongoing basis.

## **Issue: Were the worker's benefits terminated correctly?**

**Answer:** No

## **Analysis**

[93] The case manager's July 31, 2008 decision states:

Your claim for compensation was accepted for bilateral shin splints that arose out of the course of employment as an LPN. A bone scan was performed which showed evidence of bilateral shin splints. This diagnosis was clinically confirmed through Dr. McDougall's Independent Medical Evaluation. Other investigations have been performed but none of the investigations have provided new or alternative evidence to the cause of your shin symptoms. Dr. McDougall's recommendation was that a graduated return to work should be planned and if your symptoms returned then you should be precluded from doing those activities.

Under RE-02 and RE-03, you have a duty to co-operate with your employer with regards to return to work and you are responsible to mitigate your losses.

The case manager directs the worker to contact her supervisor at the continuing care facility "as soon as possible" to discuss return to work. He then advises that if he does not hear from her or her supervisor by August 15, 2008 it will indicate she does not wish to participate/co-operate in the proposed return to work recommendations.

[94] Policy RE-01, Return to Work Overview states:

### **General Information**

Return to work is a proactive approach to help injured workers return to safe and productive work activities as soon as it is functionally appropriate. It is a partnership involving employers, workers, health care providers, union and the Yukon Workers' Compensation Health and Safety Board (YWCHSB). The YWCHSB provides return to work services and programs to injured workers; the primary goals of which are to safely return each worker to employment or employability that is comparable to the pre-injury level as soon as functionally appropriate during recovery. The YWCHSB recognizes that early and safe return to work is an important part of the rehabilitation plan for most injured

workers. If a worker is able to remain at work or return to the workplace during their recovery period, the social and financial costs associated with the workplace injury are significantly reduced.

#### Definitions

1. Case Management Team: A team that assists the injured worker with their recovery, early and safe return to work plan and, if needed, vocational rehabilitation. The team always includes the injured worker and YWCHSB. Employers have a duty to co-operate in their injured worker's early and safe return to work and will be encouraged to use participation in the Case Management Team to facilitate that duty.

#### Policy Statement

The YWCHSB will encourage injured workers, health care providers, employers and other parties to work co-operatively as a Case Management Team and to explore all reasonable, creative and flexible solutions to design plans that will facilitate the worker staying at work, when possible or facilitate the worker's early and safe return to work when the worker, functionally cannot stay at work.

#### 1. Early and Safe Return to Work

Return to work following a work-related injury starts during the recovery phase of the early and safe return to work plan. In this phase of return to work, injured workers and their employers will work together with the YWCHSB and other appropriate parties to form the Case Management Team to accommodate an injured worker's functional abilities while recovery from the injury is occurring. Section 40 of the *Act* includes a duty to co-operate in early and safe return to work for all injured workers and their employers. The focus on this phase is on accommodating the injured worker in their pre-injury job with the pre-injury employer in accordance with the following hierarchy of return to work.

#### 2. Return to Work Hierarchy of Objectives

Return to work services are provided according the following sequential hierarchy of objectives to return the worker to:

- a) their pre-injury job;
- b) their pre-injury job with modifications/assistive devices (modifications do not include changing job duties);
- c) their pre-injury job with modified duties (including different duties while maintaining up to 50% of pre-injury duties).
- d) Graduated Early and Safe Return to Work, (return to pre-injury job where the main restriction is reduced time at work);
- e) a different job with the same employer;
- f) a similar or different job with a different employer (there are no obligations under the *Act* on the different employer with respect to return to work);

g) a combination of any of the above, dependent upon circumstances.

- [95] Policy RE-01 provides direction to the parties involved in the worker's return to work by following criteria from Policy RE-01 below:
- It is a "partnership" involving employers, workers, health care providers, union and the Yukon Workers' Compensation Health Board (YWCHSB)".
  - A Case Management Team "always" includes the worker.
  - During the recovery phase of the early and safe return to work plan injured workers and their employers will work together with the board and other appropriate parties to form the Case Management Team to accommodate an injured worker's functional abilities while recovery.
  - There is a hierarchy of objectives provided.
- [96] On December 10, 2007, physiotherapist Inge Tholen opines, after having the worker attend physiotherapy sessions and a daily 4-hour work-conditioning program, she should attempt a gradual return to work as an LPN, with no work restrictions. The plan involves having the worker begin full duties at 2 hours per day during week one, increasing hours of work by 2 hours per day each week until week eight (2 months) where she should be able to work up to 12 hours per day.
- [97] The worker contacted the case manager on December 19, 2007 informing him that physiotherapy had aggravated her shin splints and her doctor was sending her for compartment syndrome testing. The return-to-work plan was put on hold by the case manager.
- [98] File documents indicate the case manager tried contacting the worker "again" on July 28, 2008 in order to set up a meeting with the employer. (We are unsure of how often or when he tried calling, other than one week previously.) On July 31, 2008, after a call from the employer stating that although the worker had visited her previous workplace, she did not say that she would be returning to work, the case manager then writes to the worker advising that if she does not contact the board by August 15<sup>th</sup> (2 weeks), he will take that as an indication she does not wish to participate/co-operate in the proposed return to work program.
- [99] The worker testified she did not receive the letter nor was made aware that her benefits were being terminated until she returned home to Powell River. The July 31<sup>st</sup> letter was postmarked August 8, 2008. This indicates that although she did visit her colleagues at her previous workplace while in Whitehorse, she was not aware that she was to discuss return to work options with her supervisor.
- [100] The Return to Work Plan dated July 31, 2008 states "The case management team supporting [the worker's] recovery and return to work includes:  
Worker: [worker's name]  
Employer representative: [employer/supervisor's name]  
Family Doctor: Dr. Watson  
Physiotherapist: Inge Tholen  
Disability Manager: YWCHSB case manager.

- [101] Following the language of Policy RE-01, we can find no evidence that either the worker or her family physician, Dr. Watson, were involved in the “partnership” of her gradual early and safe return to work plan [ESRTW]. It appears the board did not follow its own policy as apparently it does not “always” include the worker in the Case Management Team. There is no indication that Dr. Watson was involved in any way in the Case Management team or “supported” the worker’s return to work. We find the worker’s functional abilities were not taken into consideration.
- [102] Dr. McDougall’s reporting on the Functional Capacity Evaluation completed in April 2007 notes the worker is not at maximum medical improvement at that time. He states the worker’s position includes “significant and prolonged” weight bearing job demands; it is not a sedentary job. In his opinion, there is increased risk if she returns to a job that is predominantly weight bearing; “therefore the weight bearing at work as part of the job description of LPN is a constant exacerbating factor”.
- [103] On October 3, 2007 physiotherapist Robin Roots noted an improvement in pain after physiotherapy but no improvement in functional ability. He states that although it is too early to predict a return to work date and status, it is expected that when she does return to work, it will be on a graduated basis over a long time frame – 3 months – due to her extended time away from the workforce.
- [104] Both Dr. McDougall and physiotherapist Robin Roots recognized the worker had difficulty with weight-bearing tolerance. Dr. McDougall states, “The weight bearing at work as part of the job description of LPN is a constant exacerbating factor.” Mr. Roots advises once the worker can participate in a graduated return to work, it will take an extended time, 3 months or greater, as she suffers an increase in pain when treatment included weight bearing.
- [105] The worker’s job description entails assisting and transferring patients weighing 100 to 300 lbs. for 15-25% of the time and standing, stooping, bending, walking, sitting and reaching for 75-80% of her workday. This indicates the worker’s functional abilities as noted by physiotherapist Tholen (1 hour of cycling, 1 hour of stretching, 1 hour of pool sessions and 1 hour of strengthening exercises in addition to lifting 12 lbs from floor to waist or waist to shoulder and rolling a dummy bag repetitively) do not match the worker’s daily job functions.
- [106] Policy RE-02-1: Early and Safe Return to Work Plans states:

#### General Information

The Case Management Team should jointly develop and agree upon an injured worker’s customized early and safe return to suitable and available employment with the pre-injury employer. The Early and Safe Return to Work (ESRTW) plan should accommodate the injured worker’s functional abilities and have a rehabilitative focus.

#### Definitions

4. Suitable employment: is work that meets all of the following criteria:

- a) the work is within the worker's functional abilities;
- b) the worker has, or is reasonably able to acquire, the necessary skills to perform the work;
- c) the work does not pose a health or safety risk to the worker or co-workers; and
- d) the work restores the worker's pre-injury earnings, if possible.

[107] We conclude the requirements of Policy RE-01 and RE-02-1 were not fulfilled. The worker's benefits were incorrectly suspended due to non-participation. Although the worker attended a work-conditioning program, there is no evidence to suggest the worker was functionally able to return to her pre-injury job, with no work restrictions and certainly not capable in 8 weeks time to be able to work 12 hours a day as an LPN. There is no evidence to suggest that the ESRTW plan was sent to the worker's doctor for review. In fact, it was the physiotherapist who suggested the worker was capable of returning to her pre-injury employment. Therefore, there is insufficient evidence to support a conclusion the worker or her family doctor were aware of the board's expectations that she was to return to work.

[108] We also conclude the worker's pre-injury job as an LPN does not meet the criteria for "suitable employment" as noted in Policy RE-02-1. The work is not within her functional abilities, the work does pose a health and safety risk to the worker and her co-workers; i.e. continues to have difficulty with weight-bearing and standing/walking for extended periods of time. Policy RE-02-1 states that "all" criteria must be met.

### **Medical Management and Diagnoses**

[109] File documentation indicates physiotherapist Tholen is the only professional who suggests the worker should return to work. The worker has seen various specialists and undergone many tests. At no point during the course of her claim is there any indication the worker was completely pain-free. Several diagnoses have been provided by different doctors and specialists. Below is a listing of test results and medical professionals' diagnoses:

- April 6, 2006 – Dr. Starks: the worker was diagnosed with "shin splints" 3 years ago.
- July 11, 2006 – Bone scan: "consistent with stress periostitis bilaterally (shin splints)
- July 17, 2006 – Dr. Newhouse: "medial tibial stress syndrome that has progressed from tibialis posterior tendonitis to a periostitis to most likely a bilateral stress fracture".
- December 5, 2006 – Dr. Starks: "she is unable to return to her work duties because of her persistent pain."
- February 8, 2007 – Dr. Newhouse: "chronic regional pain syndrome"
- April 17, 2007 – Registered Kinesiologist Sherri Beauchamp: "It is this evaluator's opinion that the worker should be limited to frequent weight bearing and sustained standing on an occasional basis."
- April 17, 2007 - Dr. McDougall, Occupational Health Consultant: In his opinion the worker is not at maximum medical improvement. Weight-bearing tolerances would continue to pose problems for the worker; she has a "chronic condition".

- July 20, 2007 – Dr. Starks: “periostitis”; “chronic condition with reoccurrence most likely”.
- August 23, 2007 – Physiotherapist, Inge Tholen: “bilateral chronic shin splints”.
- December 17, 2007 – Dr. Mann, sports medicine doctor: “A diagnosis is still elusive and while there is a degree of chronic periostitis, I do not feel this will account for her current symptomatology. Chronic ongoing periostitis can eventually result in chronic compartment syndrome.” He refers the worker to Dr. Salvian, vascular surgeon questioning “chronic anterior compartment syndrome” as a viable differential.
- February 28, 2008 - Dr. Salvian: He is not sure why the worker is suffering leg pain symptoms. Organizes a CT scan of lumbar spine and suggests the worker see a neurologist.
- March 7, 2008 - Dr. Mann: provides a diagnosis of “chronic leg pain” and advises the worker is not medically capable of working full duties.
- April 24, 2008 – Dr. Teal, Neurologist: “not certain what is causing her rather persistent calf and shin pain”.
- September 2, 2008 – Dr. Newhouse: “worker’s symptoms are in keeping with complex regional pain syndrome and peripheral neuropathy.”
- October 14, 2008 – Royal Inland Hospital Diagnostic Laboratory compartment syndrome testing: “This patient is positive for compartment syndrome in the left anterolateral compartment”.
- May 5, 2009 – Dr. Azad, Vascular Surgeon: “moderately abnormal sympathetic tone, both lower limbs”.
- September 2, 2009 – Dr. Kowbel, pain management physician: He believes the worker suffers from a chronic pain syndrome which started in 2003 when the worker developed shin splints and fractures.
- November 3, 2009 – Dr. May, M.D.: “complex regional pain syndrome in both legs”.

[110] It appears from the foregoing that the worker has not received consistent, ongoing medical management of her condition. We can understand her frustration with not being provided with a definitive diagnosis or a means of moving forward with management of her condition.

[111] Evidence on file strongly indicates the worker’s condition has become chronic. We recommend that the board investigate this. We give most weight to Dr. Kowbel’s September 2, 2009 report and concur with his recommendations wherein he states, “Ideally she would be best handled by a multidisciplinary approach and a multidisciplinary pain management team” (ref. para. #57). We hold the opinion that taking this approach would result in a conclusion being reached.

**Decision**

The worker’s appeal is allowed. The case manager’s July 31, 2008 and October 1, 2008 decisions are reversed.

The worker’s benefits shall be reinstated retroactively to August 15, 2008, including wage loss benefits, medical treatment costs and any out of pocket expenses related to the work-related disability.

Dated this **23<sup>rd</sup>** day of **August 2010** in the City of Whitehorse, Yukon Territory.

\_\_\_\_\_  
M. McCullough, Member

\_\_\_\_\_  
E. Sumner, Committee Chair

\_\_\_\_\_  
H. Hermanson, Member

**Committee Members:**

E. Sumner	Committee Chair
H. Hermanson	Member
M. McCullough	Member