Workers' Compensation Appeal Tribunal

Decision #186

Claim No.: 3000-1682

Date of Notice of Appeal: October 21, 2010

Date Notice of Appeal Received at Tribunal: January 6, 2011

Date of Oral Hearing: June 2, 2011

Date Hearing Closed: June 2, 2011

Date of Decision: July 19, 2011

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 – Derek Holmes
Observer – Michelle Kvam
Recorder - Vernna Johanson

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

Introduction

This 34-year-old woman was employed as an administrative assistant. She filed a claim for compensation for an injury to her left shoulder, neck, head and lower back which occurred on November 16, 2007 when she slipped down the steps of a school bus, hitting her head on the last step. Yukon Workers' Compensation Health & Safety Board (the "board") accepted the workers' claim for multiple contusions; muscle strain of the upper and lower back and a contusion to the back of her head.

The worker underwent multiple medical tests and treatments but was still unable to return to work. On January 23, 2009 a board case manager denied continuing compensation.

The worker continued to undergo more testing and treatment including an independent medical examination ordered by the hearing officer. On July 8, 2010 the hearing officer issued a decision concluding the worker's ongoing symptoms were not related to the original November 16, 2007 workplace injury and she was not entitled to further compensation benefits.

The Hearing Officer's Decision

The hearing officer rendered his decision on July 8, 2010. He concluded that medical evidence showed there was no link between the causation of the worker's ongoing symptoms and her workplace injury.

Relief Requested

The worker disagrees with the hearing officer's decision. She asks the tribunal to reverse his July 8, 2010 decision. She requests that loss of earnings and medical benefits be reinstated retroactively to the date they were terminated. She also asks that she be provided rehabilitation assistance until she completes her treatment and is medically cleared to return to work.

Decision

The worker's appeal is allowed. The hearing officer's July 8, 2010 decision is reversed.

1. The worker is entitled to time loss and medical benefits to be reinstated retroactively to the date they were terminated.

2. The worker is entitled to rehabilitation assistance as provided by section 44 of the *Workers' Compensation Act*, R.S.Y. 2002.

3. The board shall pay interest on compensation in accordance with board Policy EL-03 and section 31 of the *Workers' Compensation Act*, S.Y. 2008, c. 12.

Jurisdiction

[1] On January 6, 2011 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 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.

[2] Compensation entitlement decisions are made pursuant to legislation in place at the time of injury. The worker filed a claim for an injury which occurred on November 16, 2007. 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 CL-42, Arising Out of and In the Course of Employment, effective October 1, 2007
- Policy CL-54, Merits and Justice of the Case
- Policy CL-47, Pre-existing Conditions, effective 94-04-01

[4] The worker attended the hearing and testified by affirmation. She was represented by the workers' advocate. The proceedings were recorded. The employer was notified of the appeal but did not participate.

[5] The appeal committee considered the following:

- the worker's testimony
- the workers' advocate's submission
- the aforementioned policies
- the entire claim record No. 3000-1682 as provided by the board.

Background and Evidence

We will be referring to medical professionals by initial only in order to maintain confidentiality. A legend is provided before the entries:

Dr. A. – general practitioner – emergency room doctor
Dr. B. – chiropractor
Dr. C. – general practitioner – emergency room doctor
Dr. D. – worker's family physician – general practitioner

[7] The Worker's Report of Injury/Illness, dated November 25, 2007, states that she went on to a school bus to retrieve paperwork from a teacher on November 16, 2007. When she was leaving, she slipped on the first step, landing on her left shoulder blade and lower back and slid to the ground hitting her lower back and top of her buttocks. Her head whipped back and hit the first step of the bus. First aid was provided and the worker was taken to Whitehorse General Hospital (WGH).

[8] Dr. A. saw the worker at WGH on November 16, 2007. His Doctor's First Report states the worker presented with:
- full range of motion in her C-spine;
- tenderness at the base of the scalp but no abrasions/hematoma
- tender left scapula but the shoulder had a full range of motion
- tender tailbone
- an x-ray of the scapula revealed no fractures.

The diagnosis is "multiple contusions". The worker is restricted from work for one day.

[9] A November 16, 2007 x-ray of the left scapula notes "humeroscapular alignment is normal. The scapula itself appears intact. No focal lesion is seen the adjacent ribs are normal. No evidence of dislocation nor fracture visible at the moment."

[10] The worker attends Dr. B., chiropractor, on November 19, 2007 with complaints of a very stiff neck and left upper back. He notes the c-spine range of motion is reduced in all directions; spastic muscles. Dr. B. diagnoses "Acute whiplash-like condition of C/S with associated mechanical low back pain."

[11] The worker sees Dr. C. at WGH Emergency on November 21, 2007. He diagnoses "head contusion". She undergoes a CT scan of the head on the same day; the results of the report are "normal."

[12] The worker's family doctor, Dr. D. orders a cervical spine and lumbar spine x-ray which was completed on November 21, 2007. There is no evidence of acute fracture or malalignment of the cervical spine; the lower lumbar spine shows "mild degenerative changes."

Dr. D. examines the worker and reports on November 21, 2007. The worker presented with tenderness to the c-spine; tenderness to palpitation along the left paraspinal muscles in the cervical region and down to left upper & mid back region. Dr. D. recommends the worker remain off work for another week.

[13] Chiropractor Dr. B. sees the worker on November 22, 2007. He reports, "C-spine lordosis loss due to muscle spasm. Still reduced range of motion in all directions." He notes the worker is fit for light duties but she cannot sit for extended periods of time. Dr. B. estimates the worker will be fit to return to work on November 26, 2007 for half-days first and "should be" fit for full duties by December 3, 2007.

[14] Dr. D.'s November 26, 2007 progress report assessment is: 1. Lumbar/coccygeal pain. 2. Altered sensation right leg. The worker is referred for physiotherapy and advised to remain off work for one week.

[15] An initial physical therapy assessment completed on December 4, 2007 notes a clinical impression of "soft tissue injury of the upper and lower back with resulting nerve root irritation of the lumbar spine, especially L4."

[16] Dr. D.'s December 5, 2007 progress report states: 1. possible gastritis/ulcer secondary to

NSAID [non-steroidal anti-inflammatory drugs] 2. persistent lumbar pain/paresthesia & subjective weakness in lower extremities/muscle spasm. A CT scan of the lumbar spine is ordered, "recheck 1 week." Dr. D. notes "not fit for work."

[17] On December 13, 2007, the worker attends Dr. D. her family physician. The worker presents with headache; pain in her hips, lower and mid back with certain movements and tingly/numb sensations in her lower extremities if she sits too long. She is unable to sit for extended periods of time. Dr. D. reports:

> Told by worker at WCB that her symptoms were largely due to a pre-existing back problem that is evident on her x-rays. Because of this she will only receive limited coverage for her injuries. If this is correct I would like to clarify that [the worker] does not have a pre-existing back problem. She was completely asymptomatic prior to her injury. X-rays of the lumbar area show mild degeneration change that was totally asymptomatic. Not fit for work. [Underlining added by Dr. D.]

[18] A CT scan of the lumbar spine completed on December 13, 2007 indicates an "impression" of "Normal CT scan of L3 through to S1."

[19] On December 19, 2007 a board adjudicator writes to the worker advising her that her claim is accepted for multiple contusions and a muscle strain of the c-spine, upper and lower back and a contusion to the head. The adjudicator further notes, "Objective medical evidence has shown that you have pre-existing mild degenerative changes in the lower lumbar spine." She quotes from Policy CL-47, Pre-existing conditions and adds, "It also says that a non-compensable pre-existing condition is a condition that was caused by something other than your work, for example, degenerative changes in your spine."

[20] Dr. D. saw the worker on January 3, 2008 and reported the worker attended with less pain in the lumbar area but the tingling sensation in her legs has increased. Also, she has noticed tingling in her arms in the last 3 days, greater on the right. Dr. D.'s assessment is "persistent paresthesia NYD (not yet determined)". The worker is referred to a neurologist.

[21] An x-ray of the sacro-iliac joints taken on January 4, 2008 reveals no recent or old fractures or dislocation. The sacro-iliac joints are normal. No change or significant findings from previous x-ray or CT scans.

[22] Dr. D's January 9, 2008 progress report states the worker tried to return to work for 2 days but it aggravated the pain in her right buttock, radiating down to her foot. "This was despite limitation on work hours." Dr. D. notes the worker is not fit for work.

[23] A January 29, 2008 MRI was completed for brain trauma, cervical spine and lumbosacral examination. The "Impression" reads:

> 1. The study of the brain demonstrates very unusual right-sided unilateral high T2 signal within the deep and superficial but not subcortical white matter of the right frontal and parietal regions without mass effect or evidence of prior

hemorrhage, associated with mild restricted diffusion in this region. This is unusual for sequelae from trauma. Differential diagnosis is reasonably extensive, but would include an unusual expression of encephalitis, dysmyelinating conditions such as leukodystrophy, although the asymmetry is unusual, Lyme disease, and most unusual expression of MS. I would recommend ancillary tests including lumbar puncture, and further evaluation with MR pre-and post gadolinium, and with spectroscopy could be performed.

> There are no typical MR sequelae from the trauma.

2. Normal study of the cervical spine.

3. In the study of the lumbosacral spine, there is a very small left-sided T11/12 formanal disc herniation of questionable clinical significance. Otherwise normal study.

Dr. E. – neurologist
Dr. F. – medical doctor/family doctor
Dr. G. – medical doctor
Dr. H. – medical doctor

[24] The worker attends the Specialist Referral Clinic in Vancouver on January 30, 2008. Dr. E., neurologist evaluated her due to progressive neurologic symptoms the worker was experiencing subsequent to the fall. The worker reported a prior history of neurologic problems with episodic migraine headaches. She indicated she had these for many years and averaged approximately two per month without obvious triggers other than stress or fatigue. Dr. E. notes he reviewed the worker's MRI scan and it is "definitely abnormal". His assessment follows:

> [The worker] has had progressive predominantly sensory symptoms subsequent to a fall. I do not think her symptoms are due to a traumatic injury. The differential diagnosis includes multiple sclerosis, leukodystrophy, mitochondrial disorder or other inflammatory process. The mass effect and papilledema is of concern regarding possible gliomatosis cerebri.

[25] [**Note:** From *U.S. National Institute of Health, Office of Rare Diseases Research:* Gliomatosis cerebri is a type of brain cancer. It is a variant form of glioblastoma multiforme. It is characterized by scattered and widespread tumor cells that can cause the cerebrum, cerebellum, or brain stem to enlarge. Signs and symptoms may include personality changes, memory disturbance, headache, hemiparesis, and seizures. Because this tumor is so diffuse it can be challenging to treat and the prognosis for people with gliomatosis cerebri is generally poor.]

[26] A February 2, 2008 note to file by the case manager states the worker called and said she would be ready to fly home on Sunday. She said they did not know what was wrong with her after taking all the tests. She has swelling on the right side of her brain. The neurologist said that he did not want to do a brain biopsy unless her symptoms worsened. The worker is to see

her family physician every week for the next month and then follow up with Dr. E., neurologist, in a month.

[27] A March 17, 2008 MRI of the head reads, “Impression: Findings involving the right frontal and bilateral perital white matter lesion are again concerning for gliomatosis cerebri with minimal if any interval change.”

[28] The worker sees Dr. E. on March 19, 2008. He reports that he reviewed her MRI scan and it remains markedly and atypically abnormal. The leading differential diagnosis remains gliomatosis cerebri.

[29] Dr. D.’s March 26, 2008 progress report states symptoms in the worker’s lower extremities and back are likely related to the injury. The worker continues to undergo physiotherapy treatment once a week. Dr. D. notes the worker is not fit for work.

[30] The case manager writes to Dr. E. on April 2, 2008 questioning the non-work-related brain injury and work-related injury. He responds on April 4, 2008. Dr. E. notes:

1. There is no relationship between the worker’s central neurologic problem and possible diffuse brain cancer and her ongoing back pain.
2. The worker did suffer low back pain following the injury but at the time of his evaluation, this was not an issue. The diagnosis of low back injury would be lumbar strain and soft tissue/myofascial pain.
3. On the last visit he did not evaluate for low back pain. Presently it is his opinion the back pain is not her limiting factor; she has headaches, fatigue and other symptoms which he attributes predominantly to her central neurologic problem and possible brain cancer.
4. He does not feel the worker requires an active physiotherapy program at this time.

[31] Physio Plus completes an assessment on April 14, 2008. The attending physiotherapist’s report follows in part:

> My opinion is that there is still some involvement of her back that is producing all the pain. There has never been any reported examination on her mid back and it is obviously very sensitive.
>
> The MRI shows a tiny annular tear at the T11/12 level and a herniation. The outer 1/3 of the disc is innervated and therefore can be very sensitive/painful. Although there is no displacement of the T11 nerve that does not mean that there is not increased pressure on the nerve root from the herniation let alone any other structures.
>
> Progress has been admittedly very slow due to her other health complications and the multiple areas of injury. However, I believe that much of her pain and symptoms are related to her fall and that she can still benefit from physiotherapy.

[32] The worker undergoes a brain biopsy on April 25, 2008. An MRI with Gadolinium Administration notes, “Impression: Preoperative localization without any obvious vascular anomalies seen.”

[33] The worker changes family doctors and begins seeing Dr. F. He reports on May 13, 2008 that the worker should continue with physiotherapy; she is unfit for work for one month at which time he will reassess.

[34] The board chief medical consultant met with the worker and issued a report on June 3, 2008. He was unable to provide a specific diagnosis. He explained that the type of injury the worker sustained would not be expected to require treatment for an extended period of time. He remarks that her muscles feel tight and the worker noted her muscles twitch and they are uncomfortable. The medical consultant reports this muscle tightness and twitching is frequently associated with anxiety, which may delay recovery. He explained to the worker that it is completely normal to be anxious “particularly when one has been told that they may have an incurable brain cancer.”

[35] Dr. F.’s September 10, 2008 progress report recommends the worker restart physiotherapy and notes “off work”.

[36] The physiotherapist completes a functional abilities form on October 9, 2008. Details about limitations for a return to work include:

- pain if the worker sits for longer than 2 minutes
- standing limited to less than 15 minutes but could change from sit to stand
- any repetitive use of upper extremity – reaching, overhead – but can do if able to break up task
- able to lift up to 20 lbs with reported arm discomfort.

[37] In a November 18, 2008 physical therapy progress report, the physiotherapist states she believes something is going on in the worker’s upper thoracic spine which is affecting her low back and shoulder as a result of the fall “and completely separate from the brain issue.” She recommends a non-hands-on approach focusing on stabilization of the core and neck.

[38] Dr. F. completes a functional abilities form on November 19, 2008. He reports the worker is still experiencing pain in the right shoulder and left gluteus which radiates down to the right posterior left to the heel and sole while sitting. He notes the symptoms are unlikely to change significantly as they have been static for 1 year. The worker is not fit for work presently.

[39] The worker undergoes another MRI of the brain on December 7, 2008. It reveals “the previously documented changes on the previous MRI study is not seen at this study.” There are no signs of brain cancer.

[40] The case manager’s December 16, 2008 note to file mentions the worker called to let her know the results of the MRI which shows there are no longer brain lesions. The case manager questions the worker why she refused to try a return to work when she was approached by her employer. The worker responds that at the time she was hospitalized with severe headaches and pain and felt she was unable to return to work.

[41] Dr. F.'s December 18, 2008 progress report states the worker reported daily headaches associated with tension and tightness across her trapezius muscles/neck. He suggests more non-pharmalogical management of her headaches. He recommends the worker try light duties and he will reassess.

[42] Dr. F. reports on January 20, 2009 that the worker is unfit for work at the present time based on a combination of physical and psychological stressors. The worker has "pains in her upper limbs." A Functional Abilities Form provided by Dr. F. also dated January 20, 2009 notes the worker has functional limitations and can return to work provided they can be accommodated appropriately. He lists the following:

- use of upper extremity
- bending, twisting or kneeling
- reduced hours

Details of the limitations read: No lifting with left arm; 2 hours per day maximum work time; ergonomic workstation required.

[43] In a January 23, 2009 decision letter from the case manager to the worker she states the worker's claim was accepted for multiple contusions and strains. According to the Medical Disability Advisor, the length of disability for the worker's type of sprain is 56 days. The case manager further states the worker suffered from a history of migraines before and after the work injury and "it is also highly likely that anxiety may be the root of your symptoms." Following is an excerpt from the case manager's letter:

> Numbness and tingling can be caused by anxiety, back and neck injuries, tobacco use, migraines, MS, etc. A couple of times during your claim, you had numbness and tingling sensations in your face, lips and tongue. These symptoms would not be a result of any injury to the cervical or lumbar spine. Your reports of numbness and tingling also did not begin at the onset of your injury, it followed later on November 26, 2007 (legs) and January 4, 2008 (arms). You do suffer from migraines, smoke cigarettes, and may have anxiety due to your brain scan results and possibly from your inability to return to work.

The case manager concludes "it is more likely that there is another condition that is causing your ongoing symptoms" and not the work-related injury suffered on November 16, 2007. She informs the worker the board will no longer continue with her claim for compensation.

[44] The worker attended Bay College Medical and Diagnostics in Toronto in September 2009. Dr. G., medical doctor, provides a report dated September 22, 2009. His opinion is, "post-traumatic chronic pain. The patient has features of fibromyalgia."

[**Note:** *From Medicinet.com:* Fibromyalgia is a chronic condition that causes pain, stiffness, and tenderness of the muscles, tendons, and joints. Fibromyalgia is also characterized by restless sleep, awakening feeling tired, chronic fatigue, anxiety, depression, and disturbances in bowel function.

Fibromyalgia Symptoms: The universal symptom of fibromyalgia is pain. The pain in fibromyalgia is not caused by tissue inflammation. Instead, these patients seem to have an increased sensitivity to many different sensory stimuli and an unusually low pain threshold. Minor sensory stimuli that ordinarily would not cause pain in individuals can cause disabling, sometimes severe pain in patients with fibromyalgia. The body pain of fibromyalgia can be aggravated by noise, weather change, and emotional stress.

The pain of fibromyalgia is generally widespread, involving both sides of the body. Pain usually affects the neck, buttocks, shoulders, arms, the upper back, and the chest. "Tender points" are localized tender areas of the body that can bring on widespread pain and muscle spasm when touched. Fibromyalgia tender points, or pressure points, are commonly found around the elbows, shoulders, knees, hips, back of the head, and the side of the breastbone.]

[45] Consultant neurologist, Dr. H. reports on September 22, 2009 the worker presented with normal fundi and cranial nerves. There is no jaw jerk or snout reflex, normal power and tone is present in the limbs other than pain on inverting her left arm. He recommends the worker be given Botox injections to help with her headaches. An October 5, 2009 report by Dr. H. confirms the worker had 100 units of Botox injected “today”.

Dr. I. – registered psychologist
Dr. J. – psychiatrist
Dr. K. – medical doctor specializing in physical medicine and rehabilitation

[46] The worker attends Dr. I., registered psychologist, on November 9 & 10, 2009. He renders a report on November 12, 2009. His recommendations and conclusions are:

1. The worker is not suffering from any current neuropsychological dysfunction or reduction of brain functioning from brain damage. It is highly unlikely she has sustained any permanent brain damage from the slip and fall accident in November 2007. She retains full competence in her cognitive functions to be able to cope with a future return to work or return to educational upgrading if she chooses.

2. The worker is struggling with significant chronic pain and clinical depression symptoms. Currently, she remains severely disabled by the combination of physical pain problems and depression. It is unlikely she would be successful in adapting to a return to work trial unless she receives additional treatment of her pain and depression.

3. It would be appropriate to seek a comprehensive pain management programme through a Pain Clinic.

4. The worker will require active follow-up by a psychiatrist.

5. Regularly scheduled ongoing psychological counselling should be pursued for at least six months.

6. A brief re-assessment of the worker's emotional and concentration functioning should be done after completion of the recommended treatments and prior to any return to work trial.

[47] Dr. F.'s January 11, 2010 report states the worker may return to work on a part-time basis for two months.

[48] On January 26, 2010 Dr. F. reports to Sunlife [insurance] that the worker attempted to return to work half-days for 3 days a week but suffered significant fatigue. She then tried returning to consecutive half days but was unsuccessful and was forced to leave the second day due to fatigue and increased pain levels. He suggests she be accommodated by working one half-day twice a week and, if tolerable, increase to 3 or more half-days per week. He advises not to "push" her beyond 2 half-days a week.

[49] A February 2, 2009 report from Dr. F. to Sunlife provides the worker's functional limitations and restrictions as well as estimated wait times for various referrals. He notes fatigue and pain as limitations to working. At this time she is not capable of increasing her work hours.

[50] On February 11, 2010 the worker attends Dr. J., psychiatrist. Dr. J. gives his impression that the worker has:

- untreated polycystic ovarian syndrome;
- sleep deprivation from one or more sleep disorders
- traumatic brain injury, complicated by viral encephalitis
- past history of recurrent major depressive disorder.

Dr. J. recommends the worker attend a sleep lab evaluation and a multidisciplinary pain management clinic. Following are excerpts from Dr. J's report:

> It is unfortunate that Dr. I. (psychiatrist) reports his findings in the way that he does. My understanding of neuropsychological assessment is that the question in traumatic brain injury, which the patient has most certainly sustained, is not whether performance on various tests is "within normal limits" by some statistical measure, but whether or not it is normal for the patient, compared to performance before the accident.
>
> My present point is simply that it is not possible to diagnose depression based on the Beck Depression Inventory, especially in the context of traumatic brain injury. In the particular patient, we would be surprised if the injury had 'cured' the pre-injury depression, but it is clear that the symptoms this patient is reporting are distinctly different from the symptoms she associated with major depressive disorder before the accident.
>
> Because there are many misconceptions on the subject, it is perhaps worth documenting that the patient is certainly not faking or exaggerating her symptoms. Her descriptions are entirely consistent with the known symptoms of traumatic brain injury.

[51] The hearing officer renders an interim decision on April 28, 2010. He orders an independent medical evaluation under the authority of section 13 of the *Act* in order to determine whether there is any link between the causation of the worker's ongoing symptoms and the November 16, 2007 workplace injury.

[52] On June 23, 2010 the worker attends Viewpoint Medical Assessment Services Inc. for an independent medical evaluation. Dr. K., consultant in occupational medicine, completes the evaluation. He begins the report by stating he is a family physician with a special interest and expertise in musculoskeletal problems and soft tissue injuries. He provides the following opinions and conclusions:

1. There is no objective evidence of a brain injury or concussion that meets the criteria of the American Congress of Rehabilitation Medicine or the World Health Organization. In his assessment of the worker, he opines her presentation represented someone with a depressive or anxiety based disorder. He does not concur with Dr. J.'s (psychiatrist) conclusions that there was a concussion injury.

2. He found no evidence of fibromyalgia. His examination revealed pain in the occipital triangle on the upper neck, right sciatic notch and some of the scapular stabilizing muscles around the left shoulder. He reports, "In my opinion the pain in the occipital triangle on the upper neck and in the right sciatic notch might be related to the DOA [date of accident?] injury on this claim."

3. Dr. K. opines the worker likely had some concerns with depression and anxiety prior to the injury. Such symptoms have been a barrier to her recovery. He states, "Her emotional reaction to a potentially severe brain cancer likely accentuated her anxiety, even though those concerns were not related to consequences of the injury on this claim.

4. A Botox injection was helpful for her headaches. He suggests there may be a post-traumatic pain generator in the occipital triangle region. Further injections may be beneficial.

[53] The hearing officer posed 4 questions for the independent medical evaluator. We will briefly set out the questions and excerpts from Dr. K's answers in italics following:

1. Did the worker suffer a head injury at work and are there lasting consequences of that?

   Given the absence of loss of consciousness, alteration of consciousness, and the absence of any anterograde or retrograde amnesia, there is no objective evidence of a brain injury or concussion . . . . Objective neuropsychological assessment does not support the presence of any cognitive defects.

2. The worker had been diagnosed with fibromyalgia with widespread pain, however, there was never any report given on this with any detail. Could fibromyalgia be related to the incident of November 16, 2007?

In my examination there was no evidence of the physical signs usually attributed to fibromyalgia. There is no evidence that fibromyalgia arises as a consequence of specific trauma. In my opinion, [the worker's] presentation may be related to catastrophizing about her situation.

Dr. K. advises it would be counterproductive to apply this diagnosis to the worker in terms of improving her situation.

3. During the course of the claim, there were a number of neurological disorders listed that the board's medical consultant could not relate to trauma. Neurologist Dr. E. had also suggested several. [The hearing officer lists neurological disorders.] In addition, there appeared to be no neurological changes immediately after the incident in November 2007. In your opinion, is there any relationship between any of the neurological disorders and the incident in November 2007?

   Dr. K. states the conditions noted during the initial investigations are not related to the slip and fall on November 16, 2007. He does state:

   In my history with [the worker], she was extremely emotional discussing the possibility that she might have had brain cancer. In my interpretation of her presentation, she may perceive these events regarding the concurrent brain problem as being related to the worker injury. In my opinion her current presentation is also related to her reaction to these concurrent concerns that are not directly a consequence of her work injury.

4. There were several recommendations to have the worker attend a chronic pain facility. If there is a link between the current symptoms and the injury, would expedited treatment at a chronic pain facility be warranted?

   [*The worker] would likely benefit from attendance at a chronic pain facility.*

Dr. K. adds:

> One of the difficulties in [the worker's] case is that not all of her current presentation can be related to the actual work injury. Her concerns with a concurrent brain condition have accentuated her presentation. I can say though, that a portion of her current presentation can be related to her work injury, and that this presentation is most likely related to both psychological factors and a physical factor.

[54] The hearing officer renders his final decision on July 8, 2010. Included in the decision is a note by the hearing officer stating that other independent medical evaluation testing (psychiatric and physiatric) was completed while the worker was at Viewpoint. He notes these were requested by the worker's employer and not considered as evidence nor allowed to be entered as evidence after the hearing closed on April 15, 2010. [We, the appeal committee, will consider all the information contained on the worker's claim file.]

Dr. L. – registered psychiatrist
Dr. M. – medical doctor, specializing in physical medicine and rehabilitation

[55] Dr. L., registered psychiatrist, interviews the worker on June 9, 2010 and renders a report on June 10, 2010. He answers questions posed by the worker's employer. Dr. L. notes that while it has been reported the worker had multiple depressive episodes throughout her life, it was not endorsed on that day. He suggests this may be due to the fact the questions were framed around when she received care as opposed to when she subjectively believed she had depressive symptoms in the past. Dr. L. relates the worker identified two occasions in the last decade when she sought professional help with respect to depression. Both of these centered around issues concerning the break-up of her relationship with her son's father and child support/visitation issues. Dr. L. states, "She does not describe having taken antidepressant medication at those times and her treatment appears to have been isolated to her current period of post-injury."

[56] We will not set out the questions and answers in their entirety but will provide highlights of Dr. L.'s report following:

1. Based on established DSM IV [Diagnostic and Statistical Manual of Mental Disorders] criteria, Dr. L. diagnoses:
   Axis III: Encephalitis of unknown origin currently resolved. Multiple physical sequelae of traumatic fall November 2007 including headache, fatigue and pain.
   Axis IV: Financial fears, moderate to severe. Inability to engage in previous pleasurable activities, moderate to severe.
   Axis V: GAF 70

   Dr. L. states it is difficult to provide a diagnosis as he does not believe the worker's problems lie precisely within the psychiatric realm. The timeline of her depressive symptoms is not consistent enough to qualify for a diagnosis of depression because it does not persist beyond a day or two.

2. Dr. L. does not believe the worker's fatigue is psychiatric in origin; however it is the main symptom which is a barrier to her returning to work. He opines the fatigue may relate to her sleep but he does not see her as having a primary sleep disorder of a solely psychiatric origin.

3. Dr. L. does not believe the worker is currently able to return to work in any capacity. He states, "In all likelihood [the worker] is fully and permanently disabled." It is possible she may show improvement in the future.

4. The worker is not taking any medications which would impede or impair her ability to function at work.

5. Her depression issues are not the crux of her problem.

6. Dr. L. concurs with Dr. J'.s (psychiatrist) findings that depression is not playing a significant role in her symptoms.

7. Dr. L. responds to the question of whether or not her sleep disturbance is playing a significant role in her chronic pain condition by stating "undoubtedly these three symptoms interact with each other. It is difficult to comment on which one is causal to the other however improvement in her sleep would in all likelihood benefit her energy levels and even possibly her pain issues.

8. Although Dr. L. cannot say with certainty there is a causal relationship between the head injury and the worker's depression, he does note there is certainty there is a temporal one "and it would be hard to imagine that the fall and immediate onset of her pain issues do not have some degree of cause and effect."

Dr. L. suggests further psychiatric inventions are not necessary. He concurs that the worker should undergo both a sleep assessment referral and a referral to a pain clinic.

[57] The worker was assessed by Dr. M., a physician specializing in physical medicine and rehabilitation, on June 10, 2010. He reports on June 24, 2010. Again, we will not set out questions and answers in their entirety; we will summarize his report.

Dr. M.'s summary follows:

> [The worker] is presenting today with a constellation of symptoms following her injuries sustained on November 16, 2007. Her current diagnoses would include:
>
> 1. Post traumatic headaches with migrainous features.
> 2. Cervical soft tissue strain.
> 3. Left shoulder pain NYD [not yet diagnosed] with myofascial component
> 4. Diffuse and variable sensory symptoms in hands and feet.
> 5. Unverified right lumbar pain.

1. "The worker is presenting with a number of sources of pain and in the setting of her sleep disturbance and emotional lability during her assessment today this would be within the realm of a chronic pain syndrome". Dr. M. notes the worker has already demonstrated she is unable to tolerate her limited return to work program. He notes that until her pain issues are addressed she would not tolerate any meaningful return to previous employment.

2. There are a number of treatment options available to the worker, best provided in a multidisciplinary pain management clinic.

3. The worker is not currently taking any medications which would impede her ability to function at work.

4. Dr. M. is asked for his opinion whether the worker is suffering from a traumatic brain injury. Following is his response in its entirety:

   > [The worker] describes hitting her head from the fall on November 16, 2007. She had an onset of headaches immediately after the injury and they subsequently persisted. I agree with all of the comments in the documentation that it is extremely unlikely for the MRI findings to be related to her head trauma. However, it is typically expected that CT and MRI imagining of the brain following a mild traumatic brain injury is typically within normal limits. SPECT [Single Proton Emission Computed Tomography] imaging is of much greater sensitivity in traumatic brain injury but the encephalitis will confound any relevant findings. [The worker] does report issues with memory and concentration in addition to her headaches and these are typical symptoms of mild traumatic brain injury or post-concussive syndrome. Loss of consciousness is certainly not required for a mild traumatic brain injury and by definition would exclude this diagnosis, favouring a more severe category. Post encephalitic symptoms may be very similar to those seen in the setting of mild traumatic brain injury. Dr. . . . makes the comment that she feels it is unlikely that [the worker] suffered a significant head injury although I would debate the term significant as patients with very mild head trauma are often plagued with persistent symptoms on an indefinite basis.
   >
   > In summary, given the onset of headaches and cognitive complaints immediately following the accident, I would be inclined to provide [the worker] a diagnosis of mild TBI [traumatic brain injury] from the injuries sustained in November of 2007 currently confounded by the additional encephalitis.

5. The worker's headaches and neck pain are fairly typical of a cervical soft tissue strain and mild traumatic brain injury. Dr. M. finds that her current headaches and cervical symptoms relate to her fall from the bus in November 2007.

6. Dr. M. can find no association with the MRI findings and her head injury. He notes the encephalitis seems to be more related to her diffuse sensory symptoms. He states, "as for focal myofascial pain, it is much more in keeping with her mechanism of injury in her fall from the bus."

7. Dr. M. notes the worker would meet the A.C.R. 1990 criteria for a diagnosis of fibromyalgia although her current symptomatology exceeds typical symptoms from fibromyalgia alone.

8. He supports a sleep clinic program however he advises it should not be pursued in the absence of concurrent pain management as the "two are inextricably intertwined."

[58] The hearing officer renders his final decision on July 8, 2010. He notes the worker underwent a psychiatric and physiatric independent medical evaluation while at Viewpoint. These were

requested by the worker's employer and not the board. He advises the two reports were not considered as evidence in his decision as the hearing had been closed on April 15, 2010.

[59] On August 17, 2010 the case manager reviews the independent medical evaluations of Drs. K. L. & M. and concludes there is nothing that will change her January 23, 2009 decision. She notes there are conflicting opinions among the specialists. She states the worker's claim was accepted for a strain and contusions; the maximum recovery time for a strain is 56 days. She states that prior to the injury the worker suffered from various other chronic pain-type ailments. Further, "it was felt that the chronic pain [the worker] suffers may be a result of chronic fatigue. If she addresses the chronic fatigue issues, her pain will subside." The case manager then says there is a history of chronic fatigue and depressive/anxiety issues and migraine headaches that predate the injury of November 2007.

The Worker's Testimony

[60] The worker testified that on the day of the accident she went onto the school bus to retrieve some paperwork. When she was getting off, there was snow build-up on the stairs. Her foot came out from under her and she slipped on the top step, landed on her shoulder blade and slid/bumped down the stairs, landing on the ground at the bottom. Her head whipped back and hit the bottom step of the bus stairs. Her lumbar spine was impacted when she hit the ground.

[61] She said the first MRI of the brain revealed massive swelling; there were no "wavy parts"; and throughout there were white flared-out portions in 3 different parts of the brain. She said medical professionals thought she had brain cancer. The final MRI, indicating she did not have brain cancer was not until December 2008.

[62] During the interval, the worker said it was difficult to concentrate on recovering from the injury. After receiving physiotherapy, her headaches and arm symptoms would increase. Her physiotherapist did not want to work on her a lot and was worried about causing the symptoms to flare-up. They later found out that she had a facet joint injury in her neck and this is what was making her symptoms worse.

[63] The worker testified the medical professionals were focused on the brain cancer and her dying. When she would bring up pain in her leg and hip, she was told not to worry about it, it was not a priority. She said once it was discovered that she did not have brain cancer, the specialists that were involved because she had a rare form of brain cancer, lost all interest.

[64] She said that she attended a chronic pain clinic 34 months post-accident, well after it had been diagnosed. She testified that when she did attend the clinic, the diagnosis was confirmed. She suffered from two types of headaches. The neck facet joint was injured in the fall causing headaches. She also had myofascial headaches. The worker said they went in and "burned the nerves" so they could no longer send pain signals which caused headache. To alleviate the others, she received Botox injections to relax the muscles. Because her neck had been seized for so long, it developed dystonia, wherein her neck muscle always tremor. The medication helped to stop this.

[65] The worker said the shooting pain she was getting down her arm was caused by muscle [spasm]; it was not coming from the shoulder as she originally thought. She was told the shooting pain down her leg was caused by the impact of her hitting the ground. It mimics sciatica but it is actually the piriformis muscle; the muscle in the buttocks area. When this muscle is inflamed it presses on the sciatic nerve, especially when sitting and sharp pains shoot down the leg. She said in order to relieve this pain, they go in surgically and inject the muscle and paralyze it. There is a brief reprieve from the pain when it is injected. She said after she receives the injection she attends physiotherapy and slowly works it out. The end result expected is the muscle will remember what it is supposed to do. Hopefully she will not need injections anymore. Currently the time between injections is getting longer. This is an indication that the procedure is working.

[66] She says her employer is currently looking for an appropriate place for her to return to work. Some of the responsibilities of her previous position have been taken away, leaving only sedentary work. She said this is inappropriate as sitting in the same position will annoy her symptoms and she will have to return to the pain clinic. They are looking at other positions which require her to move. She is on track to return to work this month.

[67] The worker testified that it is difficult for people to understand and to live with chronic pain. She believes the other things going on (brain cancer diagnosis) overshadowed the real problem and derailed her recovery; the last 3 years of her life.

[68] When questioned about the worker's prior history of migraine headaches and personal issues she said that everyone has stressors in their lives. She dealt with them, she went to work and got on with everyday life. It was never an issue before the injury. She said her son is now 14 years old and although she did have some issues previously, they never got in the way of work.

[69] The worker said currently she is waiting for the injections to "kick in"; they take about 10 days before this happens. She is also waiting for a firm decision on where she is going to be placed for her graduated return to work. She attempted a return to work last January and could not do it. Since attending the pain clinic, she is excited and looking forward to getting on with her life and returning to work. She said the pain clinic is "absolutely phenomenal".

<u>The Advocate's Submission</u>

[70] The advocate submits the workplace accident had a dramatic effect on the worker's life. The medical information at first blush appeared complex. The worker was injured when she fell down the steps of a school bus. She injured the back of her head as well as her shoulder and buttock. He says what complicated her injury, which was originally a soft tissue injury, was the worker received a diagnosis of a potential for brain cancer immediately following the accident.

[71] The advocate contends there was an intervening period of 11 months between the worker's injury when the soft tissue could have been better managed but was not due to the diagnosis of brain cancer.

[72] The advocate says the medical practitioners who would normally deal with the soft tissue injury were out of the picture as the medical community felt they were dealing with a life and death situation. Ultimately that proved not to be true but during the intervening period, the worker developed chronic pain. It is the chronic pain that has continued to disable her and it is the chronic pain that she continues to seek treatment for today.

[73] He says the worker, through her employer, applied for and received disability insurance. Through that process, the employer managed her medical claim by securing specialists' opinions in terms of what was preventing her from returning to work, what her condition was and what her limitations and restrictions were. He said this additional medical was provided to the hearing officer but he refused to consider it. The decision was made without reviewing the specialist information made available to him. They believe the decision was flawed.

[74] The advocate submits there are 3 elements to the claim:

1. An episodic history of depression which was asymptomatic for 3 years. The medical documentation verifies this had no bearing on whether or not the worker was improving from her workplace injury.

2. The worker developed chronic pain within 6 months of the injury.

3. Although additional medical was provided to the adjudicator she stated that it would not change her mind. In their opinion, both the hearing officer and adjudicator excluded relevant medical information from the decision-making process and pre-judged the merits of the case therefore not remaining within the objects of the Act which requires fairness. This led to the claim not being properly adjudicated.

[75] The advocate says the worker is actively involved in her recovery. When she attended the chronic pain clinic she asked everybody she could what was going on because it is having a major impact on her life. She is not going to sit back and accept this bad turn in her life and not educate herself on what she can do to make it better. She is a single parent of one and was actively involved in coaching her son's soccer team before the accident.

[76] The advocate submits the preponderance of medical information leads to the conclusion the worker developed chronic pain as a result of her workplace accident. There is no evidence to demonstrate that she was disabled as a result of an underlying anxiety condition.

[77] He contends the worker suffered a workplace injury which was accepted by the board. The medical care got sidetracked through typical medical triage and the intervening period compromised her ability to recover fully from the soft tissue injuries resulting in a consistent diagnosis of chronic pain. He submits that but for the accident the worker would not be suffering from chronic pain.

Issue: Are the worker's ongoing symptoms related to the original workplace injury?
Answer: Yes

Reasons and Findings

[78] Section 3 of the *Workers' Compensation Act* R.S.Y. 2002 states that a worker who suffers a work-related disability is entitled to compensation.

[79] Section 117 of the Act states that a disability must arise out of and in the course of employment of a worker.

[80] Section 6 provides that if a disability arises out of and in the course of a worker's employment, the disability is presumed to be work-related unless the contrary is shown.

[81] Policy CL-42, Arising Out of and In the Course of Employment, states that entitlement for compensation will be awarded when a disability arises out of and in the course of employment. A disability which results from the nature, conditions or obligations of the employment and happens at a time, place and circumstance consistent with the employment will be considered to have arisen out of and in the course of the worker's employment.

[82] We find the worker's injury and resulting chronic pain did arise out of and in the course of her employment. The original soft tissue injury was caused by her employment. It is linked to her employment in terms of time, place and activity consistent with the obligations and expectations of that employment. The worker's development of chronic pain is linked to the original injury. If not for the injury and misdiagnoses of brain cancer we find that she would not be suffering from chronic pain.

[83] Early in the claim, December 13, 2007, the adjudicator advises the worker that her claim for compensation is accepted for multiple contusions and a muscle strain of the c-spine, upper and lower back and a contusion to the back of her head. The adjudicator notes the worker has pre-existing degenerative changes in her lower lumbar spine, a non-compensable pre-existing condition, preventing the worker from receiving compensation for this. However, the worker's family doctor clarifies this in a report of the same date wherein she notes the worker does not have a pre-existing back problem; she was asymptomatic prior to her injury. X-rays show only "mild" degeneration changes [ref. para. #17 & 19].

[84] Approximately 10 weeks after the injury, an MRI of the brain showed unusual signs resulting in a diagnosis of a rare type of brain cancer. It is at this point, medical professionals and board staff concentrated on the brain cancer and the work-related injury was largely ignored. We find too much weight was given to the pre-injury asymptomatic conditions and not enough to symptoms the worker was suffering due to the work-related fall from the bus. By the time testing revealed there was no longer abnormal brain scan readings (April 2008), several months had passed without proper care and attention given to the worker's low back pain and symptoms in her lower extremities.

[85] Dr. D., the worker's family physician at the time, reported on March 26, 2008 that the CT findings of the head were not related to the work injury, however symptoms in her lower extremities most likely are related to the injury. Dr. E., neurologist reports on April 2, 2008, he did not evaluate for low back pain but opines the back pain is not the worker's limiting factor; it is headaches, fatigue and other symptoms attributing to her central neurologic problem and

possible brain cancer. He does not feel the worker requires active physiotherapy treatment at this time. This is early in the claim and the neurologist is providing an opinion which essentially says the worker's symptoms are stemming from her possible brain cancer.

[86] On April 14, 2008 the physiotherapist at Physio Plus reports that in her opinion there is still some involvement of the worker's back which is producing all the pain although no examination has been undertaken. The physiotherapist notes that much of her pain and symptoms are related to the workplace fall and she could still benefit from physiotherapy. This indicates to us the physiotherapist noted a causal link of the worker's ongoing back pain and symptoms to the workplace fall.

Again on November 18, 2008 (7 months post-injury) the physiotherapist believes there is something going on in the worker's upper thoracic spine which is affecting her low back and shoulder as a result of the fall. [ref. para. #37].

[87] The board medical consultant also comments in his June 3, 3008 report that muscle tightness and twitching is frequently associated with anxiety. He tells the worker it is completely normal to be anxious when one has been told they may have an incurable brain cancer. We agree.

[88] The hearing officer denied the worker's claim for compensation after receiving an independent medical examination from Dr. K. dated June 23, 2010 [ref. para. #52 & #53]. We give less weight to Dr. K.'s assessment. He is a family physician with a "special interest" in musculoskeletal problems and soft tissue injuries. He is not a psychiatrist, psychologist or neurologist; he does not have expertise in head injuries, anxiety or headaches. He disagrees with psychiatrist Dr. J.'s conclusion that there was a concussion injury; he found no evidence of fibromyalgia. Dr. K. does recognize that the worker's reaction to a potentially severe brain cancer likely accentuated her anxiety. He states, "I can say though, that a portion of her current presentation can be related to her work injury, and that this presentation is most likely related to both psychological factor and a physical factor."

[89] We conclude that most people would react to a terminal brain cancer diagnosis in the same way. This worker was a young single parent; her son was 10 years old at the time she received the brain cancer diagnosis. If this diagnosis was accurate, she was faced with the possibility of only having one year left to live. We understand that a diagnosis of terminal brain cancer would cause much anxiety, depression and sleeplessness in the majority of the population. The worker was diagnosed with brain cancer in January of 2008. It was not until a further MRI of the brain in December of 2008 revealed no signs of brain cancer.

[90] We find the work injury had an adverse impact on the symptoms of headache, anxiety and ultimately chronic pain. The symptoms are sufficiently connected to the work injury so it forms an inseparable part of that injury and is therefore considered to arise out of and in the course of the worker's employment and it is compensable.

[91] The appeal committee accepts Dr. L, psychiatrist's opinion and gives it considerable weight [ref. para. #55]. Although the board denied the worker's claim because she had episodic periods of depression and suffered headaches prior to the accident, Dr. L. noted these episodes were brought on by personal issues relating to her son's father and child support

issues and “her treatment appears to have isolated to her current period of post-injury”.

Dr. L. made his diagnoses on established DSM IV criteria as “Axis III: encephalitis . . . currently resolved. Multiple physical sequelae of traumatic fall November 2007 including headache, fatigue and pain.” Dr. L. also finds the worker’s depression issues are not the crux of her problem. He states that her sleep disturbance is playing a significant role in her chronic pain condition and although he cannot say with certainty there is a causal relationship between the head injury and the worker’s depression, there is certainly a “temporal” one and “it would be hard to imagine that the fall and immediate onset of her pain issues do not have some degree of cause and effect.”

[92] Dr. M., a physician specializing in physical medicine and rehabilitation, completes an independent assessment on June 10, 2010 [ref. para. #57]. He notes that given the onset of headache and cognitive complaints immediately following the accident, his diagnosis is mild traumatic brain injuries sustained in November of 2007. His diagnoses include:

- Post traumatic headaches with migrainous features.
- Cervical soft tissue strain.
- Left should pain not yet diagnosed.
- Diffuse and variable sensory symptoms in hands and feet.
- Unverified right lumbar pain.

Dr. M. finds the worker’s headaches and cervical symptoms relate to her fall from the bus in November 2007.

[93] Dr. L. & M.’s opinions are clear. The worker suffered multiple physical sequelae from the workplace traumatic fall of November 2007 including headache, fatigue, sensory symptoms and pain. Both their opinions establish that the worker’s compensable injuries were a significant cause of her pain symptoms, headaches, sleep disturbance, and anxiety following the accident. We find that the misdiagnosis of brain cancer derailed the worker’s treatment. The medical professionals directed their attention to this malady and the rest of her injuries were viewed as secondary. We conclude she would not have developed chronic pain but for the workplace fall of November 2007. Dr. L., Dr. M. and even Dr. K., to some extent, attribute the worker’s current condition to the workplace accident.

[94] The presumption to be work-related is contained in Section 6 of the *Act*. It provides that if a disability arises out of and in the course of a worker’s employment, the disability is presumed to be work-related unless the contrary is shown. We cannot find persuasive supporting evidence to come to a contrary conclusion.

Decision

The worker’s appeal is allowed. The hearing officer’s July 8, 2010 decision is reversed.

1. The worker is entitled to time loss and medical benefits to be reinstated retroactively to the date they were terminated.

2. The worker is entitled to rehabilitation assistance as provided by section 44 of the *Workers' Compensation Act*, R.S.Y. 2002.

3. The board shall pay interest on compensation in accordance with board Policy EL-03 and section 31 of the *Workers' Compensation Act*, S.Y. 2008, c. 12.

Dated this **19th day** of **July 2011** in the City of Whitehorse, Yukon Territory.

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M. McCullough, Member

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E. Sumner, Committee Chair

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H. Hermanson, Member