WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 1277/09

BEFORE: R. McCutcheon : Vice-Chair

HEARING: June 11, 2009, at Toronto
Written

DATE OF DECISION: October 20, 2009

NEUTRAL CITATION: 2009 ONWSIAT 2456

DECISION(S) UNDER APPEAL: WSIB Appeals Resolution Officer (ARO) K. Gowans dated May 22, 2008

APPEARANCES:

For the worker: A. Watson, Paralegal

For the employer: Not participating

REASONS

(i) Introduction

[1] The worker seeks an increase in the 12% non-economic loss (NEL) award the WSIB granted for his left shoulder. This award was calculated by combining a 9% value for abnormal motion, 10% for surgical interventions, and a discretionary 2% award. These values were combined to reach a whole-person impairment rating of 12% for the left shoulder.

[2] In written submissions, the worker's representative does not dispute the value awarded for abnormal motion, but argues that the value for the surgical intervention and the discretionary amount ought to have been higher. In this regard, the worker's representative relies upon Tribunal decisions in similar circumstances, in particular *Decision Nos. 1624/05* (November 8, 2005) and *451/08* (2008) 85 W.S.I.A.T.R. (online).

[3] In confirming the level of the worker's NEL award, the ARO relied upon a WSIB "Adjudicative Advice" document that provides guidelines for calculating NEL awards, but is not published policy of the WSIB.

(ii) Background

[4] On March 13, 2004, this now 36-year-old worker injured his left shoulder during the course of his employment with a freight forwarding company. He was working in a trailer moving garden benches that were stacked very high. As he pulled on a bench overhead, he felt a "pop" in the left shoulder.

[5] The worker received emergency medical treatment and the initial diagnosis was a separated left shoulder.

[6] An MRI arthrogram of the left shoulder on April 27, 2004, showed a posterosuperior labrum tear. There were also moderate degenerative changes of the acromioclavicular joint with a low lying acromion, Type II.

[7] On October 26, 2004, the worker underwent surgery on the left shoulder, which consisted of arthroscopic debridement, arthroscopic acromioplasty, and coracoacromial ligament release. Dr. J. Moro, an orthopaedic surgeon, reported that the worker had an equivocal prognosis following surgery due to the inferior partial labral tearing, which displayed injury to the shoulder from the work accident. However, this was not structurally unstable requiring fixation. Therefore it was possible that the worker could require retraining to a more sedentary job in the future.

[8] The worker had persistent pain following the surgery. MRI arthrogram on July 7, 2005 showed features suggestive of a recurrent labral tear at the site of the worker's previous surgery.

[9] Dr. Moro therefore performed further surgery on September 27, 2005. Surgery consisted of arthroscopic debridement, arthroscopic pancapsular plication, rotator interval closure, posterior portal closure, and arthroscopic labral repair – one Suretac anchor.

[10] Following surgery, Dr. Moro reported that the worker developed swelling of his left hand including some sweating, redness and significant stiffness. He had pain in the entire area of the left shoulder, arm, wrist, hand and even including his neck. Dr. Moro diagnosed complex regional pain syndrome, acute, and recommended permanent light duties for the left shoulder with job retraining. The worker has since returned to modified work with the accident employer, labeling boxes.

[11] The worker underwent a NEL examination in February 2007 and, as noted above, he was granted a 12% NEL award for the left shoulder in June 2007. The WSIB denied his request for a NEL increase and the worker appeals to the Tribunal.

(iii) Law and policy

[12] Since the worker was injured in 2004, the *Workplace Safety and Insurance Act, 1997* (the "WSIA") is applicable to this appeal. All statutory references in this decision are to the WSIA, as amended, unless otherwise stated.

[13] Section 46 of the WSIA provides that if a worker's injury results in permanent impairment, the worker is entitled to compensation for non-economic loss.

[14] "Impairment" means a physical or functional abnormality or loss (including disfigurement) which results from an injury and any psychological damage arising from the abnormality or loss.

[15] "Permanent impairment" means impairment that continues to exist after a worker reaches maximum medical recovery (formerly referred to as maximum medical rehabilitation under the pre-1997 Act).

[16] Legislation and Board policy provide that the degree of a worker's permanent impairment is determined in accordance with the prescribed rating schedule or criteria, any medical assessments, and having regard to the health information on file. The prescribed rating schedule for most impairments is the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* 3rd edition (revised) (the AMA Guides). Subsection 18(2) of the applicable regulation provides that, for impairments not provided for in the rating schedule, the listings in the rating schedule for the most analogous body parts, systems or functions are to be used.

[17] Pursuant to section 126 of the WSIA, the Board stated that the following policy packages, Revision #8, would apply to the subject matter of this appeal:

- #62 – NEL Quantum – decisions prior to July 2, 2008;
- #300 – Decision Making/Benefit of Doubt/Merits and Justice.

[18] *Operational Policy Manual* ("OPM") Document # 18-05-03, "Assessing Permanent Impairment," provides that, if a type of impairment is not listed in the AMA Guides, the WSIB considers the listings for the body parts, systems, or functions which are most similar to the worker's condition.

(iv) The AMA Guides

[19] The relevant provisions of the AMA Guides, found in section 3.1j, provide, in part, as follows:

> 3.1j Impairment Due to Other Disorders of the Upper Extremity
>
> Derangements not previously described can contribute to impairments of the hand and upper extremity and should be considered in the final impairment determination. These include bone and joint disorders, presence of resection or implant arthroplasty, musculotendinous disorder, and loss of strength.
>
> Note: it must be stressed that impairments secondary to these disorders are usually rated by other parameters. The following disorders are to be rated only when other factors have not adequately rated the extent of the impairment. Whether or not to consider these disorders separately is left to the discretion of the examiner…
>
> Table 19: Impairments of Upper Extremity Following Arthroplasty of Specific Bones or Joints.
>
> Shoulder: resection arthroplasty: 24%.
>
> …
>
> Other Musculoskeletal System Defects
>
> In rare cases, the severity of the clinical findings (e.g., loss of shoulder motion) does not correspond to the true extent of the musculoskeletal defect (e.g. severe and irreparable rotator cuff tear of the shoulder), as demonstrated with a variety of imaging techniques (e.g. MRI or surgical visualization). If the examiner feels that the measured anatomical impairment does not rate the severity of the patient's condition, an additional impairment can be given at discretion.

(v) WSIB "Adjudicative Advice" document

[20] The decision under appeal referred to a WSIB Adjudicative Advice document which was "created by the Board to help in assisting with calculating NEL awards for shoulder[s] that have undergone surgical repair." The WSIB did not state that this document was applicable policy for the purposes of section 126, and a copy of this document is not in the record. However, the Adjudicative Advice document has been cited in other Tribunal decisions, including those submitted by the worker's representative.

[21] *Decision No. 451/08* described the background to the Adjudicative Advice document in the context of that appeal from a NEL award for the shoulder:

> In this case the Board awarded an 18% award for loss of motion of the right shoulder. It then considered what award was appropriate to reflect the worker's right shoulder arthroplasty. It considered the fact the worker's arthroplasty was to the acromioclavicular joint (i.e. he had an acromioplasty) and that it was not a glenohumeral arthroplasty.
>
> This distinction was addressed by Dr. D. Kanalec in a memo dated February 9, 2004, in the context of another claim. He stated in that case:
>
> > We are not supposed to borrow from the 4th edition AMA Guides. We have to use the AMA Guides edition #3. Even though the AC joint is different from the glenohumeral joint both these joints are involved in the overall function of the shoulder with the associated rotator cuff. We have no choice but to use Table 19, resection arthroplasty 24% impairment of the upper extremity in rating this NEL.

> This is the only category in which we can rate this operative procedure in AMA Guides edition #3.
>
> I understand from this memo that the 4th edition of the AMA Guides makes a distinction between the two types of arthroplasty and rates an acromioplasty at only 10%.
>
> The Board did not accept Dr. Kanalec's analysis. It developed a document entitled: "Practice for Rating Permanent Impairment for Acromioplasty" dated August 13, 2004.

[22] *Decision No. 451/08* noted that the Adjudicative Advice Document referred to the requirement of the Regulation to use the most analogous condition if a condition is not rated, and reproduced the following excerpt from the Adjudicative Advice Document:

> The AMA guides does not provide a percentage value for the rating of surgeries to the acromioclavicular (AC) joint. While the glenohumeral (GH) joint is in close proximity anatomically to the AC joint, it is a much larger joint and surgery to this joint is much more invasive than the surgeries to the AC joint. For this reason, using the GH joint as an analogy to the AC joint would not be appropriate, as the percentage rating does not reflect the extent of the surgery…There is really no close analogy.
>
> Proposed practice/process
>
> The AMA guides do allow for a discretionary rating where the severity of the clinical finding does not correspond to the true extent of the musculoskeletal defect (p. 52). In absence of a closer analogy for rating AC joint surgeries, the following practice is suggested:
>
> Acromioplasty
>
> Using a discretionary rating, an acromioplasty, including distal clavicle resection, will be rated at 10% upper extremity. This would be combined with other impairment values, such as range of motion loss and would then be reduced to whole person as per the AMA guide calculation.

[23] Thus, the Adjudicative Advice document adopts a position that the 24% rating for "resection arthroplasty," contained in Table 19 of the AMA Guides, applies only to surgery on the glenohumeral joint and does not apply to surgery to the AC joint.

(vi) Relevant Tribunal decisions

[24] *Decision Nos. 1624/05* and *451/08* directly address the correct approach to NEL awards for shoulder surgery.

[25] In *Decision No. 1624/05*, the worker had undergone a resection of the acromion, in which a portion of the acromion bone was removed. In that decision, Vice-Chair Moore noted that the AMA Guides stipulate that a resection arthroplasty represents a 24% impairment of the upper extremity. In that decision, the Vice-Chair did not accept the ARO's finding that the 24% was intended to apply only to a resection of the humeral bone. The Vice-Chair found that it was clear from the evidence that the worker had a resection arthroplasty in that she underwent removal of a portion of one of the bones that makes up the shoulder joint. In reaching this conclusion, Vice-Chair Moore noted the following definition of "arthroplasty," from *Taber's Cyclopaedic Dictionary*: "Surgical formation or reformation of a joint." That text defines "resection" as: "Surgical formation or reformation of a joint." Based upon medical evidence that the anterior acromion was removed during surgery, Vice-Chair Moore found that the worker was entitled to an award of 24% impairment of the upper extremity for the surgery. The Vice-Chair noted

further that Table 19 of the AMA Guides does not distinguish among the types of resection arthroplasty that can occur.

[26] Vice-Chair E. Smith had occasion to review a similar NEL rating issue in *Decision No. 451/08*. In that appeal, the worker's NEL award had been calculated based upon a 10% impairment of the upper extremity attributed to an arthroplasty of the acromioclavicular joint (acromioplasty). In that decision, Vice-Chair Smith agreed with the analysis of Vice-Chair Moore in *Decision No. 1624/05* and concluded that the worker was entitled to a 24% impairment rating of the upper extremity for the shoulder surgery. Vice-Chair Smith reasoned in part:

> There is nothing in the wording of the AMA Guides to suggest that the words "resection arthroplasty" refer only to the glenohumeral joint and not to the acromioclavicular joint. There is no reference in the relevant Table to either joint. While the Tribunal will often give a degree of deference to Board practice, in this case, in my view, the practice does not reflect the requirements of the Regulation. Given that that the words of Table 19 are broad enough to apply to either surgery, it is the relevant Table for rating the worker's condition.
>
> The opening words of section 3.1j suggest that the rating in Table 19 is only applicable if other ratings, such as the rating for the worker's loss of range of motion, do not fully reflect the worker's impairment. However, there is no question in this case that the 18% awarded for loss of motion was insufficient to assess the worker's impairment. The Board accepted that an additional rating was necessary. The question is only whether that additional impairment was appropriately rated under Table 19, at 24%, or under the discretionary provision that allowed for additional ratings if the specific ratings were not sufficient.
>
> In this case, in my view, Table 19 applies specifically to the worker's surgery. Therefore the specific ratings are sufficient to assess the impairment. There is no basis upon which to apply a discretionary rating. There is also no need to consider what rating might be most analogous.
>
> The Board may be of the view that Table 19 is overly generous in this instance, and that the Guides should have made a distinction between these types of surgeries. However, the third edition of the Guides did not make this distinction. The legislation has adopted this edition of the Guides as the relevant rating schedule. Therefore the worker is entitled to the 24% rating specified by the Guides.

(vii) Submissions

[27] The worker's representative submitted that the Tribunal has generally upheld the use of Table 19 of the AMA Guides in situations where it is clear that the worker has undergone a surgical resection of the AC joint. The worker's representative reviewed the medical evidence in detail, particularly with respect to the nature of the worker's surgeries. It was submitted that the worker was entitled to a 24% impairment associated with a resection arthroplasty, rather than 10%.

[28] The worker's representative also reviewed evidence which was said to reflect a severe ongoing impairment and that the worker ought to receive a discretionary award no less than 5% to account for this.

(viii) Conclusions and analysis

[29] The appeal is allowed in part.

[30] The worker is entitled to a 24% rating for impairment of the upper extremity for his shoulder surgeries. However, the worker is not entitled to an increase in the 2% discretionary rating.

(a) Rating for shoulder surgeries

[31] I accept the reasoning in *Decision Nos. 1624/05* and *451/08*, that there is no basis in the AMA Guides for limiting Table 19 to apply only to surgery of the glenohumeral joint and not to the acromioclavicular joint.

[32] As noted in *Decision No. 1624/05*, arthroplasty is defined as "Surgical formation or reformation of a joint," and resection is a "surgical formation or reformation of a joint."

[33] The evidence in this case clearly indicates that the worker underwent an acromioplasty, that is, arthroplasty of the acromioclavicular joint. In the operative note of the first procedure in 2004, Dr. Moro described the surgery in part as follows:

> The most striking finding was that of an inferior partial thickness tear of the labrum, running from 5 to 7 o'clock on the clock face. This area was probed and found to be not full thickness. Thus, shaver was brought in to debride this entire area down to stable smooth bases…
>
> Subacromial arthroscopy thus begun. Standard posterior portals established and lateral portal with needle technique. Debridement of the subacromial bursa, which was quite thickened and inflamed. Coracoacromial ligament released. Type II converted to Type I acromion. Cutting block technique used. Good decompression acromioplasty performed. Once again, the bursal side of the rotator cuff intact…

[34] The report of an MRI arthrogram dated July 7, 2005, noted that the worker had since had repair of the labral injury shown in the study of April 27, 2004. The July 2005 examination showed "resection of the distal clavicle at the acromioclavicular joint…with surrounding metallic shavings with localized artifact."

[35] In the operative note of September 27, 2005, Dr. Moro described the second operative procedure in part as follows:

> The most obvious finding was an anteroinferior labral tear from 6:30 to 8 o'clock on the clock face. There was also some fraying from 5 to 6:30. These areas were gently debrided. SLAP bur was brought in on the anteroinferior labrum to debride the labral bone interface. Unfortunately, we did not have drills for suture anchor insertion, thus a Suretac anchor was placed at the 7:30 position with good repair.
>
> Next, a pancapsular plication was performed with posterior sutures at the 4 o'clock and 5 o'clock positions, the first being #2 fibre wire and the second being #2 Ethibond. A pinch-tuck technique was used with 1 cm tightening of the capsule to the labrum.
>
> Similarly, an anteroinferior capsular plication was performed at 7 and 8 o'clock, both with #2 fibre wire. Again, a pinch tuck technique was used. Rotator cuff interval closure was performed with 0 PDS suture from the superior subscapularis edge to the superior glenohumeral ligament. The suture was tied and cut extra-articularly.
>
> …
>
> At the end of the procedure, the shoulder was well balanced with the humeral head sitting centred in the glenoid.

[36] In submissions, the worker's representative referred to definitions of relevant terms, drawn from sources that are reliable for the purposes of general definitions. Shoulder resection arthroplasty is described as "surgery performed to repair a shoulder acromioclavicular joint."[1] Acromioplasty is defined as "excision of the anterior hook of the acromion for the relief of pressure on the rotator cuff produced during movement of the joint between the glenoid cavity and the humerus."[2]

[37] In view of the evidence in this case, in particular the operative reports and the MRI arthrogram reports, I agree with the worker's representative's submission that the surgical procedures went beyond a simple arthroscopy and debridement. Taking into account the nature of the worker's two surgeries and the reasoning in *Decision Nos. 1624/05* and *451/08*, the worker is clearly entitled to the 24% impairment of the upper extremity rating in recognition of the two shoulder surgeries.

(b) Discretionary rating

[38] The worker's representative also submitted that the discretionary rating given by the NEL adjudicator ought to be increased from 2% to at least 5%. The AMA Guides describe the discretionary rating as follows at p. 52:

> **Other Musculoskeletal System Defects**
>
> In rare cases, the severity of the clinical findings (e.g., loss of shoulder motion) does not correspond to the extent of the musculoskeletal defect (e.g., severe and irreparable rotator cuff tear of the shoulder), as demonstrated with a variety of imaging techniques (e.g., MRI or surgical visualization). If the examiner feels that the measured anatomical impairment does not appropriately rate the severity of the patient's condition, an additional impairment can be given at discretion.

[39] The worker's representative reviewed the medical evidence in detail for the purposes of demonstrating the severity of the worker's condition. The worker's representative submitted that the worker had slight weakness evident in all muscle groups in the left elbow, wrist and fingers and the worker continued to require powerful medication to manage his pain. It was also submitted that the worker experienced limitations in many activities of daily living that go beyond range of motion findings. The worker's representative submitted that the worker was therefore entitled to a higher discretionary rating.

[40] However, the worker's representative's submissions do not cite any specific Tribunal decisions in support of this argument. This issue was recently addressed by Vice-Chair J. Noble in *Decision No. 862/09*. In that case, the worker was granted a 33% NEL award for cervical

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[1] "Shoulder Resection arthroplasty", from the Encyclopedia of Surgery: A Guide for Patients and Caregivers, http://www.surgeryencyclopedia.com. The website states: "The Encyclopedia of Surgery has been written by various experts in the field of surgery and has been written specifically for healthcare students and patients. The Encyclopedia covers 450 surgical procedures and topics such as laser surgery, hysterectomy, endoscopy, cryosurgery, anesthetics, biopsy, angioplasty, medications and postoperative care, and many related subjects. Each entry in the Encyclopedia of Surgery consists of a standardized format which includes the definition, purpose, diagnosis, aftercare, risks, mortality rates, and alternatives."

[2] Medline Plus, online medical dictionary, a service of the U.S. National Library of Medicine and the National Institutes of Health, at http://www.nlm.nih.gov/medlineplus/mplusdictionary.html.

impairment. The Vice-Chair in that decision denied the request for an additional discretionary rating. *Decision No. 862/09* includes the following excerpt from *Decision No. 2225/05*, which also addressed a discretionary rating:

> The *Guides* also recognize that in some cases, an assessment of the loss of range of motion will not necessarily recognize the true extent of the impairment. The *Guides* indicate (at p. 52):
>
> > In rare cases, the severity of the clinical findings (e.g. loss of shoulder motion) does not correspond to the true extent of the musculoskeletal defect (e.g., severe and irreparable rotator cuff tear of the shoulder), as demonstrated with a variety of imaging techniques (e.g., MRI or surgical visualization). *If the examiner feels that the measured anatomical impairment does not appropriately rate the severity of the patient's condition, an additional impairment can be given at discretion.* (emphasis added)
>
> The possibility that, in exceptional cases, a higher rating might be appropriate if the standard ways of assessing an impairment result in a rating that does not appropriately reflect the real level of impairment, is consistent with the requirement in the *Workers' Compensation Act* and the *Workplace Safety and Insurance Act* to consider the merits and justice of the individual merits of each case….
>
> In this case, the NEL adjudicator at the Board agreed that the range of motion impairment recorded by the NEL medical assessor did not adequately reflect the worker's impairment. An additional 1% was awarded, apparently based on the assessor's report that the worker experienced throbbing pain.

[41] In *Decision No. 862/09*, however, the Vice-Chair found that the circumstances were distinguishable, reasoning in part:

> As *Decision No. 2255/05* noted, the *Guides* recognize that in rare cases the severity of the clinical findings does not correspond to the true extent of the musculoskeletal defect, and if the examiner feels that the measured anatomical impairment does not appropriately rate the severity of the patient's condition, an additional impairment can be give at discretion. The Vice-Chair in *Decision No. 2255/05* exercised his discretion to increase the discretionary 1 percent NEL award already granted by the Board. I find that *Decision No. 2255/05* can be distinguished from the facts of the appeal before me on the following grounds.
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> First, in *Decision No. 2255/05* the NEL adjudicator agreed that the NEL assessor's findings should be interpreted to mean that the range of motion impairment recorded by the NEL medical assessor did not adequately reflect the worker's impairment. On the facts of the instant appeal, there is no corresponding finding in the NEL assessor's assessment. Dr. Garner's NEL assessment report indicates that Dr. Garner took into account an analysis of the worker's Activities of Daily Living; the worker's sensory deficits; the worker's motor deficits including range of motion and reflexes; and the worker's surgical history. The NEL assessment report also indicates that Dr. Garner completed a soft tissue pain diagram with respect to the worker's left arm and neck symptoms. There is no evidence that indicates that Dr. Garner was of the view that the worker had additional pain symptoms that were not captured by the NEL assessment. I find that the evidence indicates that the effects of the worker's pain symptoms were likely taken into consideration, given that Dr. Garner completed a soft tissue pain diagram with respect to the worker's left arm and neck symptoms.
>
> Second, in *Decision No. 2255/05* the Vice-Chair stated that he placed considerable weight on the testimony of the worker, whom he found to be a credible witness. The Vice-Chair relied on this evidence to find that the worker's 4 percent NEL award was

> insufficient given the impact that the worker's injury had on his life. In the instant appeal, which proceeded as a written appeal, the worker did not testify and therefore there is no evidence in that regard which I can weigh. More importantly, however, the worker in the instant appeal has received a 33 percent NEL award which is significantly higher than the 4 percent NEL awarded initially to the worker in *Decision No. 2255/05*. In my view a 33 percent NEL award recognizes a significant permanent impairment, and so *Decision No. 2255/05* can be distinguished in this respect.
>
> Third, I note that *Decision No. 2255/05* confirms that the *Guides* indicate that in *rare* cases, a discretionary additional award can be given. I find that the characterization of the discretionary additional award as being appropriate in rare cases should be interpreted to indicate that the discretion should be exercised with care, and only in cases where clearly warranted by the evidence. I do not find that the evidence in this case establishes that a discretionary additional award should be granted.

[42] Thus, a discretionary award is granted in rare cases, where the other aspects of the rating do not adequately reflect the extent of the worker's disability. In this case, the worker was granted 9% for abnormal motion, and, pursuant to this decision of the Tribunal, the NEL will also be increased due to an increase of the rating for the surgeries.

[43] I have noted the evidence regarding the extent of the worker's disability. The NEL adjudicator was aware that the worker was taking OxyContin, Tylenol #3 and Mobicox at the time of the NEL assessment, as those medications were listed on a NEL reporting form. The NEL adjudicator also had the benefit of a pain diagram and an Activities of Daily Living form.

[44] The worker's representative submitted that the worker suffered limitations in "cognitive and interactive functions [that]… indicate a severity that goes beyond the measured anatomical impairment i.e., range of movement." It is not entirely clear what is meant by this. I note that, by April 2006, Dr. Moro noted that the worker was exhibiting signs of depression, but this would have to be adjudicated as a separate area of entitlement to warrant a NEL rating. The discretionary award is not meant to be used to recognize symptoms that go beyond the scope of the accepted compensable impairment. Furthermore, unlike other situations in which a discretionary award is made, the worker's NEL award is not limited to the range of motion findings, but also includes a 24% impairment of the upper extremity for the surgeries.

[45] In these circumstances, there is no reason to increase the discretionary rating above 2%.

DISPOSITION

[46] The appeal is allowed as follows:

1. The Board is to recalculate the NEL award on the basis that the worker has a 24% impairment of the upper extremity associated with a resection arthroplasty, pursuant to Table 19 of the AMA Guides. Once that determination has been made, the overall NEL award granted to the worker is to be recalculated, taking into account other findings of impairment previously determined.
2. The amount allocated for "Other Musculoskeletal System Defects, Additional impairment at the examiner's discretion" is to remain at 2%.

DATED: October 20, 2009

SIGNED: R. McCutcheon