WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 378/09

BEFORE:	G. Dee: Vice-Chair A.D.G. Purdy: Member Representative of Employers J.A. Crocker: Member Representative of Workers
HEARING:	August 3, 2010 at Toronto Oral
DATE OF DECISION:	August 10, 2010
NEUTRAL CITATION:	2010 ONWSIAT 1831
DECISION(S) UNDER APPEAL:	ARO Decisions dated April 17, 2008 and May 29, 2009

APPEARANCES:

For the worker:	S. Backus, Union Representative
For the employer:	Not participating
Interpreter:	N/A

REASONS

(i) Issues

[1] The worker seeks an increase in the 5% Non-Economic Loss (NEL) award that she has received for a right shoulder injury.

[2] The worker also seeks recognition of a permanent impairment and payment of a NEL award for upper back and neck injuries.

(ii) Background

[3] The worker was working for a supermarket preparing fruit and vegetable salads when she experienced a repetitive strain injury involving her right shoulder with pain being experienced in her right neck and in the area of her right upper back to her shoulder blade. The worker sought medical attention for this condition in November 2004.

[4] The worker subsequently aggravated her right shoulder injury on August 11, 2005, when she slipped on a grape and fell backwards jarring her right shoulder.

[5] Since her injuries the worker has returned to work with the accident employer on modified duties.

[6] The worker continues to take medication for her work-related injury and continues to attend physiotherapy.

[7] Magnetic resonance imaging of the right shoulder that took place on October 25, 2006, noted:

> Findings in the supraspinatus tendon in keeping with a tendinopathy plus or minus a tiny humeral surface partial thickness tear in the middle third of this tendon.

[8] The worker's family doctor in a brief letter dated December 14, 2006 provides an opinion that the worker has a torn tendon in her right shoulder.

[9] The WSIB has accepted that the worker has a permanent impairment in her right shoulder and arranged for a NEL medical assessment that was conducted by Dr. Armstrong on December 7, 2006.

[10] A WSIB NEL Clinical Specialist noted that the findings contained in the report from the December 7, 2006, assessment did not reflect medical information that had previously been received by the Board. A second NEL medical assessment was arranged with Dr. Carbin on April 25, 2007.

[11] Based upon the results of the assessment by Dr. Carbin a NEL rating of 5% was provided by the WSIB.

[12] The worker appealed this NEL award to the level of the Appeals Resolution Officer (ARO) at the WSIB and in a decision dated April 17, 2008, the worker's appeal was denied.

[13] The worker also requested recognition of a permanent impairment in her neck and upper back. The WSIB denied this request and the worker again appealed to the level of the ARO at the WSIB. In a decision dated May 29, 2009, the worker's second appeal was also denied.

[14] The worker appeals both issues to the Appeals Tribunal.

[15] With respect to the level of the worker's NEL rating for her shoulder condition the worker does not take issue with the manner in which a NEL rating was derived from the range of motion figures that were provided by Dr. Carbin.

[16] The Panel has nevertheless reviewed the 5% rating provided by the WSIB. The Panel does not find any apparent errors in the manner in which Figures 35, 36, and 37 from the AMA Guides to the Evaluation of Permanent Impairment (3rd edition) (the Guides), that apply to the rating of shoulder injuries, have been applied by the WSIB to the range of motion figures determined by Dr. Carbin. The WSIB's calculations based on Dr. Carbin's findings respecting the worker's range of motion in her shoulder are found in the WSIB file in the "NEL Evaluation" document dated May 8, 2007.

[17] The worker submits however that the NEL rating is not appropriate because:

- The NEL assessors report did not take into consideration the fact that the worker has a torn tendon in her right shoulder.
- The report by Dr. Carbin did not include a report on all of the relevant sections of the Activities of Daily Living (ADL) Analysis Form and the limitations indicated on the ADL form were not taken into consideration when establishing the NEL.
- The shoulder determination did not take into consideration the referred pain that the worker experiences in her neck, trapezius region, and arms.

[18] The worker submits that the worker has a permanent impairment in her neck and upper back based upon the worker's reports of pain in those areas and based upon the medical reports of treating health care providers.

(iii) The law

[19] The worker was injured in 2004 and 2005. The worker's injuries are therefore governed by the *Workplace Safety and Insurance Act* (the Act).

[20] Section 47 of the Act deals with NEL determinations and states as follows:

> 47(1) If a worker suffers permanent impairment as a result of the injury, the Board shall determine the degree of his or her permanent impairment expressed as a percentage of total permanent impairment.
>
> (2) The determination must be made in accordance with the prescribed rating schedule (or, if the schedule does not provide for the impairment, the prescribed criteria) …

[21] The rating schedule that must be used is prescribed in section 18 of Ontario *Regulation 175/98* that states:

> 18(1) The American Medical Association Guides to the Evaluation of Permanent Impairment (third edition revised) as it read on January 14, 1991 is prescribed as the rating schedule for the purposes of subsection 47(2) of the Act.
>
> (2) The criteria prescribed for the purposes of subsection 47(2), for impairments not provided for in the rating schedule, are the criteria in the listings in the rating schedule for those body parts, systems or functions which are most analogous to the conditions of the worker.

[22] Use of the third edition revised of the AMA Guides is also called for in WSIB policy. *Operational Policy Manual* Document No. 18-05-03 (18-Jul-2008) that states as follows:

> Rating schedule The prescribed rating schedule is the American Medical Association's Guides to the Evaluation of Permanent Impairment, 3rd edition (revised), (the AMA Guides). 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.

[23] Impairment and permanent impairment are defined in section 2 of the Act as follows:

> "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;
>
> "permanent impairment" means impairment that continues to exist after the worker reaches maximum medical recovery;

(iv) Analysis

(1) NEL rating for the right shoulder

[24] The Panel finds that the NEL rating of 5% for the right shoulder should be confirmed and the worker's appeal of that award denied.

[25] As mentioned above, the Panel has examined the 5% rating provided by the WSIB and does not find any apparent errors in the manner in which the provisions of the AMA Guides that apply to shoulder impairment determinations have been applied by the WSIB to the range of motion figures determined by Dr. Carbin. The worker's representative did not take issue with these determinations.

[26] The worker's representative did take issue with the failure of Dr. Carbin's assessment to mention the partial tear of a tendon in the worker's shoulder, the failure of the WSIB to take into consideration the worker's restrictions on activities of daily living, and the WSIB's failure to have regard for referred pain from the worker's shoulder into her neck, upper back, and arm.

Partial tear of the tendon

[27] Under the AMA Guides, the level of the NEL award for a shoulder injury depends upon a number of factors. The most prominent factor is generally the restriction of the range of motion of the shoulder as determined in a medical examination. The other factors that enter into the determination of the appropriate NEL rating are included under heading 3.1j "Impairment Due to

Other Disorders of the Upper Extremity". However, none of these factors include the existence of a partial tear of a tendon.

[28] The existence of a partial tear therefore does not on its own result in a higher NEL award. A partial tear is taken into consideration by the effect that it has on the other factors that are measured under the AMA Guides such as range of motion and the other disorders of the upper extremity.

[29] The NEL medical assessment that was relied on by the WSIB to set the NEL award took place on April 25, 2007. At that point in time the existence of a partial tear of the tendon was confirmed. Confirmation was obtained on October 25, 2006 by an MRI test.

[30] Although the existence of the tear is not specifically mentioned in Dr. Carbin's NEL assessment report, there is no reason to believe that the factors that do affect the determination of the worker's NEL award (such as range of motion) were under-estimated due to the lack of a reference to the partial tear.

[31] The loss of range of motion in the worker's shoulder was evaluated. To the extent that a partial tear of a tendon in the worker's shoulder would have affected the range of motion of the worker's shoulder, that loss of range of motion would have been observed by Dr. Carbin.

[32] The Panel does not accept that the lack of a specific reference to a partial tear of a tendon in the worker's shoulder is an indication that Dr. Carbin did not conduct an accurate evaluation of those factors that affect the determination of the worker's NEL award.

Activities of Daily Living

[33] The fact that the WSIB has provided the roster physician who conducted the NEL medical assessment with an ADL Analysis Form does not mean that the ADL analysis is necessarily relevant to the setting of the NEL.

[34] Earlier WSIAT decisions have noted that NEL ratings in most cases are not affected by the ADL report.

[35] In WSIAT *Decision No. 1630/05* the worker objected to the fact that in setting the NEL rating for a repetitive strain injury that the WSIB had not made reference to the Activities of Daily Living chart that had been provided to the NEL assessor and completed by the assessor. The Vice-Chair asked the following questions to the WSIB obtain clarification of the role of the ADL Analysis Form:

> 1) Does the Board consider activities of daily living in determining organic impairment?
>
> 2) In the present case, should the Board have considered the impact of the worker's right shoulder impairment on her activities of daily living in determining the quantum of the NEL award for that impairment?
>
> 3) If not, why was an Activities of Daily Living Analysis Form sent to and completed by Dr. Maistrelli?

[36] The following response was received from the WSIB and relied upon in the decision:

> 1. In situations where the worker has a repetitive strain type of injury and there is little or no reduction in the range of motion when an assessment is completed, the NEL Clinical Specialist (NCS) will revert to the repetitive strain rating (RSI) protocol (attached). This is done so that the worker would not have a 0% NEL which would be the case without using the RSI guidelines. The RSI protocol takes the activities of daily living into consideration as the NCS cannot use reduced range of motion as evidence of the permanent impairment.
>
> 2. Because there was obviously reduced range of motion in this worker's assessment, the activities of daily living would not be used.
>
> 3. The ADL form was completed by Dr. Maistrelli so that if the ROM was considered to be within normal range, the NCS would be able to defer to a rating for repetitive strain injury and she would have the information that she needed to make the decision without having to resort to an additional assessment.
>
> 4. The Board should not have used the ADL form in the rating because the reduced range of motion which would have caused the changes in ADL could be measured. It is only in cases of repetitive strain where the MD is not able to measure a reduced ROM that we would use the ADL form in the rating.

[37] In this case the worker did have a loss or range of motion. The loss of range of motion would have resulted in a 3% whole person impairment. That 3% rating was subsequently rounded up to a 5% whole person impairment under the provisions found in Table 3 of the Guides.

[38] Given that the worker had a measurable reduction in her shoulder range of motion and would not have received a 0% NEL based on those measurements, the Panel finds that no error was committed by the WSIB in setting the level of the worker's NEL award without regard to the information that might have been obtained from the ADL Analysis Form.

Referred Pain

[39] The worker's claim to have a separate injury to her neck and upper back is dealt with below. However, the worker's representative has also indicated that the NEL rating for the right shoulder is deficient in that it does not take into consideration referred pain from the shoulder into the neck and upper back.

[40] The AMA Guides, following a discussion of the effects of a loss of range of motion in the shoulder, contain a section 3.1h "Impairment of the Upper Extremity Due to Peripheral Nervous System Disorders". The following excerpt is taken from that section:

> In evaluating pain associated with peripheral spinal nerve disorders, the physician should consider: (a) how the pain interferes with the individual's performance of the activities of daily living; (b) to what extent the pain follows the defined anatomic pathways of the root, plexus, or peripheral nerve; (c) to what extent the description of the pain indicates it is caused by a peripheral spinal nerve abnormality; and (d) to what extent the pain corresponds to other disturbances of the involved nerve or nerve root.
>
> *Complaints of pain that cannot be characterized as above are not considered to be within the scope of this section.*

[41] There is no indication in the medical evidence that the worker has a peripheral spinal nerve disorder.

[42] The worker's representative also stated quite clearly, and the Panel agrees, that the worker does not have a chronic pain condition as defined by WSIB policy, as a result of her injury.

[43] In the absence of:

- a chronic pain condition, which would be dealt with in a completely different manner than the rating of a shoulder condition under the Guides; and
- a peripheral spinal nerve disorder,

the worker's reports of pain do not constitute a separate factor, apart from the other factors that go into the determination of the NEL award, for which the NEL award for the worker's shoulder condition may be increased.

Crepitation

[44] During the course of her testimony the worker was asked by the Panel about the finding of the NEL medical assessment that she had crepitation in her right shoulder. The worker was not able to provide any specific information concerning the existence of crepitation in her shoulder. The worker responded to questions about the nature of her shoulder problem by describing the pain that she experienced without any specific description of crepitation.

[45] Crepitation is a condition that involves a rough working of the joint sometimes associated with noise or a grinding sensation within the joint with motion.

[46] The worker was asked these questions due to the fact that joint crepitation with motion can, in some circumstances, justify a higher NEL award and the worker's medical assessment by Dr. Carbin noted "mild" crepitation.

[47] An award for mild crepitation of the right shoulder would be 10% of the "relative value" of the right shoulder joint as determined under Table 17 of the Guides. The relative value of the shoulder is 36% of the "whole person". An award for crepitation could add 3.6% to the worker's NEL rating. This would not be as significant as it might seem however as the 3.6% would be added to the worker's impairment rating of 3% for loss of range of motion which was the worker's impairment rating before the rating was rounded up to 5% under Table 3 of the guides.

[48] However, the AMA Guidelines concerning crepitation state the following:

> Joint crepitation with motion can reflect synovitis or cartilage degeneration. The impairment degree is multiplied by the relative value of the joint (Table 17).
>
> The evaluator must use judgment and avoid duplication of impairments when other findings, such as synovial hypertrophy, carpal collapse with arthritic changes, or limited motion are present. The latter findings may indicate a greater severity of the same underlying pathological process and take precedence over joint crepitation, which should not be rated in these circumstances.

[49] The worker's representative suggested that the worker inability to relate any particular complaints about crepitation was likely the result of a language barrier. While the Panel is aware that the worker's first language is not English, the Panel found the worker's ability to communicate in English was quite good. Had the worker been experiencing significant problems with crepitation of her shoulder the Panel expects that the worker would have been able to communicate what those problems were.

[50] However, the worker has been recognized as having a loss of range of motion in her shoulder. The impairment rating on the basis of a lack of range of motion has in fact been increased from 3% to 5% under Table 3 given that the shoulder impairment is the only upper extremity impairment involved in the rating.

[51] Given the provisions of the AMA guides concerning the avoidance of duplication of impairment ratings that is quoted above, the Panel finds, based on these facts, that the joint crepitation should not be rated separately and added on to the loss of range of motion rating.

2. Neck and upper back impairment

[52] While the worker has testified about the presence of pain at the base of her neck and about pain that is present in her upper back to the right of her right shoulder blade, the Panel finds that there is insufficient medical evidence to substantiate that the worker has an injury to her cervical or thoracic spine that is separate from her compensable right shoulder injury. The Panel finds that the worker's complaints of pain in her neck and upper back are more likely related to referred pain from her right shoulder impairment.

[53] In making this finding the Panel notes the following.

[54] The clinical notes of the family doctor, Dr. Reisor, from October 25, 2006 until May 5, 2008, contain a number of references to ongoing problems in the worker's right shoulder but no apparent reference to ongoing problems in the worker's neck or upper back.

[55] The medical report of December 14, 2006, from Dr. Reisor to Premier Fitness, notes the worker's ongoing problem with her right shoulder but makes no mention of a problem with the worker's neck or upper back.

[56] The REC assessment report from the Hamilton Hospitals Assessment Centre dated January 23, 2006 provides ranges of motion measurements for flexion, extension rotation and side flexion that would provide for very minimal ratings under the AMA Guides (Tables 55, 56, and 57) at that time. Flexion of 65% would be rated at zero. Extension of 50% would be rated at between 0% and 2%. Rotation of 70% to the left and right would be at between 0% to 1% each to right and left. Side flexion of 40% to the left and right would be rated between 0% to 1% each to right and left.

[57] Dr. Reisor's medical report of July 11, 2006 to the WSIB some six months later notes that the worker has full range of motion of her cervical spine. The report does note however ongoing pain in the right side of the worker's neck and that the worker experienced increased pain with lateral rotation to the left.

[58] In Memo #36 in the Board file, WSIB Medical Consultant, Dr. Amand notes as follows as of June 6, 2008:

> She was seen by REC January 23, 2006 and range of motion of the cervical spine demonstrated full flexion, extension and near full side flexion and rotation. X-rays demonstrated DDD of the cervical and thoracic spine (December 8, 2005). There were no significant findings reported for the thoracic spine. REC concluded residual symptoms from time to time for RSI. The form 26 dated April 5, 2006 indicated full range of motion of the cervical spine. There was no significant upper back findings. The diagnosis was exacerbation of RSI of right shoulder.
>
> In conclusion, there did not appear to be a permanent impairment evident for the upper back or cervical spine. This can be revisited if more medical comes to the file for review.

[59] The Panel disagrees with the opinion of Dr. Amand with respect to the findings concerning the range of motion in the cervical spine at the time of the REC assessment. The Panel would not characterize the range of motion demonstrated as full at that time given the values for range of motion found in Tables 55, 56, and 57 of the AMA Guides. The Panel would however characterize the findings on range of motion during the REC assessment as indicating a minimal loss of range of motion. The Panel notes however that the REC assessment took place only some four months following the worker's aggravation of her shoulder condition when she fell on a grape on August 11, 2005. Subsequent medical reporting indicates a full range of motion in the cervical spine.

[60] While the worker has continued to take medications and attend physiotherapy for her right shoulder problems and the associated pain, there are no diagnostic reports that focus on the worker's cervical spine and upper back. There are also no referrals to specialists with respect to any ongoing problems in the worker's cervical spine and upper back.

[61] The strongest evidence in terms of the possibility of an ongoing problem with the worker's cervical spine as a result of the injury is the report of the Physiotherapist, H. MacLeod in reports of May 26, 2010 and May 14, 2009.

[62] The May 26, 2010 report states as follows:

> [The worker] was working in the salad bar at [employers] in November 2004 when she felt a pain in her right shoulder blade region. On April 21, 2005, [the worker] was assessed at Alevia Health and wellness to reveal a partial tear of the supraspinatus muscle, strain/sprain of the cervicothoracic muscles on the right side and radicular pain in the right upper extremity to the finger tips.
>
> WSIB approved physiotherapy, acupuncture and massage therapy at that time. [The worker] gained improved range of motion of the shoulder, increased strength of the right upper extremity, however pain and functional mobility continued.
>
> ….
>
> Currently [the worker] presents with myofascial hypertension in the right cervicothoracic musculature. She has positive upper limb tension tests in the median and ulnar distribution. Passive accessory movements of the cervical joints reveal decreased joint play from C5-T4. Manual muscle testing reveals weakness of the rotator cuff muscles, bicep and grip strength on the right as compared to the left.

> At this time [the worker continues to receive acupuncture and massage therapy every 2-4 weeks and performs a home exercise program daily then applies ice to manage pain and discomfort.

[63] The May 14, 2009 report states that the physiotherapy assessment revealed a "rotator cuff injury on the right with strain/sprain to the right paraspinal musculature and facet joint irritation".

[64] The Panel notes a lack of any diagnostic tests in the file to corroborate the physiotherapist's opinion that there has been a facet joint irritation. In addition, no reasons are provided for inferring that the involvement of the facet joints of the spine, if any, was the result of the worker's injury as opposed to being caused by degenerative or other causes.

[65] While the Panel accepts, based on the worker's testimony and the physiotherapy reports, that the worker's injury to her shoulder has resulted in pain that is somewhat diffuse and ranges to the base of her neck and into her upper back, the Panel does not find given the absence of diagnostic reports, specialists' reports, or even a strong opinion from the treating physician, and the presence of what would appear to be a full range of motion, that there is sufficient evidence of a separate injury related impairment to the worker's neck and upper back. A permanent "physical or functional abnormality or loss" has not been established.

[66] Furthermore, the Panel also notes that the medical evidence does not disclose restrictions on range of motion in the neck and upper back or the presence of neurological deficits. In the absence of such findings even if a NEL assessment was to be granted, in all likelihood the rating for such a condition would be zero.

3. Conclusion

[67] The worker's NEL award for her right shoulder condition is confirmed. The 5% award is in keeping with the provisions of the American Medical Associations Guide to the Evaluation of Permanent Impairments (3rd edition) that the WSIB is required by law to apply in the determination of NEL benefits.

[68] While, as a result of the worker's compensable shoulder injury, the worker experiences some level of pain and discomfort in her neck and upper back, medical evidence does not support that there are separate injuries to these areas of her body that were caused by a work related accident and that would warrant a NEL assessment or that the worker is experiencing a loss of useful functioning in these areas that would be sufficient to result in the granting of additional NEL entitlement.

DISPOSITION

[69] The worker's appeal is denied.

DATED: August 10, 2010

SIGNED: G. Dee, A.D.G. Purdy, J.A. Crocker