

CLAIM HISTORY AND APPEAL PROCEEDINGS:

On June 2, 1999, the Worker was involved in a work-related motor vehicle accident. The Board accepted her claim and provided her with temporary benefits.

On September 1, 1999, a Board Adjudicator found that the Worker had “chronic pain” and found that the Worker was only entitled to compensation under the former *FRP Regulations*. This meant that the Worker was offered physiotherapy and pain management services until October 13, 1999, then her claim was closed.

Following closure of the claim, the Board approved a settlement of a third party claim against the driver of the other vehicle involved in the motor vehicle accident. This resulted in the Board paying the Worker excess recovery funds (these excess recovery funds may be set-off against any future compensation that may become payable to the Worker).

In 2003, the Supreme Court of Canada found that the former *FRP Regulations* violated “chronic pain” sufferers’ *Charter* equality rights.

The Worker sought compensation under the new *Chronic Pain Regulations*. This led to the following two decisions:

- TST Decision (February 9, 2007) - Found that while the Worker is currently undergoing treatment for “chronic pain”, she could not relate it to the motor vehicle accident, given a five year gap in medical treatment.

- Hearing Officer Decision (April 30, 2007) - Confirmed the TST Decision. Found that the symptoms resulting from the motor vehicle accident had resolved by 2001.

This decision addresses the Worker’s appeal of the Hearing Officer Decision.

Her representative argues that there is sufficient evidence that the Worker’s pain symptoms continued since closure of her claim, and that the symptoms are “chronic pain” related to the motor vehicle accident.

The Worker’s representative filed post hearing submissions and additional medical records from the Worker’s treating physicians. I gave the Board until November 27, 2007 to respond to the additional evidence and submissions. The Board chose not to respond.

ISSUES AND OUTCOMES:

Is the Worker entitled to compensation under the *Chronic Pain Regulations*?

Yes. She has pain in the neck and shoulder regions, a cause of which is her workplace injury, that meets the statutory definition of chronic pain.

ANALYSIS:

“Chronic pain” for purposes of the *Chronic Pain Regulations* is not chronic pain as that term is defined in dictionaries or what doctors usually call chronic pain. Instead it is pain that is unusual for an injury, and which was historically excluded from compensation under the general scheme of the *Workers’ Compensation Act*.

The purpose of the *Chronic Pain Regulations* is to bring this unusual chronic pain into the general scheme of the *Workers’ Compensation Act*.

“Chronic pain” is defined in the *Chronic Pain Regulations* as pain continuing beyond the normal recovery time for an injury, or pain that is disproportionate to the amount of pain usually associated with an injury. Conditions such as chronic pain syndrome, fibromyalgia and myofascial pain syndrome are “chronic pain”. However, “chronic pain” is not pain explained by objective findings.

Section 4 of the *Chronic Pain Regulations* provides that workers are entitled to an assessment for chronic pain benefits when, on or after April 17, 1985:

- they had “chronic pain”; and
- the “chronic pain” is causally connected to a compensable injury.

I must decide disputed issues in the Worker’s favour if the possibilities supporting her position are at least as strong as the possibilities against it.

There appear to be three sub-issues I must resolve - (1) whether there is sufficient evidence that the Worker’s upper body pain, which was found to be “chronic pain” in the 1999, continued beyond closure of the claim; (2) whether any new evidence would take it out of the definition of “chronic pain”; and (3) whether it is related to the compensable motor vehicle accident.

The *Chronic Pain Regulations* do not contain any requirement that a worker have sought ongoing medical treatment for pain. However, a failure to seek ongoing treatment can give rise to the inference that the pain resolved. It is necessary to assess all evidence,

including testimony, to determine whether it is as likely as not that the symptoms continued despite no ongoing medical treatment for pain.

On July 25, 1999, Dr. El-Geneidy, dentist, diagnosed the Worker with a myofascial pain dysfunction syndrome. Dr. El-Geneidy believed that the motor vehicle accident was the cause of the syndrome.

On May 9, 2000, Dr. Bhan, neurologist, wrote that the Worker reported that physical activity, repetitive use of the arms and any strain on her neck aggravated her symptoms. She noticed significant improvement with avoiding activities. When she had thyroid surgery and was off all physical activities, she reported her pain being gone. On examination, she had minimal loss of range of motion of the neck. There was mild tenderness of the paracervical and trapezius muscle to the left. The right wrist was slightly tender.

Dr. Bhan thought that the Worker had myofascial pain that seemed to improve with the Worker doing less. She had some intermittent sensory symptoms that he said were common with myofascial pain. He did not believe that the Worker had a neurological problem.

On September 18, 2000, Dr. Loane, physical medicine specialist, examined the Worker. He reported that the Worker continued to complain of facial, neck, shoulder girdle and arm symptoms resulting from the accident. He reported that she found that physiotherapy and the use of a TENS machine aggravated her symptoms. In the winter after the accident, the Worker began developing symptoms in her right hand.

Dr. Loane wrote that the Worker reported that physical activity increased her symptoms. Cool or damp weather also aggravated her symptoms. When she avoids activity, the discomfort is more of a tightness or squeezing sensation. She avoids activities. She avoids medications and developed a rash when she tried using Celebrex.

Dr. Loane felt that the Worker had soft tissue injuries to her cervical spine region, an AC joint sprain on the left, left neck and myofascial pain. He noted that she had major degenerative disc disease (aging changes) at C5-6 and questioned whether the accident had aggravated this pre-existing condition. He felt that the neck pain, headaches, and radiating pain into the hand were a result of the accident. He did not feel that she had a fibromyalgia-type problem. He stated that the Worker had several risk factors for developing chronic pain, including a history of mental abuse, a disabled spouse, and increased levels of distress.

Dr. Loane recommended several investigations and noted that treatment with medication was difficult due to the Worker's reluctance to take pills. He felt that if further investigations did not reveal a physical cause for the Worker's pain symptoms than there was a strong possibility that she would have ongoing chronic pain with restrictions in physical activities due to neck and shoulder pain.

On June 5, 2001, Dr. Langley, family physician, wrote that the Worker was still experiencing left shoulder pain, and pain at the base of her neck. This was impacting many aspects of activities of daily living. Given that the Worker was still exhibiting a significant amount of pain two years post-accident, it was Dr. Langley's view that the Worker was at high risk of developing ongoing chronic pain.

On August 2, 2006, Dr. Sivakumar, family physician, wrote that she has treated the Worker since February of 2004. On January 19, 2006, she treated the Worker for back pain. On May 19, 2006, she treated the Worker for bilateral arm pain. On June 16, 2006, she treated the Worker for right-sided collar bone pain, and noted pain down the right arm to the wrist. She wrote on September 8, 2006, that the Worker complained of tenderness in her neck, and left side collar bone pain. She also wrote that the Worker had MTJ pain. She thought these may be related to the motor vehicle accident as these symptoms occurred after the accident.

Through the remainder of 2006 and 2007, Dr. Sivakumar treated the Worker for neck and shoulder pain. Dr. Sivakumar also noted tingling in both hands. Dr. Sivakumar also noted that she was unable to treat the Worker with pain medication due to allergies.

On November 14, 2006, Dr. Acres, Board physician, reviewed the Worker's file. He was unable to relate the Worker's current pain symptoms to her motor vehicle accident given a five year gap in medical treatment of pain symptoms. On January 18, 2007, he added that the current symptoms are "chronic pain" - subjective symptoms in the absence of objective findings.

On March 20, 2007, Dr. Watt, physical medicine specialist, saw the Worker for hand symptoms. He performed an EMG study on the Worker. He felt that the findings were consistent with bilateral carpal tunnel syndrome. He recommended that she wear a wrist hand orthosis on the right, as it was the side that was most bothersome. He also stated that she had right shoulder symptoms. He felt that some of this was referred from the neck, but that there was also a myofascial component.

On June 14, 2007, Dr. Watt reported that the Worker did not use the orthosis as she felt her pain was coming from her neck and did not see the point of using them.

The Worker testified that her symptoms continued after closure of her claim. She testified that she mainly treated herself by limiting activity, yoga and by trying to put the pain out of her mind. She testified that she did not go to the pain clinic as there was a two year wait list, she did not want medications (as she has reactions to them), and she could control her pain by not doing anything. She testified that the lack of activities causes her to be bored most of the time. She testified that her shoulder pain varies between impacting her left and right shoulder. The pain wanes and flares-up. She believes she has lumps on her back associated with her pain. Holding things aggravates her pain. She does not have a social life due to her restrictions.

Dr. Acres was unable to relate the Worker's current pain symptoms to her workplace accident due to the five year gap in medical treatment.

There is logic to Dr. Acres opinion - at a minimum you would expect a person with an ongoing pain syndrome to regularly see a doctor for pain medications. I will now consider whether there is something unusual about the Worker's claim such that I should not infer that the pain stopped.

Before the gap, two doctors expressed that view that the Worker was at high risk for developing chronic pain. Dr. Loane noted that the Worker's social and psychological history put her at risk. Dr. Langley felt that the duration of pain following a soft-tissue injury put her at high risk.

Before the gap, two doctors noted that the Worker controlled her pain through limiting activity. Dr. Bhan, while not endorsing this method as being in her best interests, noted that it led to a short period of being symptom-free while using bed rest following an operation. Dr. Loane also noted this to be the Worker's preferred method of self-care.

Both Dr. Loane (before the gap) and Dr. Sivakumar (after the gap) noted that the Worker was allergic to several pain medications and therefore avoided medication to treat pain. This would explain not seeking ongoing medical monitoring while physicians having nothing to offer (from the perspective of the Worker).

I accept the Worker's evidence that she did not seek ongoing medical care as she did not want medication, and found things like avoiding activity and relaxation techniques reduced her pain symptoms. I accept her evidence that the pain symptoms continued during the five year gap.

Some of the Worker's pain symptoms fall outside the definition of chronic pain. She appears to have some shoulder/neck symptoms due to degenerative changes in the neck as identified by Dr. Watt. Also, the bilateral carpal tunnel syndrome is not chronic pain under the statutory definition.

However, the myofascial pain in the shoulder and neck region does meet the statutory definition of chronic pain. This soft tissue pain has persisted in the absence of an identifiable organ dysfunction. I accept Dr. Acres' opinion that it is chronic pain.

CONCLUSION:

The appeal is allowed. The Worker is entitled to compensation under the *Chronic Pain Regulations*.