WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 1143/19

BEFORE:	C. Huras : Vice-Chair M. Watters : Member Representative of Employers I. Thompson : Member Representative of Workers
HEARING:	June 20, 2019 at Windsor Oral
DATE OF DECISION:	October 9, 2019
NEUTRAL CITATION:	2019 ONWSIAT 2259
DECISION(S) UNDER APPEAL:	WSIB Appeals Resolution Officer (ARO) decision dated March 20, 2017 and May 24, 2018

APPEARANCES:

For the worker:	R. Lesperance, Paralegal
For the employer:	Not participating
Interpreter:	Not applicable

Workplace Safety and Insurance Appeals Tribunal

505 University Avenue 7th Floor
Toronto ON M5G 2P2

Tribunal d'appel de la sécurité professionnelle et de l'assurance contre les accidents du travail

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REASONS

(i) Introduction

[1] The worker appeals a decision of the Appeals Resolution Officer (ARO) dated March 20, 2017, which denied entitlement to a recurrence of the April 8, 1996 work injury for a full thickness tear of the left shoulder and partial thickness tear of the right shoulder; denied entitlement to the left shoulder surgery; and denied entitlement for a permanent impairment for bilateral shoulders. In addition, the worker appeals a decision of the ARO dated May 24, 2018, which denied initial entitlement for a full thickness tear of the left rotator cuff and partial thickness tear of the right rotator cuff, on the basis of a new disablement injury claimed to be related to the nature of the work that the worker performed from April 8, 1996.

(ii) Issues

[2] The issues under appeal are as follows:

1. Entitlement to a recurrence of the April 8, 1996 work injury for a full thickness tear of the left shoulder and a partial thickness tear of the right shoulder. (Claim No. 1)

2. Initial entitlement for a full thickness tear of the left rotator cuff and partial thickness tear of the right rotator cuff as a disablement injury claimed to be related to the work performed from April 8, 1996. (Claim No. 2)

3. Entitlement for left shoulder surgery. (Claim No. 1)

4. Recognition of permanent impairment and entitlement to a non-economic loss (NEL) award for bilateral shoulders. (Claim No. 1)

(iii) Background

[3] The following are the basic facts.

[4] The now 55-year-old worker started with the employer as a heavy truck assembler in June 1988.

[5] On April 8, 1996 he reported a gradual onset of pain in both shoulders which he attributed to his work duties (Claim No. 1). Entitlement was granted for bilateral rotator cuff tenosynovitis as a gradual onset disablement from repetitive duties. The worker returned to his regular duties on June 3, 1996. The worker testified that he went off work in April 2009 as a result of a bilateral shoulder condition and claimed benefits through his company insurance plan. The employer ceased operations on June 30, 2009, and formally closed the facility on July 28, 2011.

[6] On June 15, 2015, the worker contacted the Board and reported a recurrence of his April 8, 1996 injury. The diagnosis was a full thickness tear of the left rotator cuff and a partial thickness tear of the right rotator cuff. On August 10, 2015, the worker had reconstruction surgery on his left shoulder.

[7] In a decision dated August 17, 2015, the Case Manager (CM) denied entitlement to the recurrence of his 1996 injury for the left shoulder surgery on August 10, 2015, and a permanent

impairment in the bilateral shoulders. The worker objected to the CM's decision of August 17, 2015, which was upheld by the ARO in a decision dated March 20, 2017.

[8] In July 2017, the worker's representative requested that the worker's entitlement to the bilateral shoulders be considered as a new disablement from the duties performed subsequent to 1996. The Board established a date of accident of April 8, 1996 for this new disablement injury.

[9] In a decision dated November 29, 2017, the CM denied initial entitlement for the full thickness tear of the left rotator cuff and a partial thickness tear of the right rotator cuff on the basis of a new disablement injury. While the Panel notes that the Board did not establish a new claim number for this new disablement injury, for the purposes of this appeal we will refer to this new disablement injury as Claim No. 2. The worker objected to the CM's decision of November 29, 2017, which was upheld by the ARO in a decision dated May 24, 2018.

[10] The worker now appeals the ARO decisions of March 20, 2017 and May 24, 2018 to the Tribunal.

(iv) Law and policy

[11] Since the worker claimed to be injured in 1996, the pre-1997 *Workers' Compensation Act*, (the pre-1997 Act) is applicable to this appeal. All statutory references in this decision are to the Act, as amended, unless otherwise stated.

[12] An "accident" is defined in section 1. (1) to include:

(a) a wilful and intentional act, not being the act of the worker,

(b) a chance event occasioned by a physical or natural cause, and

(c) disablement arising out of and in the course of employment; ("accident")

[13] General entitlement to benefits is governed by section 4:

4. (1) Where in any employment, to which this Part applies, personal injury by accident arising out of and in the course of employment is caused to a worker, the worker and the worker's dependants are entitled to benefits in the manner and to the extent provided under this Act.

(2) Where a worker is entitled to compensation for loss of earnings because of an accident, the employer shall pay to or on behalf of the worker the wages and benefits that the worker would have earned for the day or shift on which the injury occurred as though the injury had not occurred.

(3) Where the accident arose out of the employment, unless the contrary is shown, it shall be presumed that it occurred in the course of the employment and, where the accident occurred in the course of the employment unless the contrary is shown, it shall be presumed that it arose out of the employment.

[14] The statutory presumption set out in section 4(3) does not apply to an injury by disablement. See, for example, *Decision Nos. 268* and *42/89*.

[15] Section 46 of the *Workplace Safety and Insurance Act, 1997* (the WSIA) and section 42 of the pre-1997 Act, as amended, provide that if a worker's injury results in permanent impairment, the worker is entitled to compensation for non-economic loss.

[16] Tribunal jurisprudence applies the test of significant contribution to questions of causation. A significant contributing factor is one of considerable effect or importance. It need not be the sole contributing factor. See, for example, *Decision No. 280*.

[17] The standard of proof in workers' compensation proceedings is the balance of probabilities. Pursuant to subsection 4. (4), the benefit of the doubt is resolved in favour of the claimant where the evidence for and against the issue is approximately equal in weight.

[18] Pursuant to section 126 of the WSIA, the Board stated that policy packages #60, #212, #241 and #300, Revision #9, would apply to the subject matter of this appeal. We have considered these policies as necessary in deciding the issues in this appeal.

(v) Submissions

[19] The worker's representative submitted that the worker should be granted entitlement for the bilateral shoulder condition as a recurrence of the original injury on April 8, 1996, or as a new injury based on the nature of the work (repetitive) the worker performed from 1996. He argued that the bilateral shoulder injury has resulted in a permanent impairment.

[20] The worker's representative provided a very detailed closing statement in writing, which has also been considered by the Panel in this appeal.

(vi) Testimony of the worker

[21] The worker testified that prior to 1996 he did not have any issues with his shoulders, except one incident in March 1995 when he reported stiffness and discomfort in his neck and shoulder area as a result of installing plates on the roof of trucks, which required him to bend his head/neck in order to perform that job.

[22] The worker testified that he performed many jobs with the accident employer which required the repetitive use of both upper extremities in the year prior to April 1996. These jobs included drilling upward for the defroster fans and sun visors, and hanging doors, on an assembly line. The worker stated that his bilateral shoulder pain started six months into performing these jobs. The worker agreed that the description of the duties that the worker performed at the time of the initial injury in 1996 was correctly outlined by the CM in her decision of November 29, 2017. The worker also agreed that the job history and worker duties from 1988 to 2009 outlined in a letter of August 21, 2018 from C. B., the union's financial secretary, were also correct.

[23] The worker testified that he was prescribed Tylenol #3 and Naproxen for his bilateral shoulder injury in 1996 and continues to take this medication. He stated that he missed a few weeks of work in 1996, and attended physiotherapy treatment somewhere between six months to one year.

[24] He stated that after 1996 he continued to have problems with both shoulders which he described as a burning sensation, and continued to take both prescribed and over the counter medication to treat this condition. He stated that since 1996 his left shoulder has been worse than his right shoulder.

[25] The worker stated that he continued to aggravate his shoulders at work subsequent to 1996 when performing tasks such as installing doors, pulling tail lights, and drilling holes in the roof. He stated that he complained to co-workers about his ongoing shoulder issues.

[26] The worker testified that in addition to taking medication (Naproxen and Tylenol #3), he received treatment at the employer's health centre, where he used ice packs for 30 to 45 minutes, to treat his shoulder pain. He stated for example, in 1997 he would go to the health centre at least

two times per week as a result of his shoulder pain. The worker stated that he would have to walk by C. B.'s office when going to the health centre for ice and medication. He indicated that in March 2008, the company nurse sent him for an MRI arranged through a company doctor, Dr. Turnbull. The worker stated that he did not get a copy of this MRI report in March 2008 until he obtained a representative.

[27] The worker testified that Dr. Sussex was his family doctor until 2000. He then went to see Dr. G. Thompson for approximately one year until Dr. Thompson retired. The worker stated that he then had no family doctor after that and had to attend walk-in-clinics for treatment.

[28] The worker testified that he had injections in his right and left shoulders in 2006 and had a few injections over the years.

[29] The worker testified that in 2008 he was able to go back to spray painting because of his seniority and wanted to see if this job would help his shoulders. He stated that this job was easier as he could take rest breaks when needed.

[30] The worker testified that he did not contact the WSIB from June 1996 to March 2008 but was continuing to receive treatment from physicians and the employer's health care centre. He stated that he lost time from work "here and there" but did not bother claiming the lost time as he only lost a few hours from work.

[31] The worker testified that by April 2009 his bilateral shoulder pain was 9 out of 10 on the pain scale. He stated that he went off work and applied for benefits for his bilateral shoulder condition through his employer. He stated that after being off work for his bilateral shoulder condition for one month, he was involved in a motor vehicle accident where he sustained a low back injury. The worker stated that he made a full recovery from his low back injury approximately one and a half years later.

[32] The worker testified that after leaving work in April 2009 he received benefits through his company insurance for approximately 11 months, 16 weeks of benefits through employment insurance, and then benefits from Ontario Works until 2017 when he received his annuity and severance pay from his employer.

[33] The worker testified that he had surgery on his left shoulder in August 2015.

(vii) Analysis

[34] The appeal is allowed for the reasons set out below.

(a) Entitlement to a recurrence of the April 8, 1996 work injury for a full thickness tear of the left shoulder and a partial thickness tear of the right shoulder (Claim No. 1)

[35] In this case, the Board granted entitlement to the bilateral shoulders as a disablement gradual onset type of injury as a result of the worker's repetitive duties. The Panel notes that entitlement was initially granted for bilateral tenosynovitis (Board memorandum dated June 6, 1996) and was later revised to bilateral shoulder tenosynovitis/rotator cuff syndrome, which were the diagnoses confirmed by Dr. D.M. Patterson, general surgeon, in his report of May 14, 1996 (Board memorandum dated July 17, 1996). In June 2015, the worker claimed a recurrence of his bilateral shoulder injury, including entitlement for the upcoming surgery on his left shoulder on August 10, 2015 to repair a left shoulder rotator cuff full thickness tear.

[36] *Operational Policy Manual* (OPM) Document No. 15-02-05, "Recurrences," states in part that:

> A worker may be entitled to benefits for a recurrence of a work-related injury/disease if the worker experiences a significant deterioration that
> - does not result from a significant new incident exposure, and
> - is clinically compatible with the original injury/disease.
>
> **Purpose**
> The purpose of this policy is to outline the circumstances under which a worker may be entitled to benefits for a recurrence of a work-related injury/disease.
> ...
>
> **Clinically compatible**
> To establish that the significant deterioration is clinically compatible with the original injury/disease, the decision-maker must determine that
> - the body parts and/or functions affected now are the same as, or related to, those affected by the original injury/disease, and
> - there is a causal link between the significant deterioration and the original injury/disease.
>
> To make these determinations, the decision-maker considers the nature and severity of the significant deterioration, the original injury/disease and any relevant non-work-related conditions that are present.
>
> The decision-maker may also consider whether a worker has experienced continuing symptoms since the original injury/disease. Generally, continuing symptoms are an indicator of a causal link, though they are not required to establish a causal link.
>
> Indicators of continuing symptoms may include
> - continuing clinical treatment
> - continuing workplace accommodations, or
> - evidence that continuing symptoms were reported to health care providers, supervisors or co-workers on an ongoing basis.
>
> If the decision-maker determines that the existing evidence does not clearly demonstrate whether the significant deterioration is clinically compatible with the original injury/disease, the decision-maker may seek a clinical opinion to assist in making this determination.

[37] After considering all of the evidence before us in this appeal, the Panel finds that the worker has entitlement for a recurrence of his bilateral shoulder injury of April 8, 1996, as of March 12, 2015 (the date of the MRI which identified these conditions) for the following reasons.

[38] First, the Panel finds that there is no evidence of significance before us to indicate that the worker's bilateral shoulder condition in March 2015 was caused by a significant new incident/exposure. The Panel notes that there is no indication in any of the medical reports of a new incident/exposure which could have caused a new onset of bilateral shoulder pain in 2015.

[39] Second, the Panel finds, on a balance of probabilities, that the diagnosis of a full thickness tear of the left rotator cuff and a partial thickness tear of the right rotator cuff in March 2015 is likely clinically compatible with the bilateral tenosynovitis/rotator cuff syndrome from April 1996. In reaching this conclusion, we placed considerable weight on the indicators of

continuing symptoms which included ongoing clinical treatment/medication; continuing workplace accommodations up to the plant closure in 2009; evidence of continuing symptoms being reported by the worker from 1996 to 2015; and on the Tribunal's Medical Discussion Paper entitled "Shoulder Injury and Disability."

[40] In his report of August 14, 2015, Dr. S. Somerville, occupational medicine, Medical Consultant (MC) stated in part that:

> **Rotator cuff tears can occur due to injury, over time due to tendinitis or impingement, as a natural consequence of aging, or a combination of these factors.** They are often present without clinical symptoms (1). Acute tears of the rotator cuff typically occur when one falls down on an outstretched arm, lifts a heavy object straight up with a jerking motion or suffers direct trauma to the shoulder, which may also result in a dislocated shoulder or fractured collarbone. The prevalence of both symptomatic and asymptomatic rotator cuff tears increases after age 40. Little information is available as to why some rotator cuff tears are painful while others are completely asymptomatic. Over time, asymptomatic rotator cuff tears can increase in size and become symptomatic though (2). Rotator cuff tears due to degenerative changes and aging are more common in the dominant arm. However, a degenerative tear in one shoulder is a risk factor for a rotator cuff tear in the opposite shoulder. Rotator cuff tears and other shoulder joint pathology are often described in diagnostic imaging reports and cadaveric reports, but the importance of the radiological findings need to be correlated with the clinical history (3). Other factors, such as smoking, hypercholesterolemia, and genetics have all been shown to influence the development of rotator cuff tearing (4). Additionally, obesity has been associated with risk for rotator cuff tendinitis, tears and related surgical procedures (5). Idiopathic and age-related changes to the shoulder joint are common in middle-aged individuals and the elderly, and caution needs to be applied in assigning cause to a particular accident or repetitive duties.
>
> Note is made that the IW is 51 years old, has high cholesterol, obesity, and is a smoker.
>
> **Given the above, and the fact the IW returned to regular work duties with no evidence of medical follow-up from 1996 to 2008, there is insufficient evidence the full thickness tear of the left anterior supraspinatus tendon and partial thickness tear of the right supraspinatus tendon are a direct result of the workplace injury.** [emphasis added]

[41] The Panel acknowledges Dr. Somerville's conclusion that there is "insufficient evidence" that the full thickness tear of the left anterior supraspinatus tendon and the partial thickness tear of the right supraspinatus tendon are a direct result of the workplace injury; however, the Panel is unable to give Dr. Somerville's report any weight as his opinion appears to be largely based on an absence of "evidence of medical follow-up from 1996 to 2008." However, the Panel finds that there is medical evidence of significance before us to establish ongoing issues with the worker's bilateral shoulders from 1996 to 2008. The Panel notes that Dr. Somerville may not have been aware of this medical evidence, as it was not mentioned in his report. The Panel also acknowledges that Dr. Somerville did not have the benefit of the letter of August 21, 2018 from C. B., the union's financial secretary, who provided continuity of shoulder issues and continuing workplace accommodations (self-accommodations); the worker's testimony; or the Patient Profile dated April 4, 2017, which was provided at the hearing and confirmed the ongoing need for medication from at least 2007, when reaching his conclusions.

[42] In an Employer's Continuity Report dated February 21, 2003, the employer's occupational health nurse noted:

> Claimant called in absent February 13, 2003 due to a flare up of his right shoulder pain which he relates to this claim. He says that from time to time since it originally happened he has flare ups and sees the Dr. for a prescription and in a few days it is better. He says he saw Dr. Dawson on February 13/03 and got a prescription for Celebrex. He lost 8.5 hours of work and returned to his regular job on February 14/03. He says that his job is putting brakes on. It involves maneuvering a hoist to move the brake to the job, although he does lift a smaller brake (weighing approx. 40 lbs.)

[43] In an Employer's Continuity Report dated November 9, 2004, the occupational health nurse noted:

> Claimant called in absent Nov 3 and 4 due to a flare up of his right shoulder pain which he relates to this claim. He saw Dr. Thomson on Nov 04/04. Returned to work on November 8 with a note disabling him from Nov 3 & 4. He says that there has been no specific incident to cause the flare up, his job involves pushing cabs out of the oven, taping trucks to be painted, and paint touch up.

[44] The Panel finds that the Employer's Continuity Reports of February 21, 2003 and November 9, 2004, support a finding that the worker continued to have ongoing issues with his bilateral shoulders in February 2003 and November 2004, which required medical attention, and resulted in lost time. The Panel finds that this is consistent with the worker's testimony that he continued to receive treatment from the employer's health care centre "here and there" but did not bother claiming the lost time as it was only a few hours.

[45] The Panel notes that there is no evidence before us to indicate that the employer questioned the cause of the worker's ongoing shoulder issues in February 2003 and November 2004 as the employer completed these continuity reports for the April 8, 1996 workplace injury and sent them into the Board.

[46] Moreover, the Panel notes that the MRI of the left shoulder taken on March 12, 2008, which identified "Damage to supraspinatus, subscapularis and lesser extent the infraspinatus as described" noted "John Turnbull" as the interested party, who the worker testified was the company doctor. This is consistent with the worker's testimony that the company nurse sent him for an MRI arranged through Dr. Turnbull and his testimony that he did not have a family doctor as the MRI report noted "No family doctor."

[47] The Panel also finds that the Employer's Continuity Reports of February 21, 2003 and November 9, 2004 are consistent with the worker's testimony that he had been taking prescribed medication for his bilateral shoulder injury since 1996.

[48] Moreover, the Panel finds that the preponderance of evidence before us indicates that the worker continued to have an ongoing disability in his bilateral shoulders from March 2008 up to the surgery on his left shoulder in August 2015.

[49] A patient profile for the period of January 2007 to March 2017, which was submitted at the Tribunal hearing, indicated that the worker was prescribed Naproxen from at least September 2007 to June 2015 and ongoing. This is consistent with the worker's testimony that he has continued to take medications for his bilateral shoulder injury.

[50] A patient profile for the period of January 2007 to March 2017, which was submitted at the Tribunal hearing, indicates that the worker was prescribed acetaminophen/codeine from at least October 2007 to June 2015 and ongoing. This is consistent with the worker's testimony that he has continued to take medications for his bilateral shoulder injury.

[51] In a Board memorandum dated June 9, 2015, the worker advised the CM that he saw Dr. Thompson until 2008, Dr. Naidoo from 2008 to 2011 and Dr. Toms for "the last few years." The Panel notes that this is consistent with the patient profile which shows that Dr. N. Naidoo and Dr. Toms prescribed acetaminophen/codeine and Naproxen to the worker during the above mentioned periods.

[52] Moreover, the Panel notes that clinical notes from Dr. G. Toms also documented ongoing shoulder issues and requests for medication from 2008 to 2015. These included clinical notes dated May 30, 2013 (left shoulder pain in joint and medication); June 4, 2013 (shoulder pain and medication); and August 26, 2014 (right shoulder pain and medication); October 27, 2014 (rotator cuff syndrome, taking medication); December 19, 2014 (request for medication); January 19, 2015 (bilateral shoulder pain, taking medication); February 9, 2015 (wants to apply for disability based on shoulders); May 6, 2015 (shoulders); May 12, 2015 (left shoulder injection) May 21, 2015 (shoulders); and June 12, 2015 (ROM loss noted in both shoulders).

[53] In addition to the medical reporting documenting an ongoing bilateral shoulder condition from 1996 to 2015, the Panel notes that there is also other evidence supporting an ongoing bilateral shoulder condition and workplace accommodations (self-accommodations) from 1996. The Panel has placed considerable weight on the letter of August 21, 2018 from C. B., who was then the union plant person. In her letter of August 21, 2018, C. B. reported that the worker had "flare-ups" of his bilateral shoulder injury from 1996 to 2009 (when all injured workers in the facility were reportedly placed on layoff), and would report these flare-ups to the occupational health department, where he would be given medication and ice. She stated that "His work following the Shoulder injury in 1996 was somewhat regulated by the jobs posted in an effort to relieve the wear and tear on his shoulders." In her letter of August 21, 2018, C. B. also outlined all of the worker's jobs from 1996 to 2009 and indicated that all of the jobs required repetitive and above shoulder work, and lifting, at varying degrees, with some of the jobs being less repetitive as they were not performed on a moving line.

[54] The Panel accepts the evidence presented in C. B.'s letter of August 21, 2018, as it was presented in a very detailed manner, outlining specific duties and timelines, which indicates to us that it was based on both factual evidence and first hand knowledge. Moreover, the Panel notes that C. B.'s letter is consistent with the contemporaneous evidence in the claim file with respect to the job history provided by the worker to the Board. It is also consistent with the Employer's Continuity Reports of February 21, 2003 and November 9, 2004, which indicated that the worker had ongoing problems in February 2003 and November 2004, and with the worker's testimony that he would pass by C. B.'s office when going to the health centre for ice and medication. The Panel finds that C. B.'s evidence establishes that the worker had ongoing issues with his bilateral shoulder injury from 1996 to 2009, and when possible, despite continuing to perform repetitive lifting and above shoulder activities, he attempted to self-accommodate by posting into jobs that were less strenuous or were not performed on a moving line.

[55] After considering the totality of evidence before us from April 1996 to August 2015, the Panel finds, on a balance of probabilities, that the evidence of continuing clinical treatment, workplace self-accommodation (from 1996 up to plant closure in 2009), and reported symptoms, establish a causal link between the original disablement injury on April 8, 1996 and the worker's bilateral shoulder condition in March 2015.

[56] The Panel also finds, on a balance of probabilities, that the full thickness tear of the left rotator cuff and the partial thickness tear of the right rotator cuff are clinically compatible with the work-related disablement on April 8, 1996. In reaching this conclusion, we have placed considerable weight on the Tribunal's Medical Discussion Paper entitled "Shoulder Injury and Disability" which was prepared for the Tribunal by Dr. Hans K. Uhthoff, orthopaedic surgeon, and revised in October 2010.

[57] Tribunal Medical Discussion Papers provide parties in an appeal with information on complex medical issues. They are written by independent experts who are recognized in their fields of specialization. The papers are not peer-reviewed publications, but are rather intended to provide parties and representatives with a broad, general overview of medical topics. A discussion paper is included in the case materials for an appeal when it appears that the paper may provide some relevant background to an issue in dispute. Medical Discussion Papers are also available on the Tribunal's website and in its library. A Vice-Chair or Panel is not bound by any information or opinion expressed in a discussion paper, but may consider and rely on the general medical information provided by the paper. Every Tribunal decision must be based upon the facts of the particular appeal. It is always open to the parties to rely upon a discussion paper, or to distinguish or challenge it with other evidence. In this case, the Shoulder Injury and Disability Paper was included in the Case Materials, and the worker's representative made references to this Paper in his written closing submissions. The Panel has found the Shoulder Injury and Disability Paper to be useful in this appeal and have relied on the opinion of Dr. Uhthoff with respect to the diagnosis of tendonitis and its relationship to a rotator cuff tear.

[58] In the Shoulder Injury and Disability Paper, Dr. Uhthoff states in part that:

> **B. Tendonitis-Tendinitis, a disorder**
>
> In the strict sense of the word, it means an inflammation of a tendon. However, microscopic examination of a biopsy sample rarely shows the presence of inflammatory cells. The process is rather characterised by other, usually degenerative, tendinous changes that lead to a thickening of the tendon. Often the diagnosis of tendinitis is based on a clinical examination. All too often, additional testing later on reveals an incomplete tear of a cuff tendon. It is therefore my opinion, that the diagnosis tendinitis should only be provisional; more detailed examinations (ultrasound, MRI or even a diagnostic arthroscopy) should be done to exclude partial tears.
>
> ...
>
> **D. Rotator Cuff Tear (Figure 7)**
>
> ...
>
> Work requiring repetitive or prolonged use of arms above the shoulder level (either flexion or abduction) may accelerate the progress of degenerative tendonitis and thus, may predispose to tears (work-related).

[59] Entitlement was granted for bilateral rotator cuff tenosynovitis as a gradual onset disablement from repetitive duties.

[60] The Panel finds, based on the evidence before us in this appeal, that the full thickness tear of the left shoulder and the partial thickness tear of the right shoulder identified in the MRI of March 17, 2015, are more likely than not related to the work-related disablement injury of April 8, 1996. This is consistent with Dr. Uhthoff's opinion that the diagnosis of tendinitis should only be provisional and that more detailed examinations should be done to exclude partial tears. It is also consistent with the diagnoses of tenosynovitis/rotator cuff syndrome which were

confirmed by Dr. Patterson in his report of May 14, 1996, which were also accepted by the Board.

[61] In this case, the worker did not have any detailed examinations on his bilateral shoulders until the MRI of his left shoulder on March 12, 2008, and the MRI of his bilateral shoulders on March 17, 2015. However, the Panel is satisfied, in the absence of any evidence of significance of any specific new incidents/exposures that the full thickness tear of the left shoulder and the partial thickness tear of the right shoulder that was identified on the MRI of March 17, 2015, is causally linked to the work-related disablement injury of April 8, 1996.

[62] For the reasons stated above, the worker has entitlement to a recurrence of his April 8, 1996 injury, for a full thickness tear of the left shoulder and a partial thickness tear of the right shoulder, as of March 17, 2015, the date of the MRI which confirmed the full thickness tear of the left shoulder and the partial thickness tear of the right shoulder.

(b) Initial entitlement for a full thickness tear of the left rotator cuff and partial thickness tear of the right rotator cuff as a new disablement injury from April 8, 1996 (Claim No. 2)

[63] As the Panel has granted entitlement to the full thickness tear of the left rotator cuff and the partial thickness tear of the right rotator cuff as a recurrence of the April 8, 1996 work-related injury, it is not necessary to consider the worker's entitlement as a new disablement injury from April 8, 1996.

(c) Entitlement for left shoulder surgery

[64] As the Panel has found that the worker has entitlement to a recurrence of his bilateral shoulder injury as of March 17, 2015, for a full thickness tear in the left shoulder and a partial thickness tear of the right shoulder, it would follow that the worker has entitlement for the left shoulder reconstruction surgery on August 10, 2015. In other words, the Panel is satisfied that the workplace accident on April 8, 1996 made a significant contribution to the need for the worker's left shoulder reconstruction surgery on August 10, 2015.

(d) Recognition of permanent impairment and entitlement to a non-economic loss award for bilateral shoulders

[65] OPM Document No. 11-01-05 states in part that:

> A work-related impairment is considered permanent when it continues to exist after maximum medical recovery (MMR) has been reached.
>
> A recovery from the work-related injury/disease is considered to have been made if there is no evidence of an ongoing work-related impairment at the time MMR is reached.
>
> A permanent impairment is not considered to exist if a determination made on or after January 11, 11998 according to 118-05-03, Determining the Degree of Permanent Impairment, results in a zero percent rating.
>
> **Definitions**
> **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.

> **Maximum medical recovery (MMR)** means that a plateau in recovery has been reached and it is not likely that there will be any further significant improvement in the work-related injury/disease.
>
> **Permanent impairment** means impairment that continues to exist after the worker reaches MMR.
>
> **Significant improvement** means a marked degree of improvement in the work-related injury/disease that is demonstrated by a measurable change in clinical findings.

[66] The Panel finds that the worker is entitled to a NEL award for bilateral shoulders.

[67] The Panel finds, on a balance of probabilities, that the worker's bilateral tenosynovitis/rotator cuff syndrome disablement injury from April 8, 1996, which resulted in a recurrence in March 2015, has more likely than not become permanent. In reaching this conclusion, we have placed considerable weight on the medical evidence before us in this appeal.

[68] In a report of July 28, 2015, Dr. J.F. Stone, orthopaedic surgeon, noted an ongoing bilateral shoulder condition. Dr. Stone noted during his examination that:

> ...He has full passive range of motion of both shoulders but on the right side he can only flex to about 120° and on the left side 90°. He is [sic] signs subacromial impingement on both sides more so on the left side. There is no obvious rotator cuff insufficiency on the right side but he does have significant external rotation weakness on the left side. There is some mild tenderness over the bicipital grove bilaterally. He is a grossly normal neurovascular assessment of the upper extremities.

[69] Following the worker's left rotator cuff reconstruction surgery on August 10, 2015, there is evidence of ongoing impairment in the worker's left shoulder. In his report of November 8, 2015, Dr. Stone stated:

> On examination today he still had fair bit of pain with passive manipulation the shoulder. He had about 70° of forward flexion and 50° of abduction and passively not much more than this. I suggested that we try a cortisone injection as he may be developing some adhesive capsulitis.

[70] In the Physiotherapist's Treatment Extension Request of November 27, 2015, the physiotherapist indicated that the worker had "limited ROM of left shoulder."

[71] On January 15, 2016, the worker was given a cortisone injection by Dr. Stone; however, in his report of March 3, 2016 Dr. Stone continued to identify functional limitations in the left shoulder of "130° of forward flexion with 100 of abduction, 40 ° external rotation, and 30° internal rotation," and also noted "some mild discomfort in the right shoulder." The worker was to continue with physiotherapy and home exercises.

[72] In a follow-up report of June 2, 2016, Dr. Stone indicated that the worker "continues to have some limitations in range of motion" but did not make any arrangements to see the worker again.

[73] The Panel accepts Dr. Stone's opinion of June 2, 2016 that the worker had an ongoing impairment in his left shoulder, despite having had left rotator cuff reconstruction surgery on August 10, 2015, which we have found earlier in this decision is within the scope of entitlement in this claim. The Panel finds, on a balance of probabilities, that the presence of an ongoing left shoulder impairment in June 2016, approximately 10 months after surgery, indicates that the worker's left shoulder injury has resulted in a permanent impairment.

[74] The Panel acknowledges that there is limited medical reporting with respect to the right shoulder. However, the Panel found earlier in this decision, that the partial thickness tear identified in the MRI of March 17, 2015 was causally linked to the work-related disablement injury of April 8, 1996. The Panel finds, on a balance of probabilities, that the worker's partial thickness tear in the right shoulder has also resulted in a permanent impairment. This is consistent with Dr. Stone's report of July 28, 2015 which identified range of motion (ROM) deficits in the right shoulder. In the Panel's view, these ROM deficits in the right shoulder support that the worker has experienced a functional abnormality or loss, which resulted from his compensable right shoulder injury.

[75] For the reasons stated above, the worker has entitlement for the recognition of permanent impairment for bilateral shoulders and is therefore entitled to a NEL award for bilateral shoulders.

DISPOSITION

[76] The appeal is allowed as follows:

1. The worker has entitlement to a recurrence of his April 8, 1996 disablement injury for a full thickness tear of the left shoulder and partial thickness tear of the right shoulder as of March 17, 2015. (Claim No. 1)

2. The worker has entitlement for the left shoulder surgery on August 10, 2015. (Claim No. 1)

3. The worker has entitlement for the recognition of permanent impairment, and is therefore entitled to a non-economic loss award for bilateral shoulders. (Claim No. 1)

[77] The nature and duration of benefits flowing from this decision will be returned to the WSIB for further adjudication, subject to the usual rights of appeal.

DATED: October 9, 2019

SIGNED: C. Huras, M. Watters, I. Thompson