Citation: ***P. R. v. Minister of Employment and Social Development*, 2015 SSTGDIS 110**

Date: October 1, 2015

File number: GT-125273

GENERAL DIVISION - Income Security Section

Between:

P. R.

Appellant

and

Minister of Employment and Social Development
(formerly Minister of Human Resources and Skills Development)

Respondent

Decision by: Jeffrey Steinberg, Member, General Division - Income Security Section

Heard by Videoconference on September 21, 2015

REASONS AND DECISION

PERSONS IN ATTENDANCE

P. R., the Appellant

Mark Baker, the Appellant’s legal representative

E. R., the Appellant’s spouse (witness)

INTRODUCTION

[1] The Appellant previously applied for a *Canada Pension Plan* (CPP) disability pension on February 8, 2007. She did not appeal the denial of her application to the Officer of the Commissioner of Review Tribunals (OCRT). Her most recent application for a CPP disability pension was date stamped by the Respondent on May 2, 2012. The Respondent denied the application initially and upon reconsideration. The Appellant appealed the reconsideration decision to the OCRT and this appeal was transferred to the Tribunal in April 2013.

[2] The hearing of this appeal was by Videoconference for the following reasons:

a) Videoconferencing is available in the area where the Appellant lives

b) There are gaps in the information in the file and/or a need for clarification; and

c) The form of hearing respects the requirement under the Social Security Tribunal Regulations to proceed as informally and quickly as circumstances, fairness and natural justice permit.

THE LAW

[3] Section 257 of the *Jobs, Growth and Long-term Prosperity Act* of 2012 states that appeals filed with the OCRT before April 1, 2013 and not heard by the OCRT are deemed to have been filed with the General Division of the Social Security Tribunal.

[4] Paragraph 44(1)(b) of the CPP sets out the eligibility requirements for the CPP disability pension. To qualify for the disability pension, an applicant must:

a) be under 65 years of age;

b) not be in receipt of the CPP retirement pension;

c) be disabled; and

d) have made valid contributions to the CPP for not less than the minimum qualifying period (MQP).

[5] The calculation of the MQP is important because a person must establish a severe and prolonged disability on or before the end of the MQP.

[6] Paragraph 42(2)(a) of the CPP defines disability as a physical or mental disability that is severe and prolonged. A person is considered to have a severe disability if he or she is incapable regularly of pursuing any substantially gainful occupation. A disability is prolonged if it is likely to be long continued and of indefinite duration or is likely to result in death.

ISSUE

[7] There was no issue regarding the MQP because the parties agree and the Tribunal finds that the MQP date is December 31, 2007.

[8] In this case, the Tribunal must decide if it is more likely than not that the Appellant had a severe and prolonged disability on or before the MQP.

EVIDENCE

[9] On April 16, 2012, the Appellant completed the Questionnaire in support of her application. She stated she completed Grade 10. She attended a one year Seneca College Business Course and in 1995, she obtained her certificate as an optometric technician. She worked between December 2004 and November 2005 in a physician's office performing pre-exams and dispensing and preparing OHIP documentation. She stopped working due to depression and chronic back pain. She states she could no longer work on account of her medical condition as of November 2, 2005. She described prolonged Major Depressive Disorder, arthritis affecting multiple joints, fibromyalgia affecting muscles, spinal stenosis, osteoarthritis,

pain on sitting, bending and standing, fatigue, hypersomnia, poor concentration and irritability with people and noise. She stated her illnesses impaired her from working as follows: "depressive mood disorder changes; resist interaction with others, too much pain with the physical aspect of working in an office or retail environment, depression makes it next to impossible for me to want to eat, get out of bed or leave the house. Hypersomnia, poor concentration and cognitive function". She also described restless leg syndrome (RLS), incontinence, obesity, low energy, low iron, hypothyroidism (Hashimotos), ulcer, reflux disease, hernia, shortness of breath climbing stairs or walking, strained right rotator cuff, carpal tunnel, hypertension and cholesterol. She stated she cannot sit or stand for prolonged periods of time and must change position constantly. She can walk ten minutes, lift under 5 lbs. and carry no more than 10 lbs. She cannot extend her right arm due to rotator cuff pain and has limited bending capacity. Her spouse performs household maintenance activities. She seldom drives due to problems with concentration and shoulder pain. She has had physiotherapy and will attend the Simcoe Pain Clinic. She will also see an orthopedic surgeon and cardiovascular surgeon. She uses a grab bar to reach/pick up objects. She is prescribed Effexor, Wellbutrin, Lisinopril, Synthroid, Lipitor, Hydrochlorothiazide, Palafer, Ralivia, Tramadol and Naproxen.

[10] In her September 26 2012 Reconsideration request, the Appellant stated her depression has been diagnosed as severe and chronic. Her condition is treatment resistant. She also has chronic back pain that limits standing, sitting and walking; neck and shoulder pain; arthritis; carpal tunnel surgery on the right hand that limits her grasp, writing and typing; bursitis; reflux; thrombosis; muscle weakness; restless leg syndrome with spasm; sleep disorder; heel spurs and 18/18 fibromyalgic tender points. Her inability to hold down a job is due to her chronic severe conditions. Dr. Harris, her family doctor, has sent a letter stating her conditions are severe and chronic and that she cannot work. She sees Dr. Urson, psychiatrist, every other week for severe chronic depression, treatment resistant.

[11] On March 1, 2012, Dr. Harris, family physician, completed the CPP Medical Report. She stated she knew the Appellant for 17 years. She diagnosed fibromyalgia, osteoarthritis and Major Depressive Disorder (partial remission). She described i) chronic low back pain since 2004, episodic acute exacerbations; ii) fibromyalgia – diagnosed by rheumatologist, Dr. Yuen 2006; and iii) Major Depressive Disorder recurrent since 1995 and iv) osteoarthritis. In terms of

Major Depressive Disorder, she described depressed mood, problems with concentration, reduced energy, hypersomnia, reduced socialization and motivation. In terms of fibromyalgia and osteoarthritis, Dr. Harris described limitations affecting vacuuming, cleaning, making meals, gardening and doing outside work. She is unable to lift greater than 10- lbs. and suffers increased pain with prolonged sitting and standing. Her spouse has assumed most of the household chores. She has pain in her right shoulder with overhead work. Dr. Harris described the following physical findings: tender pressure points, tender L45-S1, antalgic gait, and reduced abduction of shoulder. Dr. Harris prescribed Ralivia, Lyrica (unable to tolerate), Tramadol, Effexor and Wellbutrin. Naproxen was helpful for low back pain; Tramadol and Ralivia were partially helpful for fibromyalgia; and Effexor and Wellbutrin assisted with Major Depressive Disorder. According to Dr. Harris, the prognosis was guarded. She indicated that consultations were pending i) at CMHA for treatment resistant depression; ii) with Dr. Wilson, orthopaedic surgeon, for degenerative disc disease and lumbar spinal stenosis; and iii) at a chronic pain clinic for pain management.

[12] In support of her original CPP application, Dr. Harris completed a CPP Medical Report dated 2007 and date-stamped received by the Respondent on January 23, 2007. She stated she knew the Appellant for over 10 years and started treating her for fibromyalgia in June 2005. She diagnosed fibromyalgia and Major Depressive Disorder recurrent. She described a history over 5 years of multiple joint pain and complaints of ongoing fatigue and generalized musculoskeletal pain. She indicated the Appellant had reduced ability to do housework due to fatigue and chronic generalized pain. She stated the Appellant's spouse was now assisting her, that it took her longer to complete household tasks and that she required rest brakes. She had reduced ability to perform her bookkeeping job for her spouse as her fingers would cramp using the keyboard and due to problems with concentration. She also had reduced ability to perform her activities of daily living, e.g. grooming. She indicated the Appellant would follow up with rheumatology on a PRN basis and would be referred back to psychiatry. She was prescribed Naprosyn, Nortriptyline, Effexor and Tramacet. She stated that medication for fibromyalgia was only partially successfully. Medication side-effects resulted in fatigue (problematic). Physiotherapy was somewhat helpful. She was referred to the Fibromyalgia outpatient program at Southlake Hospital and to the Chronic Pain Program in Barrie. She had also participated in Dr. Menuck's (psychiatrist) Group Therapy. Her Major Depressive Disorder was not in complete remission.

Higher doses of Effexor were helpful however she could not tolerate the side-effects. Her Fibromyalgia was guarded and Major Depressive Disorder had the potential for improvement.

[13] In support of her initial CPP application, the Appellant completed a Questionnaire dated February 4, 2007. She stated she completed Grade 10 and obtained a one year business diploma. Between December 2004 and November 2005, she worked as an optometric technician for Dr. S. She stopped working due to depression, hypertension and chronic back pain. Between June 1998 and December 2006, she also worked two hours per week inputting invoices for the accountant on behalf of her husband's contracting business. She described the following job history:

- 1973-1978 Clerk Typist
- 1978-1992 Administrative Assistant
- 1993 – 1995 Customer Service – Asst Manager
- 1995 to 2002 Dr. S. P., Optometric Asst.

[14] She explained that she took time off work with Dr. S. P. due to hypertension and depression and returned to work on reduced hours and work load. When she was cleared to return to work full-time, the position was no longer available. Two years later, she re-entered the workforce with Dr. S. She described depression, inability to concentrate and focus on assignments, poor memory, muscle weakness and decreased range of motion. She further described challenges interacting with others, word finding problems, stuttering, depression, reduced emotional control, mood swings, fatigue, inability to sit/stand long periods, chronic low back pain, leg swelling, cramping in fingers when writing or typing, leg and groin muscle spasm and poor memory and attention. She further described a myriad of other symptoms including migraines, shortness of breath and reflux disease. She listed her medications as Lisinopril, Synthroid, Hydrochlorothiazide, Pantaloc, Tramacet, Naproxen, Effexor, Wellbutrin, Nortriptyline and Vesicare (overactive bladder). She attended Dr. Menuck's Pain Management Group Therapy program, physiotherapy and had received counseling with Dr. Yuen. She had been referred to the Southlake Hospital Outpatient Fibromyalgia Program, was still in

physiotherapy, would see Drs. Yuen and Harris in February 2007 and was waiting to see a psychiatrist.

[15] In a letter dated July 2, 2007, the Appellant stated that her mental disability has contributed to memory loss, impaired ability to concentrate, chronic disabling fatigue, hypertension and cognitive behavior for many years. Her physical limitations include chronic back pain, neck and shoulder pain, arthritis, CTS, bursitis, reflux, thrombosis, muscle weakness, restless leg syndrome, spasm, sleep disorder and heel spurs. She sees her family doctor regularly and a social worker for emotional support. She has attended a group psychotherapy program for chronic pain sufferers and practices aquatic therapy at home. Changes to her medications have become very common. She has done everything within her power to improve her well-being. She is incapable of regularly working at any gainful occupation.

[16] In a report dated February 28, 2006, Dr. Noorani, psychiatrist, reported on his assessment of the Appellant. He stated she had not worked since November 2005 mainly because of her back pain. She reported she had been struggling with her depression for at least four years. She had stable times but suffered a relapse in October 2005 after her father died in April 2005. She described sleeping most of the time, decreased appetite and weight gain, lack of energy and motivation, poor concentration, panic attacks at times and depressed mood. On mental status examination, her mood was depressed. She did not exhibit psychomotor agitation or retardation. Dr. Noorani diagnosed Major Depressive Disorder moderate recurrent, bereavement (Axis IV: Recent death of her father, stress about going back to work) and set out a GAF of 55-60. He recommended that she increase her Effexor and try Wellbutrin in addition. He also recommended psychotherapy, grief counselling and CBT for depression.

[17] On September 6, 2006, Dr. Yuen, rheumatology, saw the Appellant for her multiple joint pain. He stated she had a greater than 5 year history of joint pain, which involved her back, elbows, knees, buttock areas, hips and feet. It was worse in the morning and after activities. She had attended Dr. Menuck's Pain Management Program. Dr. Yuen noted she was not currently working. On examination, she had good range of motion of her C-spine and mild limitation in lumbar flexion and extension. She had good range of motion of all her peripheral joints with no active synovitis. She had 12 out of 18 fibromyalgia tender points. X-rays of her hands, elbows

knees and feet were all unremarkable except for mild degenerative changes at the first MTP joints bilaterally and small spurs at the plantar fascia. A lumbar spine MRI from February 2006 showed mild degenerative bulging at L4-5 and L5-S1 but no focal disc herniation or spinal stenosis. Clinical exam was unremarkable excerpt for the presence of fibromyalgia tender points in all four quadrants. Dr. Yuen stated he felt the Appellant's symptoms were likely due to fibromyalgia. He requisitioned blood work and a whole body scan and placed her on Nortriptyline. He also referred her to the Fibromyalgia Program at Newmarket.

[18] On October 18, 2006, Dr. Yuen saw the Appellant in follow up. He stated the investigations were unremarkable. However she still had fatigue and "rather widespread pain." There was no active synovitis, however she continued to be fibrositic with tender points in all four quadrants. He asked her to increase the Nortriptyline, and stated he would see her in two months.

[19] On February 12, 2007, Dr. Yuen saw the Appellant in follow up for her fibromyalgia. He stated she had responded well to Tramacet and had "significant improvement "in her symptoms. She had less pain. She did not try Flexeril. She told Dr. Yuen that Dr. Harris, her family doctor, discontinued Nortriptyline due to sleepiness. The Appellant noted some weakness in her hips and thighs. On examination, she had no active synovitis and had fibromyalgia tender points in all four quadrants. Her motor strengths were normal. Dr. Yen asked her to continue using Tramacet. In terms of her thigh and hip weakness, clinically, her strengths were normal and she was able to stand up from a sitting position unaided. Dr. Yen suspected her symptoms may be related to underlying fibromyalgia. He did not schedule a specific follow up.

[20] On May 8, 2008, Dr. Wilkins, physical medicine, saw the Appellant for her two year history of pain, numbness and tingling in both hands, right worse than left. It awakened her at night. She used a splint which no longer helped as much. On examination, she had good range of motion of the neck and upper extremities and there was no evidence of any joint effusions, stress pain or muscle wasting. Strength was grade 5/5 in all muscle groups. EMG studies confirmed evidence of CTS bilaterally, worse on the right than left. She was very symptomatic on the right and wanted to consider surgical release. According to Dr. Wilkins, surgical referral would be prudent.

[21] On January 5, 2009, the Appellant underwent open right carpal tunnel release.

[22] An April 1, 2009 CT of the lumbar spine revealed: multilevel degenerative changes in the spine worse at L5-S1 and L4-5. There was moderate spinal canal stenosis at L4-5 due to a combination of disc bulge and facet joint arthropathy. At L5-S1, there appeared to be a left paracentral disc herniation. The findings at L-5-S1 appeared to be new compared to previous.

[23] A June 29, 2009 imaging report of the lumbar spine revealed: mild spinal canal stenosis at L3-4 and L4-5, which predominantly related to thickening of the ligamentum flavum and congenital shortening of the pedicles. There was no focal herniation or neural foraminal narrowing.

[24] On December 15, 2009, Dr. Harris reported the following conditions: i) hypothyroidism – remote; 2) hypertension since 1990s; 3) GERD (normal gastroscopy Aug 08); 4) Major Depressive Disorder in Remission – history of recurrent major depressions; 5) fibromyalgia and osteoarthritis – diagnosed 2007 by Dr. Yuen, rheumatologist; 6) Restless Leg Syndrome diagnosed July 2006 on sleep study; and 7) Chronic Low Back Pain – recent CT and MRI.

[25] On August 16, 2011, Dr. Casses saw the Appellant for pain in her back, buttocks, hips, knees and right shoulder. She was noted to have a history of fibromyalgia. He indicated she had a history of a fall in 2005 landing on her tailbone. Since then, her lower back pain had increased in intensity. On physical examination, she walked with a normal gait pattern and there was no evidence of antalgic gait. She had completely normal and unrestricted range of motion of the hips and no major pain on passive range of motion to the hips. She had normal and smooth range of motion in the knees and could walk on heels and tiptoes. He did not see any advanced osteoarthritis. A CT scan showed spinal stenosis on the lumbar spine with mild spinal canal stenosis, predominantly related to thickening of the ligamentum flavum but no focal disc herniation or neural foraminal narrowing. He stated she had pain in both lower extremities related to a mild to moderate degree of spinal stenosis. He recommended she lose at least 100 lbs. He stated: “She unfortunately doesn’t believe that this is the treatment for her”. He stated that from an orthopedic point of view, she did not require joint replacement.

[26] On September 15, 2011, Dr. Wilkins, physical medicine and rehabilitation, saw the Appellant. She reported meeting with the Appellant several years earlier concerning her CTS.

The Appellant was now presenting with two problems: i) increased pain, numbness and tingling in the left hand over the past four or five months (which bothers her driving and ii) back pain, which she described as being in her hips and which was made worse with walking. She indicated she could walk past the pain and that doing things such as using a grocery cart did not make a difference when pushing it. Her back pain outweighed her leg pain. According to Dr. Wilkins, this was not typical of spinal stenosis pain. On examination, she had good range of motion of the left upper extremities. There was no muscle wasting and her strength was grade 5/5. She had decreased range of motion of her back. Her hip range of motion was done quite well. She was tender in all of the fibromyalgia points. EMG testing confirmed mild CTS on the left side. It had improved as compared to two years earlier. Surgical intervention was not warranted. In terms of back pain, Dr. Wilkins stated: "I think this is much more typical of pain from fibromyalgia and mechanical pain as opposed to pain from spinal stenosis. It is doubtful surgical intervention would be of benefit here. Dr. Wilkins discussed the importance of postural exercises, core exercises, weight loss and overall exercise in managing her symptoms.

[27] On October 4, 2011, Dr. Yuen, internal medicine/rheumatology, reported he first saw the Appellant in 2006. He stated she had more than a 5 year history of multiple joint pain and felt she had fibromyalgia. Dr. Yuen noted the Appellant could not tolerate Amitriptyline or Nortriptyline and that he had placed her on Tramacet. She had some symptomatic improvement. She was also found to have leg movements on her sleep study but no evidence of significant obstructive sleep apnea. He stated she also suffers from depression. She indicated her mood was not good "at the present time" and that she did not leave the house. According to Dr. Yuen, she still had widespread pain and he described poor sleep, low energy and fatigue. He noted that recently, she started having pain in the right shoulder. On examination, she had no active synovitis, mild patella-femoral crepitus in her knees, 18 out of 18 fibromyalgia tender points, a painful arch and positive impingement sign in the right shoulder. He stated she had ongoing pain from her fibromyalgia and that her mood remained low. Clinical exam of the right shoulder pointed toward a rotator cuff tendinopathy. She agreed to a trial of Lyrica and he referred her to physiotherapy for right shoulder rotator cuff tendinopathy.

[28] On April 4, 2012, Dr. Rampes, psychiatrist, CAMH, assessed the Appellant in the Mood Disorders Clinic. The Appellant reported that her difficulties with concentration, word finding,

feeling sad, jittery, angry and frustrated, not sleeping and loss of interest, went back to 2005 when her father passed away. She indicated she lived with her spouse who runs a restoration company. She stays at home all day. Some days she does not even attend to her personal care ends. Other days, she sits on the computer and bids on E-bay items or plays a game on Facebook. She reported that she left her job seven years earlier as an optometrist assistant, stating it was quite repetitive and that she was not learning. Dr. Rampes noted a history of blunt force trauma to the coccyx in 2005, a diagnosis of fibromyalgia in 2007 and spinal stenosis in 2009. She noted the Appellant was first diagnosed with depression in 1969 at age 16. She had been on long-term antidepressants. In 2002, she was on Effexor and Celexa. In 2006, she had CBT with Dr. Menuck. She took an overdose age 16. She reported that Effexor and Wellbutrin had worked well and she had reduced the Effexor which coincided with worsening of her symptoms. Under Opinion, Dr. Rampes stated the Appellant was clearly someone who has had chronic depression and was currently severely depressed. She was suffering from a Major Depressive Disorder, scoring 21 (severe depression) on the Quick Inventory of Depressive Symptomatology and 49 (severe anxiety) on the Beck Anxiety Inventory. He recommended a combination of high dose Venlafaxine and Citalopram and adjustment to other medications. He indicated she may benefit from admission to the Alternate In-Patient Milieu, an elective in-patient program for patients with mood disorders, to focus on CBT techniques. She agreed to do so. He also recommended physical activity and referral to a pain specialist to optimize pain relief. He set out a GAF of 41-50.

[29] According to a May 4, 2012 clinical note of Dr. Harris, the Appellant was in remission of depression for several years. She had been on Effexor for 1-2 years, with remission and then relapsed. Wellbutrin had been added in 2005. She had been on 300 mg for the past 5 years with improvement in energy and mood. She was in remission for several years. She relapsed in 2010.

[30] On May 11, 2012, Dr. May, Simcoe Pain Clinic, assessed the Appellant for fibromyalgia and chronic low back pain. The Appellant reported having had low back pain for a long time and falling on her tailbone in 2005. Since that time she had noticed her back had been particularly bad. She described the pain as an aching in the low back extending into the buttock and around to the knees and calves. The leg pain would ache and affect the right and left sides. She had a CT in 2009 which showed several levels of degenerative disc disease and moderate spinal

stenosis at L4-5 caused by bulging disc and facet disease. At L5-S1, there was left paracentral disc herniation. The Appellant indicated she was suffering with right shoulder pain for the last four months. She reported being diagnosed by Dr. Yuen in 2007 with fibromyalgia. She described the pain as "sharp nagging, aching pain throughout most of her body but particularly involving her shoulders, back and legs. Notes from visits with Dr. Yuen indicated he recommended a trial of Lyrica for fibromyalgia which made her itchy. She did not continue it. She was referred to Dr. Wilkins in September 2011 who diagnosed mild left CTS and pain in the back, most in keeping with fibromyalgia, mechanical back pain versus spinal stenosis. EMG studies confirmed the findings. The Appellant admitted to ongoing depression over the years. Dr. May noted she was offered admission at CAMH and was awaiting a bed. Dr. May also noted she had attended Dr. Menuck's mindfulness based reduction program in 2006 which did not provide significant improvement in the way she deals with her chronic pain. On examination, she had limited flexion, extension and rotation. She was quite tender in the lumbar spine. Examination of the shoulder with internal rotation exacerbated her pain and she was tender in the right anterior shoulder area. SLR was unremarkable. Dr. May diagnosed 1. Fibromyalgia; 2. Chronic low back pain with degenerative disc disease, facet disease and moderate spinal stenosis; 3. Right rotator cuff tendonitis; and 4. Chronic pain with underlying depression. In terms of her low back, Dr. May opined that most of her symptoms were mechanical in origin. Her leg pain could be related to spinal stenosis. He recommended a trial of Gabapentin although the Appellant was not "keen" given that both the family doctor and psychiatrist at CAMH were changing her antidepressants at that time. Dr. May indicated he left further treatment options open once her mental health issues had stabilized.

[31] A May 30, 2012 MRI of the lumbar spine revealed: 1. areas of central canal stenosis present particularly at L3-4 and L4-5 disc space level; 2. areas of degenerative changes; and 3. fluid collection identified in subcutaneous tissues posteriorly at level of sacrum.

[32] On May 30, 2012, Dr. Harris provided an update letter with respect to the Appellant's application for CPP Disability benefits. She stated the Appellant suffers from Treatment Resistant Depression and Chronic Pain due to Fibromyalgia, Moderate Spinal Stenosis and Osteoarthritis, which render her unable to work. They are chronic and severe. She saw a psychiatrist at CAMH who recommended an elective admission, and was referred to Dr. Urson,

psychiatrist, and was awaiting an appointment with Dr. Wilson, orthopaedic surgeon, concerning her chronic low back pain and spinal stenosis. She was recently seen by the chronic pain clinic. She was referred back to Dr. Yuen, rheumatologist, for assessment of her right shoulder pain and consideration of a cortisone injection. A May 30, 2012 MRI of the lumbar spine revealed mild to moderate lumbar stenosis and facet joint osteoarthritis.

[33] A July 8, 2012 MRI of the right shoulder revealed: 1. Fluid in the subacromial subdeltoid bursa; there may be associated synovitis in the axillary recess area; 2. Full-thickness tear of the anterior fibers of the supraspinatus tendon near the rotator cuff interval; 3. Tendinosis of the posterior fibers of the supraspinatus tendon and anterior fibers of the infrapsinatus; 4. Degenerative changes of the A.C. joint with mass effect on the supraspinatus tendon; and 5. Abnormal appearance of the superior labrum. A labral tear was suspected.

[34] On August 20, 2012, Dr. Urson, psychiatrist, saw the Appellant, who reported she had been suffering from depression for many years. The Appellant indicated the family has a home business in which she was previously very active; she was not currently involved in the business. She indicated she has been severely depressed since 2005, at which time she had too much pressure at her job and her father passed away. She had been taking antidepressant medications regularly since 2000. In 2006, she was involved in CBT in group therapy. She recently saw Dr. Rampes at CAMH in 2012, who referred her to in-patient admission that would probably take place in September 2012. According to Dr. Urson, the Appellant's medical history was significant for RLS. She also had osteoarthritis and spinal stenosis with lots of back pain. On mental status exam, her affect was dysphoric and thought process coherent. She was alert and oriented in all three spheres. Dr. Urson wrote: "In summary, this fifty-nine year old female has a long standing history of depression. She meets the criteria for Major Depressive Disorder, severe, chronic. Patient also shows some anxiety symptoms that are secondary to her depressive symptoms. Patient has lots of medical problems that could (sic) a perpetuating factor to her depressive symptoms". Dr. Urson recommended changes in medication and indicated she would see the Appellant in several weeks.

[35] On September 11, 2012, Dr. Harris wrote a letter in support of the Appellant's CPP Disability application. She stated she was the Appellant's family physician for 17 years and that

she was unable to work due to Treatment Resistant Depression, which is severe and prolonged. She was currently seeing Dr. Urson. She previously saw Dr. Rampes, psychiatrist, CAMH, who recommended an elective admission to CAMH, which was pending.

[36] In an October 12, 2012 clinical note, Dr. Harris stated the Appellant had a recurrence of Major Depression by November 28, 2005. She noted that Wellbutrin had been added to Effexor and stated that by 2008 it was in remission (son had settled lawsuit at this time).

[37] On October 25, 2012, Dr. Harris sent a letter to the Respondent. She reiterated she has been treating the Appellant for almost 18 years. She stated the Appellant had a relapsing and remitting Major Depressive Disorder for as long as she knew her. She saw Dr. Kuch from November 2002 to June 2004 when he retired and Dr. Noorani in consultation in February 2006. She received CBT with Dr. Menuck in 2006. In 1995 when the Appellant came into the practice, she was on Paxil for depression. Over the years, she was treated with different antidepressants, saw five psychiatrists and received Cognitive Behavioral Therapy (CBT). She was assessed at the Centre for Addiction and Mental Health Mood (CAMH) Disorders Clinic in 2012 and recommendations for elective admission were made. According to Dr. Harris, the Appellant's Major Depression had become refractory to treatment with time, having become severe and prolonged, such that she had been unable to hold gainful employment. She last held gainful employment in November 2005 when she left work on disability leave due to chronic pain and depression. Co-morbid with her treatment resistant depression has been chronic pain. She has had chronic low back pain with acute exacerbations for at least 15 years. In 2005, Dr. Yuen diagnosed her with fibromyalgia and reassessed her in 2007 and 2011. She had physiotherapy over the years and was assessed by the Simcoe Pain Clinic. Her functioning due to chronic pain has impaired her ability to perform housework and yard work. She cannot walk or sit for prolonged periods of time without pain. Despite her best efforts, she has been unable to work due to her severe and prolonged illness.

[38] On November 26, 2012, the Appellant was seen for her right shoulder. The pain was noted to have started insidiously about two years earlier. A September 2012 MRI showed a full thickness tear supraspinatus and partial thickness tearing of the long head of biceps and severe AC joint arthrosis with spurring. She received a sub acromial corticosteroid injection.

[39] A July 15, 2013 radiology report of the cervical spine revealed normal alignment, minor end plate osteophytes and facet OA on the right at C4-5.

[40] An August 18, 2013 MRI of the left knee revealed findings consistent with grade 4 chondropathy. The impression was of degenerative changes of the medial meniscus with possible tear, moderately severe osteoarthritic changes in the medial compartment of the knee, moderate joint effusion and prepatellar bursitis.

[41] An October 16, 2013 left knee radiological report revealed mild to moderate tricompartmental O"A with a minimal suprapatellar joint effusion.

[42] On November 13, 2013, Dr. Newman wrote that the Appellant was seen at the Arthroplasty Clinic for her left knee. She had presented with a greater than one year history of left knee pain. She stated the Appellant presented with moderate osteoarthritis and was keen to continue with nonsurgical treatment intervention.

[43] On May 23, 2014, Dr. O'Sullivan saw the Appellant for her left knee. It bothered her mostly when returning from a kneeling position. Examination did not show effusion. The knee was ligamentously stable and range of motion was well maintained. There was some medial joint line pain. Plain films showed mild to moderate osteoarthritic changes. She indicated she wished to pursue nonsurgical intervention. He proceeded with an intra-articular corticosteroid injection. On September 18, 2014, Dr. O'Sullivan saw the Appellant in follow up. The injection helped for about two months. The pain returned. It would bother her when returning from kneeling to standing. Her sleep was also disturbed. Dr. O'Sullivan noted she had co-morbidities of depression and fibromyalgia. He did not feel she was a surgical candidate. He injected her again with corticosteroid injection.

[44] On January 12, 2015, Dr. Urson stated the Appellant was under her care since August 2012. She was diagnosed with Major Depressive Disorder, chronic severe and anxiety symptoms secondary to her depressive symptoms. Dr. Urson noted a lot of medical problems which contribute to and perpetuate the Appellant's mood symptoms. She stated the Appellant continues to suffer from low mood and lack of motivation. She had low energy and ongoing problems sleeping. Her memory and concentration were not good.

[45] On February 3, 2015, Dr. Isaac sent a letter to the Tribunal. She stated she had assumed care of the Appellant in June 2014. She stated the Appellant continues to suffer from chronic mental health and physical health issues that are severe and prolonged. She also continues to suffer from disability - chronic pain. She further suffers from fibromyalgia and has chronic pain in her lower back as a result of degenerative disc disease of the lumbar spine and right shoulder pain with full thickness supraspinatus tear and severe AC joint arthrosis. She has more recent onset of hip pain. She also continues to suffer from chronic and severe Major Depressive Disorder and related anxiety. She is seen regularly by Dr. Urson, psychiatrist. Her psychiatric symptoms are perpetuated by her chronic pain and other conditions. Her physical and mental health problems have been severe and prolonged. It is not expected they will improve.

Oral Testimony

[46] She is married and has two children, a son, age 39 and a daughter, age 32. She has lived in X in a ranch bungalow for 17 years. Her spouse is a renovation contractor and he also installs appliances.

[47] She completed Grade 10 and part of Grade 11. She left school to work at Loblaw's as a cashier. She also performed administrative duties part-time, e.g., typing and transcribing, etc. She worked at Loblaw's between 1969 and 1972. She left Loblaw's to return to school at Seneca College where she completed a six month business course. She then went to work for Ajet Sales in 1973 as a receptionist. She also did some invoicing. She was 21 or 22 at the time and in good health. She left Ajet Sales to work for R. N. Manufacturing Co as a "girl-friday". She did invoicing, manual booking, etc. She worked there for five years until the company moved its location. She was then hired by Division Construction as executive assistant to the company president. She issued contracts, tender submissions, prequalifications for contractors, etc. She worked there between 1978 and 1992. During that time, she suffered from depression and was off work for nine months in 1982 for depression while her mother was dying. She was also off work on another occasion due to stress and depression. She enjoyed the work and carried on despite the challenges. During that period of time, her bodily function was fine. In 1992, the company went into receivership. She was eventually hired by Penningtons as a fashion and sales consultant. Penningtons went bankrupt. It was bought by Reitmans which subsequently

contacted her to work as assistant manager. She worked there between 1993 to 1995. In 1995, she started to work part-time at a newly formed optometry practice for Dr. S. P. She took specific courses which enabled her to work in dispensing. She also did reception, OHIP billings and patient assessment. After a co-worker left, she started working full-time for Dr. S. P. but continued work part-time at Reitmans during evenings. She noted that her stress was building up. She also did a lot of bending, kneeling and squatting and also noted that her back was starting to ache. She had thrombosis in her legs. She went off on sick leave due to depression in 2002. She was off work for eight weeks primarily due to the stress she was under. When she returned to work, she was not over the depression. She was let go along with other staff. She then received a call from Dr. S.'s office asking her to work for him. She was known in the optometry community and had set up golf games. She was not able to golf herself as she could not walk the course or ride a golf cart, which would exacerbate her back pain. She started working for Dr. S. "full-swing" in or around the beginning of 2004. The work was stressful as and involved a lot of paperwork. She worked for Dr. S. until November 2005 or some point prior to that.

[48] While working for Dr. S., she experience stress and anxiety. Dr. S. hired a second employee whom she trained. She went off work due to depression for approximately four to five months in 2005. Dr. S. would phone her weekly to ask when she could return to work. Dr. Harris advised her she could not return as she could not "get herself together" or speak without crying. She was also experiencing excruciating low back pain. She had had trouble standing and talking to patients. Sitting for long stretches of time was also a problem. Although Dr. Yuen diagnosed fibromyalgia in 2006, Dr. Harris discussed this condition with her in 2005 and stated she was sure the Appellant had fibromyalgia and conducted pressure point testing. Although the Appellant talked with Dr. S. every week, she could not return to work. Dr. Harris was against her going back to work. There were days she could not get out of bed. Dr. S. eventually hired someone else.

[49] She never worked for anyone after she left Dr. S.'s office, other than occasionally answering the phone or doing a small amount of invoicing for her spouse's business. She did this once weekly for 2-4 hours. She could get up and walk away and did not always complete the invoicing. She was never paid a salary. They shared income for tax purposes. He never issued her a T4 slip.

[50] Between the time she stopped working for Dr. S. and prior to her first CPP Application, she saw Dr. Yuen, continually saw Dr. Harris and was doing physiotherapy. She tried a chronic pain management program with Dr. Menuck. She attended once weekly for group therapy, joined in a discussion group, performed exercises, yoga, meditation and written exercises. Mentally, she was still stressed. Her father had died in April 2005, which triggered her depression. She was also having problems with severe headaches, neck problems, and pain in her shoulders which felt as though they were coming out of their sockets. Dr. Harris sent her to Dr. Toye in X, who suggested breast reduction. She underwent this in 2006, which provided only a small amount of relief. Since this time onward, she has felt as though she physically cannot hold her head up. She could only sit for short periods of time and did not possess concentration due to depression and stress. She would spend time on line when she could not sleep and buy and purchase merchandise on line or play games until she could fall asleep.

[51] In 2005, she had a serious fall and fell on her tailbone. She has a large hematoma at the bottom of her spine. She has spinal stenosis and her cervix dropped as result of the fall. She had to undergo a partial hysterectomy in or around 2010. Although she had back pain before the fall, the fall magnified her back pain. She is unable to stand on the spot without having to move around or sit down. She cannot do her gardening. Her spouse had to take over doing the laundry, housecleaning and meal preparation after the pain became magnified in her back following the 2005 fall.

[52] She first applied for CPP in February 2007 as neither she nor her doctor believed she could return to work. She had severe depression and no concentration or focus. All she wanted to do was sleep all day and night even though she was not sleeping due to insomnia. She did not want to see anyone or leave her home. She could not return to her previous optometry office job as she could not stand or serve the patients.

[53] During the period between her first and second CPP applications, she had depression and back problems. There were no changes in how she was feeling either physically or mentally. She was still suffering with depression. She did not pursue the denial of her first application as she felt she was not believed and gave up.

[54] Although her first Questionnaire was neatly handwritten, it took her one month to complete. She would spend a few hours at a time on it.

[55] During the period between 2006 and 2012, she would see Dr. Harris and attend physiotherapy and have acupuncture treatments. Dr. Harris "pushed" her to apply for CPP disability in 2012. By that time, she had changes in her body. She had had a hysterectomy and osteoporosis had surfaced. She was dealing with fibromyalgia and tears in her muscles. She had tried a muscle relaxant, hot and cold, acupuncture, physiotherapy and walking for fibromyalgia. She was not able to walk even one block without pain. Sitting was also bad as she would feel the hematoma in her low back which consisted of pressure

[56] In 2006, she was prescribed Effexor and Celexa. This was changed to Effexor and Wellbutrin. Dr. Harris was concerned she was becoming resistant to medications. Dr. Harris referred her to see a psychiatrist in 2012. She now sees Dr. Urson monthly. Dr. Urson feels she is medication resistant. She takes 450 mg Wellbutrin which exceeds the Canadian limit and Pristiq 100 mg. She also tried Ability and several other medications. She understands her condition is refractory.

[57] She believes she is worse now. She has lost her confidence, self-esteem and does not want to get out of bed or attend doctors' appointments. She spends her days at home. She sleeps quite a bit, gets up around 11 am, has breakfast (couple pieces of toast), takes a cocktail of pills, naps at 1:00 pm and wanders around the house and property. She does not do any housework. She spends time online at night when she cannot sleep. She has spent her days this way for years going back to when she left work.

[58] Her second Questionnaire was typewritten because it was a faster process. When she handwrites, her hands cramp. It took her a couple weeks to complete it.

[59] Her body is failing her. She is filled with pain, has arthritis throughout her body and is unable to stand or be happy. She has bad mood swings. She knows she cannot concentrate. She cannot get out of her depression. She hopes to have a better quality of life in the future and will see her grandchildren grow up. However, she sees herself in a wheelchair as she is unable now to get around. She takes cortisone in her knees for pain and has had cortisone in her shoulders. She is straining and tearing her muscles.

[60] In response to some questions from the Tribunal, the Tribunal referred the Appellant to Dr. Yuen's February 2007 report in which he stated she had significant improvement in her symptoms and asked her how long the improvement he mentioned lasted. She stated it did not last too long. She continued to see her family doctor for medication. Dr. Yuen had prescribed medication which caused her to suffer a rash. She had to come off of it. By December 2007, she was struggling with the muscles in her legs and excruciating muscles spasms at night. Once she went off the Celebrex Dr. Yuen prescribed, her pain worsened.

[61] After her 2005 fall, she was struggling with being able to sit. By December 2007, she still struggled with sitting. At home, she can sit between 20-30 minutes and then has to get up and stretch her neck, arms, back and hips.

[62] In terms of Dr. Casses' August 2011 report in which he recommended that she lose 100 lbs. and stated that unfortunately, she did not believe this was the treatment for her, the Appellant stated she took this as an insult. She is 230 lbs. Losing 100 lbs. would bring her down to 130 lbs. which is what she weighted as a teenager. She does not eat a lot now, is on a slew of medications and cannot exercise to lose weight. She also had a breast reduction, which removed 5 lbs. off of each breast.

[63] In terms of Dr. Wilkin's September 2011 report which referred to driving, the Appellant explained that she will drive herself to a doctor's appointment in town. Once she stopped working, driving was limited to attending doctors' appointments.

[64] In terms of GT11-78-79, i.e., the clinical notes of Dr. Harris referring to the depression being in remission by 2008, the Appellant disputes the assertion that her depression was in remission. She states she understood Dr. Harris was going to provide a letter denying she ever stated her depression was in remission. According to the Appellant, Dr. Harris denied stating this and mentioned that is not what she meant. The Tribunal also asked the Appellant to comment on GT11-93, another clinical note of Dr. Harris in which she stated that the Appellant's condition was in remission for several years and had relapsed in 2010. The Appellant denied that there was any remission during this period. She states she was on medication with no changes and does not recall any improvement.

[65] In terms of the Respondent's submission that telephone calls were placed to her home telephone number in 2012 and that the outgoing message was from E. R. (her spouse) and P. R., the Appellant explained that she is not involved in the business. The business did not have a separate telephone line. E. R. had a separate fax number for the business.

[66] In re-examination, the Appellant testified that at no time between 2007 and her current application, did Dr. Harris discuss explore a return to work with her. Dr. Harris encouraged her to complete the 2012 application.

[67] The Appellant's spouse testified. He solely owns X contracting. The Appellant is not on the bank. There were times he asked her to help out with some invoicing. A bookkeeper comes in who looks after things. She was sick. He would come home and find her in bed. He would drive her to out of town specialist appointments.

[68] His accountant recommended an income split for tax purposes. She is not a salaried employee or part owner of the business.

SUBMISSIONS

[69] The Appellant submitted that she qualifies for a disability pension because:

a) She stopped working for any third party in November of 2005 as a pre-exam technician due to depression and chronic back pain. She only worked after that entering invoices on a computer for her husband's business accountant. Income and CPP contributions subsequent to her cessation of work in 2005 were for the purposes of income splitting.

b) Against a history of depression, it was only with the diagnosis of major depression in 2005 that she was no longer able to work. Her history revealed she was also grappling with back pain and general physical pain for 15 years preceding 2012, with a first diagnosis of fibromyalgia made in 2005. It is conceded that current complaints and treatment of the right shoulder arose subsequent to the MQP.

c) Dr. Harris outlined Fibromyalgia and Major Depressive Disorder. In the initial CPP Medical Report received by the Respondent in January 2007, she noted a 5 year history of multiple joint pain, complaints of ongoing pain and generalized pain-

musculoskeletal. The Appellant was noted to have reduced ability to perform housework due to fatigue and chronic generalized pain; reduced ability to carry out bookkeeping tasks for her spouse's business due to fingers cramping using a keyboard and problems with concentration; and reduced ability to perform her activities of daily living. In the second CPP Medical Report dated March 2012, Dr. Harris reported chronic low back pain since 2004 with acute exacerbations, fibromyalgia diagnosed by Dr. Yuen in 2006, Major Depressive Disorder since 1995 and osteoarthritis.

d) It is clear the low back pain was chronic for 15 years preceding 2004. The date of diagnosis for fibromyalgia does not mean she was not suffering from this disorder for a considerable time before the diagnosis was made. Major Depressive Disorder was noted as recurrent since 1995. Dr. Harris described the physical findings and functional limitations associated with Major Depressive Disorder and Pain in the right shoulder with overhead work. In terms of the issues set out in her March 2012 report, the only new condition described since the 2007 application was the shoulder.

e) In her October 26, 2012 report, Dr. Harris stated that the Appellant had suffered from a "relapsing and remitting Major Depressive Disorder for as long as I have known her". She stated the depression had become refractory to treatment with time, having become severe and prolonged such that she was unable to hold gainful employment. She confirmed the presence of chronic pain stating the Appellant had had chronic low back pain with acute exacerbations for at least 15 years.

f) Dr. Urson, who took on the Appellant's case in 2012 confirmed the presence and diagnosis of Major Depressive Disorder – something pointed out by Dr. Harris in 2005.

g) Dr. Day, Simcoe Pain Clinic, in his May 11, 2012 report referred to a fall in 2005, with a long history of back pain. He reviewed the 2009 lumbar CT, noting it revealed several levels of degenerative disc disease and stenosis at L4-5 and facet joint disease at L5-S1. He also felt the low back issues were mechanical. Since many complaints of pain involving fibromyalgia are made without a clear mechanical or physical origin, this is a significant finding. Management of the symptoms of fibromyalgia would not fully manage those symptoms brought about by mechanical or physical issues involving the

Appellant’s back.

h) In his April 2012 report, Dr. Rampes noted the Appellant had an early history of depression commencing at age 16. He further noted the continued use of medication and the attempt at CBT with Dr. Menuck in 2006.

i) The attempt at CBT with Dr. Menuck may be the first indication in the Appellant’s history that Dr. Harris was finding that her depression was not responding to medication alone. Dr. Rampes confirmed the existence of chronic depression and found her to be suffering from Major Depressive Disorder. One sees a continuing history of depression with a final diagnosis of Major Depressive Disorder between the 2005 diagnosis and the present date.

j) In her first CPP application the Appellant reported she was unable to work due to depression, with inability to concentrate and focus. She reported muscle weakness and spasms, decreased range of motion and loss of emotional control. She reported an inability to sit or stand for long periods of time, chronic low back pain, swelling of legs, cramping in the fingers when writing or typing and leg/groin muscle spasm. In her second CPP application, she reported an inability to work since November 2005 due to, among other things, prolonged major depressive disorder, arthritis, fibromyalgia, pain with sitting, bending, standing, fatigue, hypersomnia, concentration, irritability with people and noise. Her complaints in 2012 are clearly consistent with the issues reported as preventing her from working due to depression in 2007 at the time of the first application.

k) In her July 2, 2007 report, she indicated she and her doctors had changed her medications many times. She is treatment resistant. She reported extensive physical limitations including chronic back pain, CTS surgery that limits her grasp and writing, bursitis, reflux thrombosis, RLS, sleep disorder, heel spurs and 18/18 fibromyalgia hot spots. In her February 2007 Questionnaire, she reported she could not complete Dr. Menuck’s course in June 2006 as she “couldn’t concentrate or stay focused and complete assignments”.

l) In her initial application, she stated she did bookkeeping one day per week for two hours inputting invoices for the accountant for her spouse's business. She did not report this in her second application. She has provided copies of her income tax returns for the years between 2003 and 2007. The income reported was for the purposes of income splitting between the Appellant and her spouse. Her duties were never other than casual work for her spouse and the reported amounts and the duties she assumed are not reliable or credible evidence of her ability to engage in any substantially gainful occupation.

m) Her disability is severe and prolonged as defined in the CPP. She has not worked outside the home since November 2005 and has performed only minor work for her spouse's company. Despite considerable effort and various medical and rehabilitation interventions, her condition has continued to prevent her from engaging in any employment and has severely limited her activities of daily living.

n) In denying the initial application, the CPP adjudicator seized on the Appellant's response to fibromyalgia medication only being "partially helpful" as being a sign of likely future recovery, when read in conjunction with her prognosis and attendance with Dr. Menuck's group therapy at the Chronic Pain Clinic. This is an error. While a person may recover from a disabling illness and return to work, if they are at the point in time where the adjudication is made still suffering from a disability that satisfies the test under s. 44 of the CPP, the possibility they may recover is not a fact to be taken into account.

o) The Appellant takes issue with the adjudicator's focus in the August 2012 denial letter on the absence of ECT or hospitalization or the statement in the 2012 psychiatry report that she appeared to be well in 2006. This ignores her own doctor's reports that her depression has proven refractory since 2005. It also ignores her attempts made with Dr. Menuck to undergo therapy in 2006 and is based on the notion a person must be hospitalized for depression before it may be considered severe enough to be disabling.

p) The conclusion that her fibromyalgia may have been managed in 2007 ignores the fact that her depression and pain level had not improved by the end of 2007. Also, many of the back issues were in fact mechanical in origin. Therefore, whether or not the

fibromyalgia symptoms were managed, that would not assist with back pain and discomfort. Her diagnosed medical conditions are severe, chronic and degenerative in nature.

q) The *Villani* case enunciated a new much more liberal approach to determinations of disability under the CPP.

r) The Income Security Program (as it was then known) Policy Directive about determining whether an occupation meets the threshold of “substantially gainful” specified a threshold or benchmark of $8,559 in 1995. In 2013 dollars, that figure would be $12,002.16. With the exception of the income split in 2013, the income split between her and her spouse has been substantially less than the threshold amount. The split for 2013 is an anomaly created by how the Appellant’s spouse’s business affairs performed that year.

s) In oral submissions, the Appellant’s counsel made an analogy to a tool kit. The Appellant has reinventing herself during her work history. It is also apparent she has cycled into and out of the workplace. As time has going on, the cycle of her depression regressed. The word “remission” is cautionary. She has a severe and prolonged disability due to depression and her physical problems. As these other conditions started to kick in, her ability to cope with the depression and her other issues (e.g., her fall, erupting fibromyalgia) has decreased. She could no long power through. By the MQP, her disability was severe and prolonged.

t) Her condition is refractory. Prolonged fits this description. By 2007, she could no longer work through her condition or reinvent herself. She could not recover again.

u) Dr. Casses’ recommendation for weight loss was not realistic and he ignored her lack of capacity to exercise.

[70] The Respondent submitted that the Appellant does not qualify for a disability pension because:

a) She bases her disability claim on depression, arthritis, fibromyalgia, spinal stenosis, pain, fatigue, hypersomnia, irritability and poor concentration. She says she stopped

working as an optometric technician in November 2005 due to depression and chronic back pain.While she may not be able to perform her usual work, she has not tried any alternate lighter work.

b) She was age 54 at the MQP and 59 at the date of application. She has a college diploma in Business and obtained an Optometric Technician certificate.

c) Her medical condition is not serious. In September 2006, Dr. Yuen, rheumatology, indicated she had no significant arthritis or generalized osteoarthritis. Her physical exam and diagnostic tests were unremarkable. In February 2007, Dr. Yuen stated she was responding well to medication and had “significant improvement in her symptoms”. While diagnosed with fibromyalgia, no limitations were recorded on examination to support a condition that would prevent her from all work.

d) In May 2008, Dr. Wilkins, physician medicine, assessed her. She reported that the Appellant had good range motion to her upper and lower extremities, normal strength in all muscle groups and no muscle wasting. Dr. Wilkins diagnosed her with CTS and recommended surgery. No physical limitations were described to support a condition that would preclude all work after the MQP.

e) Investigative test results dated April and June 2009 showed some changes to her low back however no significant abnormalities were identified.

f) There is a lack of objective medical reports indicating incapacity to work around the MQP. In August 2012, Dr. Urson reported that the Appellant felt her depression became severe in 2005 because of stress at work and significant situational circumstances. However, treatment history included medication since 2000, group therapy in 2006 and a psychiatric assessment in 2012. No ongoing follow up by a mental health professional was recorded to support an ongoing severe depression from the MQP to the present.

g) In September 2012, Dr. Harris stated that the Appellant’s treatment resistant depression prevented her from working. She currently sees Dr. Urson, psychiatrist, and previously saw Dr. Rampes, psychiatrist. In her Questionnaire of May 2012, she stated she saw Dr. Rampes in April 2012 which is more than 4 years after the MQP. She declared she saw

no additional psychiatrist over the past two years. There is insufficient information to support psychiatric limitations preventing her from all work since December 2007.

h) She says she stopped working in November 2005. Telephone calls were placed to her home phone number in June 2012 and December 2012. Of note, the outgoing message was from "E. R. and P. R." indicating a business known as X Contracting. Her Record of Earnings included Self –Employment earnings of $9,380 in 2007 and $8,500 in 2012 after the MQP.

i) The Appellant subsequently explained that her self-employed earnings in 2012 and 2013 (after the MQP) were on account of shared income from her spouse to reduce the tax burden.

j) She submitted multiple medical reports and diagnostic test reports spanning from 2013 to 2015. While informative, her MQP is December 31, 2007. Evidence dated several years after this date has no bearing on her ability to work at that time.

k) The Respondent recognizes she has some limitations resulting from her fibromyalgia and depression of many years. However, the medical evidence does not show any serious pathology of impairment which would prevent her from performing suitable work since December 2007. Investigations did not show any significant impairments. Physical examinations by a rheumatologist/physical medicine and rehabilitation specialist did not record any physical limitations. While she has longstanding depression, she retained the ability to work with this condition for many years. She did not require ongoing follow up by a mental health professional from 2005 to the present. Her only mental health treatment at the MQP consisted of medication.

l) While her condition may have deteriorated in 2011 and 2012, there is a lack of medical reports around the MQP to show an ongoing medical condition that would prevent all work since the MQP and continuously after.

ANALYSIS

[71] The Appellant must prove on a balance of probabilities that she had a severe and prolonged disability on or before December 31, 2007.

Severe

[72] The medical record supports a finding that the Appellant suffered from depression and fibromyalgia both before and after the MQP. The Respondent takes the position that contemporaneous medical evidence does not exist at or around the MQP which supports the existence of a severe disability at that time and continuously thereafter.

[73] The Tribunal will examine all of the evidence including both the pre and post MQP medical reports, the Appellant`s oral testimony and the entire record to determine the severity of the Appellant's disability at the MQP.

Major Depressive Disorder

[74] Dr. Noorani, psychiatrist, reported on February 28, 2006, that the Appellant had struggled with depression for at least four years and suffered a relapse in October 2005 following her father's death in April 2005. The Appellant described difficulties sleeping most of the time, decreased appetite, lack of energy and motivation, poor concentration and panic attacks. Dr. Noorani set out a GAF of 55-60.

[75] In support of her initial CPP application, Dr. Harris completed the CPP Medical Report in or around January 2007. She diagnosed Major Depressive Disorder. She indicated that the Appellant had problems with concentration, had participated in Dr. Menuck`s Group Therapy and that her Major Depressive Disorder was not in complete remission. Although higher doses of Effexor were helpful, the Appellant could not tolerate the side-effects. Dr. Harris stated that the depression had potential for improvement.

[76] The Tribunal is satisfied that the Appellant had significant issues with depression which required her to stop working in November 2005. As noted, Dr. Noorani, psychiatrist, described a relapse in October 2005 after the Appellant's father died in April 2005. In her July 2007 letter created only five months before the MQP, the Appellant stated that her mental disability was

severely contributing to memory loss, impaired ability to concentrate, chronic disabling fatigue and problems with cognitive behavior. She further described challenges interacting with others, including word finding problems, stuttering, reduced emotional control, mood swings, poor memory and attention. She stated she was waiting to see a psychiatrist.

[77] The Tribunal is satisfied that the Appellant has suffered from functionally disabling depression both before and after the MQP. She was first diagnosed with depression in 1969 at age 16 and has been on long-term antidepressants. However, there is also no question she had been able to work for many years with this condition. The test for CPP-D focuses not on the diagnosis but on the functional impairment arising from the condition and its impact on the capacity regularly to pursue substantially gainful work. The question before the Tribunal is whether the Appellant was rendered incapable regularly of pursuing any substantially gainful occupation resulting from her October 2005 relapse and any other disabling medical conditions as of December 31, 2007.

[78] The Tribunal is satisfied based on the Appellant's testimony and the documentary evidence that her depression, on balance, was severely disabling at the MQP.

[79] The Tribunal notes that on December 15, 2009, Dr. Harris reported that the Appellant's Depressive Disorder went into remission in 2008 (GT11-78 and 789). This supports a finding that as of the MQP, it had not yet gone into remission. According to Dr. Harris' May 4, 2012 clinical note (GT11-93), the condition relapsed again in 2010.

[80] Therefore, at the MQP, the Tribunal is satisfied that the depression continued to render the Appellant severely disabled given her difficulties with mood, concentration, memory, sleep, fatigue and issues with motivation. The Tribunal is satisfied that the Appellant's challenges with these symptoms would have rendered her incapable regularly of pursuing any substantially gainful occupation.

[81] The Tribunal will address below the Appellant's recurrent Depressive Disorder as it relates to the prolonged aspect of the CPP definition of disability.

Fibromyalgia/Back Pain

[82] Dr. Yuen saw the Appellant in September 2006 for multiple joint pain with a reported history greater than 5 years. Her pain was noted to involve her back, elbows, knees, buttock areas, hips and feet. It was noted to be present most of the time, worse in the morning and after activities. However, on examination, straight leg raising was negative and she had good range of motion of her C-spine, mild limitation in lumbar flexion and extension, good range of motion of her peripheral joints and no active synovitis. Dr. Yuen stated she had an unremarkable clinical examination. This would seem to suggest that her functional impairment was not significantly affected. However, he also stated she had fibromyalgia tender points in all four quadrants and felt her symptoms were likely due to fibromyalgia. Therefore, he changed her medication and referred her to the Fibromyalgia Program. The import of this report suggests Dr. Yuen took the Appellant`s complaints of pain and limitations seriously despite the limited examination findings. Similarly, in his October 2006 report, Dr. Yuen stated that despite unremarkable investigations, the Appellant still had fatigue, widespread pain and continued to be fibrositic with tender points in all four quadrants. However, in his February 2007 report, Dr. Yuen reported that the Appellant had significant improvement in her symptoms and had less pain – although he noted she reported some weakness in her hip and thighs despite clinically normal strengths.

[83] Following Dr. Yuen's February 2007 rheumatology report, the medical record falls largely silent as of the MQP and for a significant period of time afterwards concerning the Appellant's fibromyalgia. Therefore, as with the case of depression, the Tribunal will examine all the evidence including the Appellant`s oral testimony, which the Tribunal notes is particularly critical in assessing an applicant's eligibility for a condition such as fibromyalgia, where there are few objective tests to ascertain the functionally disabling nature of the condition, to assess whether it is more likely than not that the Appellant suffered from a severe disability.

[84] The Tribunal notes the Appellant credibly testified without any challenge that the gains Dr. Yuen described in his February 2007 report were not long lasting. She also testified that ever since the fall onto her back in 2005, she has had significant back pain. That pain continued unabated and as of December 2007, she still could not stand or sit for prolonged periods of time.

Despite ongoing physiotherapy and medication, she continued to experience widespread bodily and lower back pain, which resulted in functional restrictions.

[85] In his May 2012 report, Dr. May, Simcoe Pain Clinic, reported that the Appellant stated she fell on her tailbone in 2005 and since that time, she had noticed that her back had been particularly bad. She described aching in the low back extending into the buttock, around the knees and into the calves. Dr. May noted that Dr. Yuen diagnosed fibromyalgia in 2007 which the Appellant described as nagging, aching pain in her body but particularly involving the shoulders, back and legs. Dr. May diagnosed fibromyalgia, chronic low back pain with some degenerative disc disease, facet disease, moderate spinal stenosis and chronic pain with underlying depression. In terms of back pain, Dr. May opined that most of the Appellant's symptoms were mechanical in origin and indicated her leg pain could be related to spinal stenosis.

[86] The Tribunal notes that Dr. Harris stated in her March 2012 CPP Medical Report that the Appellant had chronic low back pain since 2004 with episodic acute exacerbations.

[87] The Tribunal further notes that Dr. Yuen saw the Appellant in October 2011 having last seen her in 2007. He stated he previously put on her Tramacet and that she had some symptomatic improvement. On examination, she had 18 out of 18 fibromyalgia tender points. Dr. Yuen stated he first saw the Appellant in 2006, that she had more than a 5 year history of multiple joint pain and he reaffirmed his earlier diagnosis of fibromyalgia. He stated she **still** (emphasis added) had widespread pain and described poor sleep, low energy and fatigue and had **ongoing** (emphasis added) pain from her fibromyalgia.

[88] In his September 2011 report, Dr. Wilkins stated: "I think this is much more typical of pain from fibromyalgia and mechanical pain as opposed to pain from spinal stenosis.

[89] The Tribunal is satisfied that the post MQP medical reports together with the Appellant's oral testimony support a finding that the Appellant suffered ongoing widespread and multiple joint pain on an ongoing basis since the MQP. The Tribunal is further satisfied, on balance, that she was incapable regularly of pursuing any substantially gainful occupation at the MQP including light sedentary work. Her incapacity resulted significantly from her global

restrictions affecting prolonged sitting and standing, poor sleep, low energy and fatigue and difficulties with focus and concentration. Given these ongoing problems, it is difficult to envision how the Appellant could realistically function in the competitive labour market whether on a full or part-time basis.

CTS

[90] In her May 8, 2008 report, Dr. Wilkins reported that the Appellant, a right-handed bookkeeper, had a two year history of pain, numbness and tingling in both hands worse on the right than left. It would awaken her at night. She would use a splint intermittently but it did not help much.

[91] Given the above time frame set out by Dr. Wilkins, the Tribunal is satisfied that the CTS relates back to approximately May 2006 which is prior to the MQP. She indicated that surgical release would be prudent. Therefore, the Tribunal is satisfied that the CTS contributed to the severity of the Appellant's globally severe disability as of the MQP.

Shoulder/Knees

[92] The Tribunal has also reviewed the other described medical conditions set out in the medical record and is not satisfied that individually or cumulatively, they resulted in a severe disability on or before the MQP. In particular, the Tribunal notes that the Appellant started to experience right shoulder pain approximately four months before she saw Dr. May at the Simcoe Pain Clinic in May 2012. This time frame is after the MQP. According to a November 2012 report from Royal Victoria Regional Health Centre, the Appellant was seen for a right shoulder problem which began about two years earlier "insidiously". Although she was reported to have knee pain according a November 2013 report of Dr. Newman, she had presented to the Arthroplasty Intake Clinic with a greater than one year history of left knee pain, which the Tribunal notes indicates a condition of recent onset.

Work Capacity/Earnings

[93] The Tribunal has also considered the evidence concerning the Appellant's limited bookkeeping work for her spouse's business (two hours per week between June 1998 and

December 2006) and finds it did not reflect a capacity regularly on her part to perform a substantially gainful occupation at the MQP. The Tribunal further accepts the Appellant's explanation, as corroborated by her spouse's testimony, that the earnings attributed to her on her Record of Earnings were on account of income splitting between her and her spouse.

Prolonged

Major Depressive Disorder

[94] The Tribunal is satisfied that the Appellant's Major Depressive Disorder is long continued. She was first diagnosed with depression in 1969 at age 16. There is also no question that she has been able to work for many years with depression. She last stopped working in 2005 after she suffered a recurrent bout of Major Depressive Disorder following the death of her father. Given Dr. Harris's evidence as set out in her clinical notes that the Appellant's condition went into remission sometime in 2008 and relapsed in 2010, the question arises whether this condition was also of indefinite duration at the MQP.

[95] Given the recurrent or episodic nature of the Appellant's Major Depressive Disorder, including a lengthy history of prior relapses, her 2005 relapse which required her to leave work in 2005, the lengthy nature of her relapse between 2005 and 2008 (which period included the MQP), her remission in 2008 only to be followed by another relapse in 2010 with ongoing depressive symptomatology since that time despite ongoing treatment and therapy, and the treatment resistant nature of her condition, the Tribunal is satisfied that the Appellant's Major Depressive Disorder was prolonged at the MQP.

Fibromyalgia/Back Pain

[96] If the Tribunal is in error in concluding that the Appellant's Major Depressive Disorder was prolonged at the MQP given her post MQP remission, in any event, the Tribunal is satisfied that her fibromyalgia/back condition were prolonged at the MQP and that the severe and prolonged nature of these conditions qualify the Appellant to receive a CPP Disability pension.

[97] Despite physiotherapy, medication, and attendance at Dr. Menuck's pain clinic in 2006, the Appellant has continued to suffer from ongoing pain and physical restrictions which affect

her tolerance for prolonged standing and sitting. The Tribunal has noted above that Dr. Yuen in his October 2011 update report noted that the Appellant had ongoing pain from her fibromyalgia, which speaks to its long continuing nature. In the May 11, 2012 Simcoe Pain Clinic report, Dr. May noted the Appellant reported having had low back pain for a long time since falling on her tailbone in 2005. He diagnosed fibromyalgia and chronic low back pain with degenerative disc disease, facet disease, moderate spinal stenosis, and chronic pain with underlying depression. In her February 3, 2015 medical report, Dr. Issac, who assumed care of the Appellant after Dr. Harris retired, reported that the Appellant continues to suffer from chronic mental health and physical health issues that are severe and prolonged. These reports, on balance, support the finding of a prolonged disability at the MQP.

CTS

[98] Although the Tribunal is satisfied this condition would have contributed to a severe disability as defined in the CPP on or before the MQP given its impact on function in relation to the Appellant's dominant hand, the Tribunal is not satisfied this condition was prolonged. In her September 2011 report (GT1-81), Dr. Wilkins reported that she previously assessed the Appellant several years earlier for right-sided CTS. According to Dr. Wilkins, the Appellant presented with two problems: i) increased pain, numbness and tingling in the left hand over the past four or five months; and ii) back pain. Significantly, Dr. Wilkins did not describe ongoing problems with the right hand. The Tribunal notes the Appellant underwent open right carpal tunnel release on January 5, 2009 (see GT11-342). The Appellant did not file any post-surgical reports reporting on the outcome of surgery. Dr. Wilkins stated that the increased problems with the left hand had an onset of the past four or five months, which time frame falls after the MQP. In any event, EMG studies revealed only mild CTS on the left side, which according to Dr. Wilkins, had improved compared to studies performed two years earlier.

CONCLUSION

[99] The Tribunal finds that the Appellant had a severe and prolonged disability as of the MQP (December 31, 2007) given the cumulative impact of her chronic mental health and physical health issues. For payment purposes, a person cannot be deemed disabled more than fifteen months before the Respondent received the application for a disability pension (paragraph

42(2) (b) CPP). The application was received in May 2012; therefore, the Appellant is deemed disabled in February 2011. According to section 69 of the CPP, payments start four months after the date of disability. Payments will start as of June 2011.

[100] The appeal is allowed.

Jeffrey Steinberg
Member, General Division - Income Security