Social Security Tribunal of Canada | Tribunal de la sécurité sociale du Canada

Citation: *B. J. v. Minister of Employment and Social Development*, 2016 SSTGDIS 42

Tribunal File Number: GP-14-1455

BETWEEN:

B. J.

Appellant

and

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

Respondent

SOCIAL SECURITY TRIBUNAL DECISION

General Division – Income Security Section

DECISION BY: Verlyn Francis

FORM OF HEARING: On the Record

DATE OF DECISION: June 3, 2016

Canada

REASONS AND DECISION

INTRODUCTION

[1] The Appellant's application for a *Canada Pension Plan* (CPP) disability pension was date stamped by the Respondent on July 30, 2013. The Respondent denied the application initially and upon reconsideration. The Appellant appealed the reconsideration decision to the Social Security Tribunal (Tribunal).

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

a) The member has decided that a further hearing is not required.

b) The method of proceeding provides for the accommodations required by the parties or participants.

c) The issues under appeal are not complex.

d) There are no gaps in the information in the file or need for clarification.

e) This method of proceeding 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] 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).

[4] 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.

[5] 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

[6] There was no issue regarding the MQP because the parties agree and the Tribunal finds that the MQP date is December 31, 2013.

[7] 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 date of the MQP.

EVIDENCE

Application Materials

[8] The Appellant was 47 years of age at his MQP. He completed high school and has one year of accounting but does not have a degree. He was a warehouse worker in 2006 and worked in construction from 2007 to 2008. He was a truck driver for a linen company from 2001 to 2010 and stopped working because of low back, neck and leg pain. He received regular Employment Insurance (EI) benefits from 2011 to 2012. He did not have to do a lighter job or different type of work because of his medical condition.

[9] In the Questionnaire accompanying his application, the Appellant indicated that the impairments that prevent him from working are low back pain, pain in neck and pain in leg which make it difficult to stand, sit, lift, push, bend and kneel. As a result, he has had to cease playing soccer and basketball.

[10] His functional limitations and difficulties are 10 minutes sitting or standing; three to four minutes walking. He can lift and carry five pounds for ten metres. He cannot reach above shoulder level with his left arm. He has minimal range of motion for bending. He is able to attend to his personal needs and he has no difficulties with bowel and bladder habits. He is only able to do lighter activities of household maintenance. He has no restrictions with seeing, speaking and breathing. His medication for pain impacts his memory and concentration. Pain makes it hard to sleep. He can drive a car for short distances.

[11] He has been a patient of Dr. Seema Aggarwal, family physician, since 2005 and he visits her for low back pain, neck pain and left arm pain. His medications are Cymbalta 60 mg twice daily, Arthrotec 75 mg twice daily, and Baclofen 75 mg twice daily. He has also received physiotherapy treatment. He uses no medical devices and has no future treatments or medical tests planned.

Medical Evidence

[12] On October 20, 2011, the Appellant complained to Dr. Aggarwal of knee stiffness and pain. She prescribed Naprosyn 500 mg one tablet b.i.d. and advised him to apply heating pads and exercises. Bilateral knees x-rays on October 21, 2011 showed no fractures or mal-alignment, no effusions, and no significant degenerative change. An ultrasound of the right knee on November 14, 2011 showed a 2.8 cm long Baker's cyst in the popliteal fossa. A small amount of fluid was also present in the superior joint space. Dr. Aggarwal's office chart indicates she saw the Appellant on November 23, 2011 for complaint of pain in the right knee with swelling at the back of the knee. He was advised to apply warm compressions and Naproxen 500 mg b.i.d. was prescribed.

[13] Dr. Aggarwal next saw the Appellant for right knee pain on June 7, 2012. He had no associated trauma. He described the pain as dull aching with stiffness in the morning lasting less than an hour and getting better as the day progresses and then worse. He had no problem with weight bearing and the pain was worse getting up after prolonged resting. On examination, Dr. Aggarwal found no acute distress, normal gait, no scar, no erythema, no deformity and no effusion of the knee. There was joint line tenderness and range of motion was normal. She arranged an MRI and for a consultation with Dr. Elashaal.

[14] An MRI of the Appellant's right knee on June 23, 2012 found extended horizontal oblique undersurface tear across the posterior horn and the body segment junction of the medial meniscus, associated with moderately severe degenerative chondropathy and high-grade cartilage height loss within the medial joint space compartment. An enlarged popliteal Baker's cyst was noted. Other features of degenerative osteoarthritic disease were also noted with mild to moderate joint effusion. The lateral meniscus was grossly intact and no acute ligamentous injury was identified. Dr. Aggarwal's next saw the Appellant on June 29, 2012 for right knee pain. She refilled his prescription for Arthrotec 75 mg, one tablet b.i.d.; and coated Enteric 20 mg one tablet daily.

[15] Dr. Abdelrahman Elashaal, orthopaedic surgeon, reported on July 18, 2012, that he saw the Appellant for worsening right knee pain that started three years before. The complaint was sharp pain in the joint line and difficult walking. On examination, Dr. Elashaal found a bump on the back of the knee which looked like a small Baker Cyst and joint line tenderness. The recommended treatment included arthrosopic surgery and partial meniscectomy. The Appellant told Dr. Elashaal that he was going to Albania for the summer and would contact the office on his return to book the procedure.

[16] Dr. Aggarwal's chart on October 1, 2012 indicates that the Appellant was following up on right knee pain which started a few months previously. MRI showed a meniscal tear and the Appellant was working full-time cooking pizza. The assessment was acute knee pain.

[17] On December 4, 2012, Dr. Seema noted in the Appellant's chart that he had been rear ended six days previous, November 28, 2012 and the car was towed from the scene. His seat belt was on and the air bag did not deploy. He did not lose consciousness, had no head injury but had been experiencing headaches and some neck pain. A few days later, he started feeling dull aching neck pain radiating to his upper back and lower spine. He had limited range of motion leading to some difficulty carrying out activities of daily living. He had tried Tylenol #3 and Advil. Dr. Seema found positive spasm in the neck and limited range of motion especially with flexion and extension. He had pain in the back on palpation of the right side of the lumbar spine, and limited range of motion. Her assessment was acute sciatica, lumbar sprain. He was given a prescription of Naproxen and Flexeril along with physiotherapy.

[18] X-ray of the lumbar spine on December 6, 2012 showed minimal degenerative disc disease and no traumatic injury was identified. An x-ray of the cervical spine on January 3, 2013 showed alignment is anatomic with all pedicles present and no fractures. The lumbar spine showed anatomic alignment with all pedicles present and no fractures.

[19] Dr. Aggarwal's chart noted on January 3, 2013 that the Appellant was having neck pain mid-spine, headaches and shoulder pain. Physiotherapy twice a week, Motrin and Flexeril at night were not providing relief. He said he was not working and could not work. He said his lower back pain, left hip pain were spreading to the lower leg with numbness, weakness and tingling and nothing had changed. The observation was that he had limited neck range of motion, neck and back spasm, and limited range of motion. He was prescribed Arthrotec 75 mg, one tablet b.i.d. for one month.

[20] On January 24, 2013, Dr. Aggarwal noted that the Appellant had back pain spreading in posterior left thigh to back of knee, numbness in lower left back and he could not bend. He felt he could not sit, lie flat for long and massage made it better. Naproxen did not help. Arthrotec was helping but he had indigestion from it. His complaints were neck pain spreading to back of head and shoulders and medial aspects of scapula with headaches and shaking in bed. He had anxiety, palpitations and sweating when driving or as a passenger and he got upset when discussing the accident. Physio twice a week and a TENS machine at home helped. He worked as a machine operator, truck driver and had been laid off work for a year and he wanted a letter for the insurance company. He stated he could not bend and stood during the visit. His shoulder strength were equal bilaterally, limited external rotation, flexion, extension. In his back, there were no skin changes, no tenderness, limited mobility, decreased motivation. The assessment was acute back pain, sciatica, lumbar sprain; depression, neck and back sprain, whiplash; and anxiety. The plan was for the Appellant to see an optometrist. He was given samples of Tecta 40 g for six weeks, Voltaren gel prescription, Cymbalta 30 mg, asked to continue physio; and referred to a psychologist.

[21] On February 7, 2013, the Appellant reported to Dr. Aggarwal that his back was getting worse with shooting needles in tail bone. Aquatherapy once a week helps but pain came back in two hours. Arthrotec helps and he had no more belly issues with Tecta. He had neck pain and

headaches. He had no more problems with shakes, felt more comfortable in an SUV and was more vigilant in a smaller car. His right elbow pain had not changed intensity for the previous two years but felt more prominent then with all the other pain. The finding was acute back pain, sciatica, lumbar sprain; neck/pack pain, whiplash; anxiety; depression. The plan was to continue back management with medication, CT head to rule out mass, encouraged optometrist and psychologist; and use Voltaren gel, sleeve with gel.

[22] A computed tomography (CT) of the Appellant's head on February 9, 2013 showed no significant abnormality and no change from a previous examination of November 14, 2010.

[23] During an office visit on March 7, 2013, the Appellant reported to Dr. Aggarwal that he was not having any more problems with shakes, and that his depression and anxiety were better on Cymbalta 30 mg once a day. He drives for short distances. He was not seeing a psychologist because the shakes were no longer present. He had no numbness or tingling sensation. The x-rays of his lumbar spine and neck were normal. The plan was to do an MRI of the lower back, continue therapy and Arthrotec b.i.d.

[24] An MRI of the lumbar spine on March 19, 2013 showed neural foraminal canal narrowing on the left at L4-L5. The exiting nerve root did not appear to be affected but there was annular tearing identified involving the left lateral/neural foraminal zone. There was no evidence of central canal compromise.

[25] Dr. Robert Yovanovich, orthopaedic surgeon, carried out an orthopaedic assessment of the Appellant on April 16, 2013 for a home and auto insurance company regarding a November 28, 2012 motor vehicle accident. The physical findings were a well-conditioned young man with poor posture and good muscle tone. He appeared to be in emotional and physical distress during the interview. He walked cautiously but without an observed limp. He had no spasm or deformity in his cervical spine and his range of motion was full in all directions with flexion and extension generating mild neck and primarily low back pain. He had very mild tenderness in his paracervical area and midline. Neurological assessment of his upper limbs demonstrated good muscle tone with no muscle wasting, weakness, nor pain on resistive testing. His sensation was normal. He had significant increased muscle tension throughout his lumbar spine and tenderness from L4 to the sacrum with mild tenderness about the left buttock. Range of motion

was limited and painful. Hip movements were full but generated intense low back pain. Straight leg raising was restricted by pain to about 50 degrees bilaterally. No evidence of active or chronic joint disease in lower extremities although tender on the medial aspect of his right knee and some pain on forced flexion. There was no muscle wasting or weakness. He had normal sensation and no measurable leg length discrepancy. Knee and ankle reflexes were symmetrical and relatively brisk.

[26] Dr. Yovanovich concluded that, based on the Appellant's subjective complaints, he suffers from an impairment in the function of his back as a consequence of mechanical low back pain and restricted lumbar mobility. This impairment would preclude him from engaging in activities which involve repetitive bending/twisting/stooping; heavy lifting/carrying; heavy pushing/pulling; and prolonged and unrelieved sitting/standing/walking. There was mild impairment in the function of his neck and his pain would be aggravated by sudden repetitive movements of the head and neck; static and unrelieved posturing of the head and neck in a flexed or extended position; heavy lifting/carrying; and heavy pushing/pulling. As far as limitations, Dr. Yovanovich concluded that the Appellant did not suffer a complete inability to carry on a normal life and he was capable of returning to gainful employment if the employment involved activities that did not include repetitive bending, twisting or stooping; heavy lifting or carrying; heavy pushing or pulling; and prolonged and unrelieved sitting, standing or walking.

[27] Dr. Yovanovich recommended that the Appellant be referred to a pain clinic for epidural steroid injections and/or left facet injections and, if that failed to relieve his symptoms, he should be referred for a surgical consult. He indicated no further investigation is necessary.

[28] The Appellant saw Dr. Aggarawal on May 27, 2013 where she reported that he had mechanical lower back pain. He refused epidural steroids because he was scared and needed the Flexeril. At the office visit on April 4, 2013, Dr. Seema filled forms and discussed the MRI and refilled his medication.

[29] On July 12, 2013, Dr. Aggarawal completed the Medical Report which accompanied the application. She had known the Appellant for seven years and her diagnosis was chronic lower back pain and anxiety/depression. The relevant history is a motor vehicle accident in November

2012 and since then low back pain – likely mechanical. He had not been admitted to hospital in the previous two years. The functional limitations and physical findings were that he was unable to lift, bend or push as he had low back pain. His medications were Lyrica and Arthrotec. He did physiotherapy and acquafit with some relief. MRI showed osteoarthritis with disc bulge.

[30] In her office note of July 12, 2013, Dr. Aggarwal noted the Appellant felt his back was getting worse with shooting needles in his tail bone, left lower back pain radiating to the upper back and radiating to left buttock, and radiation in the knees and ankle. There was no incontinence and no saddle paresthesia. He stopped aquatherapy and acupuncture; was attending physio on hip twice a week and massage therapy. He reported that Arthrotec helps and his headaches and neck pain were better. The CAT scan was normal and the MRI was okay. Dr. Aggarwal's observation was positive spasm, no limited range of motion, and neuro okay. The plan was to continue Lyrica b.i.d. and Arthrotec b.i.d. Dr. Aggarwal's note on July 23, 2013 was similar to that of July 12, 2013. He was on Arthrotec b.i.d. which helped and headaches and neck pain were better. He had taken himself off Cymbalta and was then on Lyrica b.i.d. Dr. Aggarwal found spasm but no limited range of motion and neuro was okay.

[31] Dr. Pankaj Kapoor, psychiatrist and neurologist, saw the Appellant on October 10, 2013 for a consultation regarding low back pain. On examination, Dr. Kapoor found no cranial nerve deficits. Motor examination revealed that the Appellant had normal strength, tone and bulk. He was able to hell and toe walk unassisted, SLR was positive on the left side. Deep tendon reflexes were one-quarter and symmetric, except the left patellar reflex was perhaps slightly hypoactive. Plantar responses were mute. Sensory examination was normal. Gait had a slight antalgic quality. There were no cerebellar signs. Dr. Kapoor's impression was that the Appellant probably had mechanical, myofascial low back pain and he referred him for electrodiagnostic studies to assess for L4-L5 radiculopathy. He recommended Baclofen 5-10 mg as needed. The Appellant declined epidural steroid injections. Dr. Kapoor did not feel surgical intervention was clinically indicated and he had no further treatment options to offer at that point.

[32] A needle electromyography (EMG) and nerve conduction study conducted on November 13, 2013 was normal and there was no suggestion of peripheral neuropathy or lumbosacral radiculopathy.

[33] Dr. Aggarwal's office notes indicate that she saw the Appellant on November 14, 20013 for back pain. He indicated he felt pins and needles on the leg and sharp pain in the thigh, severe low back pain, tightness. He went to the gym, swimming pool and massage and felt temporary relief. His pain was more intense in the previous two weeks which he attributed to weather change. He denied recent trauma. He had no saddle paresthesia, no incontinence, no urinary retention, and showed no red flags. The MRI report was discussed with him and the potential for pain to be present for a long time and he was not happy. Dr. Aggarwal discussed epidural but the Appellant was not willing at that time. Her assessment was acute sciatica, lumbar sprain pain. The plan was to increase his medication to 10 mg t.i.d. prn for the next week until pain subsides and start Lyrica only qhs.

[34] An MRI of the cervical spine on March 18, 2014 showed mild degenerative change at C6-C7 with lesser disc dislocation above this level. There is no disc extrusion or canal stenosis. There is moderate bilateral foraminal narrowing at C6-C7, mild bilateral foraminal narrowing at C4-C4, C4-C5 and C5-C6. Disc osteophyte complex at C3-C4 and C6-C7 indent the thecal sac without deforming the spinal cord.

SUBMISSIONS

[35] The Appellant submitted that he qualifies for a disability pension because:

a) He has neck, back and leg pain, headaches and anxiety/depression.

b) He is functionally limited to sitting or standing for 10 minutes, three to four minutes walking, and he can lift and carry five pounds for ten metres. It is difficult for him to stand, sit, lift, push, bend and kneel. He cannot reach over shoulder level with his left arm and he is only able to do lighter activities of household maintenance.

c) As a result of the pain, he has difficulty sleeping, his memory and concentration are affected by pain medication, and he can only drive short distances.

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

a) The Appellant complains of low back, neck and leg pains but the objective medical evidence does support a finding that the Appellant is ineligible for CPP disability benefits.

b) The Appellant has declined to undertake the treatment recommended and continues to be treated conservatively.

c) The medical evidence does not show serious pathology which would support the Appellant's incapacity for all work.

ANALYSIS

[37] The Appellant must prove on a balance of probabilities that he had a severe and prolonged disability on or before December 31, 2013.

Severe

[38] Paragraph 42(2)(a) of the CPP defines disability as a physical or mental disability that is severe and prolonged. A disability is severe if a person is incapable regularly of pursuing any substantially gainful occupation. A person with a severe disability must not only be unable to do their usual job, but also unable to do any job they might be reasonably expected to do. A disability is prolonged if it is likely to be long continued and of indefinite duration or is likely to result in death.

Guiding Principles

[39] The severe criterion must be assessed in a real world context. This means that when deciding whether a person's disability is severe, the Tribunal must keep in mind factors such as age, level of education, language proficiency, and past work and life experience when determining the "employability" of the person having regard to his or her disability (*Villani v. Canada (A.G.),* 2001 FCA 248).

[40] The “real world” context also means that the Tribunal must consider whether the claimant’s refusal to undergo medical treatment and what impact that refusal might have on the claimant’s disability status should the refusal be considered unreasonable (*Lalonde v. Canada* (*MHRD*), 2002 FCA 211).

[41] It is the Appellant’s capacity to work and not the diagnosis of her disease that determines the severity of the disability under the CPP (*Klabouch v. Canada (MSD)*, 2008 FCA 33).

[42] To establish severe disability, Appellants must not only show a serious health problem, but where there is evidence of work capacity, must show effort at obtaining and maintaining employment has been unsuccessful by reason of that health condition (*Inclima v. Canada (A.G.)*, 2003 FCA 117).

Application of the Guiding Principles

[43] The Appellant was 47 years of age at his MQP in December 2013. He bases his claim for CPP disability pension on low back, neck and leg pain, headaches, and anxiety/depression. He states that he worked as a truck driver from 2001 to 2010 and stopped working because of low back, neck and leg pain. He received EI benefits from 2011 to 2012.

[44] In October 2011, the Appellant had an x-ray of both elbows which was normal. Around the same time, he complained of knee stiffness and pain and bilateral knees x-rays was normal. An ultrasound showed a Baker’s cyst at the back of right knee and he was treated with pain medication by his family doctor who referred him to Dr. Elashaal, orthopaedic surgeon, in July 2012. Dr. Elashaal diagnosed a small Baker’s cyst and joint line tenderness and recommended arthroscopic surgery and partial meniscectomy. The Appellant indicated to the surgeon that he was leaving the country for the summer and would contact his office on his return to book the procedure. The evidence does not disclose that the Appellant followed Dr. Elashaal’s recommended treatment. In October 2012, the Appellant saw Dr. Aggarwal to follow up on right knee pain and indicated he was working full-time cooking pizza. Since there is no further evidence filed regarding this condition and the Appellant was working full time, the Tribunal

finds that the Appellant's right knee pain was not a severe condition within the meaning of the CPP criteria.

[45] On December 4, 2012 the Appellant indicated to Dr. Aggarwal that he had been in a motor vehicle accident six days previous. He was belted, the air bag did not deploy, and he did not lose consciousness. He complained of headaches, neck and back pain. Dr. Aggarwal diagnosed acute sciatica and lumbar sprain and prescribed analgesics and physiotherapy. By January 2013 he complained that his pain was spreading, he was shaking in bed and he displayed signs of anxiety. Dr. Aggarwal found no tenderness or skin changes in his back but there was limited mobility and decreased motivation. Her assessment at that time was acute back pain, sciatica, lumbar sprain, depression, neck and back sprain, whiplash and anxiety. She prescribed further medication and referred the Appellant to an optometrist and a psychologist. It does not appear from the record that the Appellant ever consulted a psychologist and by March 2013, he indicated that it was not necessary for him to see a psychologist because the shakes were no longer present. He also had no numbness or tingling sensations at that time and an MRI in March 2013 showed no evidence of central canal compromise but there was an annular tearing in the left lateral/neural foraminal zone. CT and x-rays taken during this time were normal.

[46] Dr. Yovanovich saw the Appellant in April 2013 for an orthopaedic assessment and identified impairment in the function of his back as a consequence of mechanical low back pain and restricted lumbar mobility. The doctor recommended that the Appellant be referred to a pain clinic for epidural steroid injections and/or left facet injections. This recommendation was obviously communicated to the Appellant's family doctor who indicated in May 2013 that the Appellant refused epidural steroids because he was scared. In October Dr. Kapoor, psychiatrist and neurologist, also reported that the Appellant declined epidural steroid injections. In November 2013, the Appellant reported to Dr. Aggarwal that his back pain was severe, and he felt pins and needles on the leg, and sharp pain in the thigh. Dr. Aggarwal again discussed epidural with the Appellant but he refused. The Tribunal finds that where two specialists and his family doctor recommended a course of treatment, it was not reasonable for the Appellant to refuse that treatment on the basis that he was scared. By refusing to undergo epidural steroid injections, the Tribunal finds that the Appellant failed to cooperate in his healthcare by

following a reasonable course of treatment which could have eliminated or controlled his mechanical, myofascial low back pain and symptoms.

[47] Significantly, in March 2013, Dr. Yovanovich found that, although the Appellant had limitations, he was capable of returning to gainful employment with certain restrictions. This is confirmed by the normal radiological and electrodiagnostic test results and the conservative pharmacological treatment.

[48] While Dr. Aggarwal also listed depression and anxiety as disabling conditions, the evidence indicates that by March 2013, the Appellant refused to see a specialist and he reported that these conditions were better and were being managed by medication.

[49] The Appellant's other complaints were headaches and neck pain but by July 2013, Dr. Aggarwal reported that these conditions were better with the help of medication.

[50] Having considered the totality of the evidence and the cumulative effects of the Appellant's medical conditions, the Tribunal is not satisfied on a balance of probabilities that the Appellant suffers from a severe disability in accordance with the CPP criteria.

Prolonged

[51] Since the Tribunal found that the disability was not severe, it is not necessary to make a finding on the prolonged criterion.

CONCLUSION

[52] The appeal is dismissed.

Verlyn Francis
Member, General Division - Income Security