Manitoba

# Automobile Injury Compensation Appeal Commission

**IN THE MATTER OF an Appeal by [APPELLANT]**
**AICAC File No.: AC-17-013 and AC-18-132**

| | |
|---|---|
| **PANEL:** | **Jacqueline Freedman, Chair**<br>**Lorna Turnbull**<br>**Sandra Oakley** |
| **APPEARANCES:** | **[text deleted] (the "Appellant") was self-represented; Manitoba Public Insurance Corporation ("MPIC") was represented by Matthew Maslanka.** |
| **HEARING DATES:** | **October 11, 12 and 17, 2022.** |
| **ISSUES:** | **Whether the Appellant should be entitled to funding from MPIC for further physiotherapy treatment after October 6, 2016, as it relates to the injuries sustained in his motor vehicle accidents.**<br><br>**Whether the Appellant should be entitled to funding from MPIC for the medications Vimovo and/or Lyrica related to the injuries sustained in his motor vehicle accidents.**<br><br>**Whether the Appellant should be entitled to a permanent impairment benefit as a result of the injuries sustained in his motor vehicle accidents.** |
| **RELEVANT SECTIONS:** | **Subsections 70(1) and 127(1), and paragraphs 136(1)(a) and (d) of The Manitoba Public Insurance Corporation Act (the "MPIC Act"), sections 5 and 8 of Manitoba Regulation 40/94, and section 1 of Manitoba Regulation 41/94.** |

## Reasons For Decision

**Background:**

The Appellant was the driver of a vehicle when he was involved in accidents on three separate occasions:

1. December 1, 2014 (the "First MVA");
2. June 25, 2017 (the "Second MVA"); and
3. February 1, 2018 (the "Third MVA").

All of the accidents may collectively be referred to as the "MVAs".

The Appellant suffered various injuries as a result of the MVAs and he received certain treatments pursuant to the Personal Injury Protection Plan ("PIPP") provisions of the MPIC Act, including physiotherapy treatment.

The Appellant had initially been allotted funding for 24 physiotherapy treatments following the first MVA by MPIC. On March 12, 2015, the Appellant's treating physiotherapist wrote to MPIC and requested further physiotherapy treatments. This request was reviewed by the Benefits Administration Unit ("BAU"), and the medical information was reviewed by MPIC's Health Care Services ("HCS") medical and physiotherapy consultants. The BAU issued a decision dated May 28, 2015, which stated that there was no medical requirement for treatment beyond 24 physiotherapy visits.

The Appellant disagreed with the decision of the BAU and filed an Application for Review. The Internal Review decision, dated September 28, 2015, overturned the BAU's decision. It provides, in part, as follows:

> MPI's Medical Consultant completed a thorough analysis of the medical information available. The consultant provided an opinion that the June 16, 2015 MRI findings are not causally related to your accident of December 1, 2014. However, it is possible that the accident adversely affected pre-existing problems involving the lumbar spine to the extent that symptoms developed.
>
> It is reasonable to expect that continued physiotherapy treatment would increase your level of function and decrease your pain levels. In my opinion, it may be premature to end treatment at this time given the opinion of the Medical Consultant and your reported ongoing symptoms.

> While I am mindful of the Physiotherapy Consultant's opinion, giving consideration to all information on your file, in my opinion, the medical information on file supports additional physiotherapy treatment is deemed "medically required" within the meaning of the PIPP legislation.
>
> Therefore, I am overturning the BAU's decision of May 28, 2015 and approving funding for additional physiotherapy treatment.
>
> I am returning your file to the BAU to handle in accordance with my decision. Your further entitlement to physiotherapy treatments will be monitored and assessed by BAU and it is likely that BAU will request additional medical information.

Subsequently, by email dated October 9, 2015, the BAU advised the Appellant that five additional physiotherapy treatments were approved. No formal decision letter was issued.

MPIC then conducted a further review and gathered additional medical information. The BAU issued a subsequent decision dated October 6, 2016, confirming its earlier decision (dated May 28, 2015) that there was no medical requirement for physiotherapy treatment beyond 24 visits.

The Appellant disagreed with the decision of the BAU and filed an Application for Review. The Internal Review decision, dated December 21, 2016, upheld the BAU's decision, but varied its effective date. It provides, in part, as follows:

> The BAU approved treatment to October 9, 2015. No further physiotherapy treatment was approved while the BAU further investigated your entitlement. A year later, on October 6, 2016, the BAU issued a decision denying your entitlement to any further physiotherapy treatment. While I agree with the decision, the decision does not conclusively determine your rights under the Personal Injury Protection Plan.
>
> The BAU's decision of October 6, 2016 is retroactive in its effect. In general, the Review Office is disinclined to give effect to retroactive decisions.
>
> […]
>
> Given the above, this will confirm I am approving your entitlement to physiotherapy treatments to October 6, 2016 when your entitlement was concluded by a reviewable decision as required by Section 170 of the Act. The BAU will reimburse you for

> physiotherapy treatment to October 6, 2016 less any amounts paid through any other insurance plan.

The Appellant disagreed with this Internal Review decision and filed an appeal with the Commission.

Subsequently, on January 18, 2018, the Appellant wrote to MPIC and asked for compensation in respect of his "permanent injuries on my left 5 lumbar nerve root", as well as reimbursement for medication expenses in respect of Vimovo and Lyrica, which he said were required for his MVA injuries. This request was reviewed by the BAU, and the medical information was reviewed by MPIC's HCS medical consultant. The BAU issued a decision dated March 1, 2018, which stated "there is no entitlement to reimbursement of Lyrica and Vimovo medications or a permanent impairment payment under the Personal Injury Protection Plan (PIPP)."

The Appellant disagreed with the decision of the BAU and filed an Application for Review. The Internal Review decision, dated November 8, 2018, upheld the BAU's decision.

The Appellant disagreed with this Internal Review decision and filed a second appeal with the Commission.

**Issues:**

The issues which require determination on this appeal are as follows:

1. Whether the Appellant should be entitled to funding from MPIC for further physiotherapy treatment after October 6, 2016, as it relates to the injuries sustained in the MVAs;

2. Whether the Appellant should be entitled to funding from MPIC for the medications Vimovo and/or Lyrica related to the injuries sustained in the MVAs; and
3. Whether the Appellant should be entitled to a permanent impairment benefit as a result of the injuries sustained in the MVAs.

**Decision:**

Following a review of the documentary evidence on file, the testimony of the witnesses and the submissions of the parties, and for the reasons set out below, the panel finds as follows:

1. That the Appellant has not met the onus to establish, on a balance of probabilities, that funding from MPIC for further physiotherapy treatment after October 6, 2016, is medically required;
2. That the Appellant has not met the onus to establish, on a balance of probabilities, that funding from MPIC for the medications Vimovo and Lyrica is medically required; and
3. That the Appellant has not met the onus to establish, on a balance of probabilities, that he is entitled to a permanent impairment benefit in respect of a left L5 radiculopathy.

**Preliminary and Procedural Matters:**

This hearing was held during the COVID-19 pandemic, and took place entirely by videoconference, with the consent of the parties.

In preparation for the hearing, the Commission compiled an indexed file, which contains all documents agreed upon by the parties as evidence to be relied upon at the hearing. These

documents are numbered for ease of reference by the parties and the panel. Attached to these reasons and marked as Appendix A is a copy of the indexed file Table of Contents.

In advance of the appeal hearing, on October 6, 2022, a Case Conference was held with the parties, to review the issue of the documentary evidence related to the Second and Third MVAs. The Appellant had previously expressed his position that the Second and Third MVAs aggravated his injuries arising from the First MVA. It was noted that the indexed file in this appeal initially contained documentary evidence primarily relating to the First MVA. Accordingly, at the Case Conference the parties agreed that MPIC would provide the documentary evidence in its records relating to the Second and Third MVAs to the Appellant and to the Commission in advance of the appeal hearing, and that was done. (Appendix A to these Reasons reflects the addition of these documents.)

At the outset of the appeal hearing, the Chair reviewed the issues under appeal with the parties. The issues initially had been framed as being in relation to the First MVA. However, given the Appellant's position with respect to the impact of the Second and Third MVAs, and the recent addition to the indexed file of documentary evidence related to those MVAs, the parties agreed that the Commission could consider the issues under appeal as they related to all of the MVAs. The hearing accordingly proceeded on that basis.

**Opening Statements:**

After concluding discussions of the preliminary matters, the parties were invited to give opening statements. The parties very briefly stated their respective positions, which will not be summarized here, as they are reflected in the submissions, below.

**Legislation:**

The relevant provisions of the MPIC Act are as follows:

> **Lump sum indemnity for permanent impairment**
>
> **127(1)** Subject to this Division and the regulations, a victim who suffers permanent physical or mental impairment because of an accident is entitled to a lump sum indemnity of not less than $500. and not more than $100,000. for the permanent impairment.
>
> **Reimbursement of victim for various expenses**
>
> **136(1)** Subject to the regulations, the victim is entitled, to the extent that he or she is not entitled to reimbursement under *The Health Services Insurance Act* or any other Act, to the reimbursement of expenses incurred by the victim because of the accident for any of the following:
>
> **(a)** medical and paramedical care, including transportation and lodging for the purpose of receiving the care;
>
> [ …]
>
> **(d)** such other expenses as may be prescribed by regulation.
>
> **Powers of commission on appeal**
>
> **184(1)** After conducting a hearing, the commission may
>
> **(a)** confirm, vary or rescind the review decision of the corporation; or
> **(b)** make any decision that the corporation could have made.
>
> **Effect of lack of formality in proceedings**
>
> **183(7)** No proceeding before the commission is invalid by reason only of a defect in form, a technical irregularity or a lack of formality.

Manitoba Regulation 40/94 (the "Expense Regulation") provides, in part, as follows:

> **Medical or paramedical care**
>
> **5** Subject to sections 6 to 9, the corporation shall pay an expense incurred by a victim, to the extent that the victim is not entitled to be reimbursed for the expense under *The Health Services Insurance Act* or any other Act, for the purpose of receiving medical or paramedical care in the following circumstances:

> **(a)** when care is medically required and is dispensed in the province by a physician, paramedic, dentist, optometrist, chiropractor, physiotherapist, registered psychologist or athletic therapist, or is prescribed by a physician;
> […]
>
> **Medication, dressings and other medical supplies**
>
> **38** The corporation shall pay an expense incurred by a victim for the purchase of medication, dressings and other medical supplies required for a medical reason resulting from the accident.

Manitoba Regulation 41/94 (the "PI Regulation") provides, in part, as follows:

> **Compensation for permanent impairment based on Schedule**
>
> **1** Compensation for permanent impairments shall be determined on the basis of Schedule A.

It should be noted that in the Internal Review decision dated November 8, 2018, when dealing with the issue of medication, the Internal Review Officer referred to paragraph 136(1)(a) of the MPIC Act and section 5 of the Expense Regulation, which both deal with medical and paramedical care. Those provisions would not appear to have specific application to the funding of medication expenses. Although paragraph 136(1)(d) of the MPIC Act and section 38 of the Expense Regulation were not mentioned in that Internal Review decision, under subsection 184(1) of the MPIC Act, the Commission may make any decision that MPIC could have made. Therefore, the panel is able to consider those provisions of the legislation in this appeal.

**Evidence for the Appellant:**

The Appellant relied on several medical reports from his health care providers in support of his appeal. He also testified at the hearing of his appeal.

**The Appellant:**

The Appellant briefly described his life prior to the First MVA. He was an active person, and was in the process of pursuing an online university degree. He was employed as a [text deleted]. He had no back pain prior to the First MVA. The Appellant described the First MVA, in which his car was rear-ended while stopped at a red light. He felt something painful in his back right away. He said his life was "switched" by that MVA. It changed his relationship with his wife, affected his work and impacted his daily activities. After the First MVA, he had trouble sitting for more than 20 minutes at a time. He had difficulty concentrating on his online program of studies, because he could not find a comfortable sitting position.

In the First MVA, the Appellant was driving and his son was a passenger. They went to the [text deleted] Hospital and were eventually seen by a nurse. While they were waiting to be assessed, he started to develop pain in other areas (in addition to his back), and he believes that this is why the nurse's concentration was on his neck. The Appellant recognized that his lower back pain was not recorded in the nurse's evaluation. He said he had no control over what the nurse wrote down in her assessment notes. However, he did have back pain, and he was having significant difficulty at work later that day, with pain going down both legs. The following day he made an appointment for physiotherapy, and went to a walk-in clinic. His symptoms developed substantially and impaired him. Fortunately, his work was flexible so he was able to sit, lay down, and change positions to relieve the pain. It was hard, but he continued working.

He continued with physiotherapy treatment until MPIC's funding of the treatment ceased. Because his symptoms continued, he looked for other treatment alternatives. He sought out chiropractic treatment; however, on assessment, the chiropractor was concerned that imaging showed a possible L4 compression fracture and did not want to provide treatment at the risk of

causing deterioration. The Appellant noted that various wedge compressions in his spine were identified on diagnostic imaging, but not consistently, and this inconsistency was troubling to him. He said that the inconsistency led the case manager to deny his request for further physiotherapy treatment in May 2015.

The Appellant had symptoms of tingling in his toes, and pain down his left leg. In March 2015, he was referred to a sports medicine physician, [Doctor 1], whose impression was that he suffered from a lumbosacral sprain. The Appellant questioned [Doctor 1]'s conclusion, as the doctor had advised him that he did some work for MPIC, and so he could not treat him, but he could provide an assessment. In the Appellant's view, this raised an ethical concern. The Appellant was then referred to a neurosurgeon, [Doctor 2], in September 2015. The Appellant noted that even though he explained all of his symptoms to [Doctor 2], and the doctor reviewed an MRI from June 16, 2015, which showed an L4-L5 disc extrusion, the doctor said he could not detect any ongoing radiculopathy.

The Appellant was still having difficulties at this time. Although he continued to work, he had problems there, and he struggled to do certain things at home, such as vacuuming, and cutting the grass. He would have pain shooting down his left foot, and would need to stop and change positions. When the Internal Review office overturned the case manager's decision, the Appellant was glad to get more physiotherapy treatments, although he did not think that enough treatments were provided.

His general physician was concerned that he was still having pain, and sent the Appellant for a further x-ray in November 2016, which showed no compression fractures. The Appellant still had pain shooting from his back to his toes, so his doctor then sent him for an MRI in January

2017, which showed that there was resolution of the prior damage, but the L5 nerve was possibly pinched. Based on the MRI results, his general physician referred him for a nerve conduction study, which was conducted by [Doctor 3] in June 2017. The Appellant pointed out that [Doctor 2] stated that he was recovering from a left L5 radiculopathy, and that the numbness in his toes was likely to be permanent.

The Second MVA occurred on June 25, 2017. The Appellant described that he was driving his wife and youngest son and was stopped at a red light when two other cars collided and then crashed into the front end of his car. He was still trying to recover from his injuries arising from the First MVA, and the Second MVA shook his head and his back. Prior to the Second MVA he had been paying for physiotherapy from his own funds. Subsequent to this MVA, MPIC funded treatments, and he showed a lot of progress. Then, on February 1, 2018, the Third MVA occurred, in which the Appellant was rear ended when stopped at a red light. His back was affected once again, and he received further physiotherapy treatments.

The Appellant's general physician referred him to [Doctor 2] and his colleague in February 2019, for evaluation of his continuing back pain and left leg symptoms. The Appellant said that his walking was not symmetrical. When he tried to compensate for the pain in his left foot, he developed pain in his right side. The Appellant underwent various tests, and was told that the damage to the nerve was permanent, so the only possibility was to provide treatment for relief of pain. He received injections for his hip pain, and these provided relief; however, the symptoms in his left foot and his right leg continue. The Appellant noted that although there is no documentary evidence, he had three injections from [Doctor 2] from May 2019 to 2020. Although he got pain relief from those injections, [Doctor 2] said they were not intended to be a permanent treatment, and he would like to refer to the Appellant to another neurosurgeon.

However, in 2020 the pandemic began, everything shut down, and there has been no follow-up since then.

The Appellant stated that he has not fully recovered from the MVAs. He has to be careful how he does things. His doctor prescribed Lyrica, which he takes at night to reduce the tingling and pain going down to his foot. The doctor also prescribed Vimovo for lower back pain. He takes those medications continuing to this day. Another impact of the MVAs is that he had to struggle to complete his online degree. Because it was an online program, it had to be completed within seven years. He was halfway through the program when the First MVA occurred. In 2017, he requested an extension; it was granted, but unfortunately, he had to get a student loan which he had not been planning on. He did manage to complete the degree this year. All aspects of his life were affected, from his leisure activities, including no longer being able to jog or go to the gym, to his physical relationship with his wife. His back flares up for different reasons depending on what he does; for example, gardening, cutting the grass, kneeling and squatting all bring back the pain. In June of this year, he had to go for physiotherapy for that reason. His back is vulnerable now, and it was not that way prior to the First MVA. He has never stopped working, and he has tried to manage with modifications. His leg is still weak, and he still has symptoms; although they are reduced, they are not gone. He has followed his home exercise program and he takes his medications.

The cross-examination of the Appellant briefly covered his employment. [Text deleted]. There is not a significant physical aspect to the job, although they do some walking and cycling.

The Appellant was questioned regarding the paraesthesia, or numbness, in his left toes. Counsel for MPIC noted that the first documentary evidence of the numbness is in the June 28, 2017,

report from [Doctor 2]. He asked the Appellant when the numbness started and why there were no earlier references in the documentation, despite him having seen multiple health care providers. The Appellant said that this symptom was there from the beginning, and some things are outside the patient's control, such as what the health care providers write about his symptoms. He noted that the [text deleted] Hospital assessment does not contain any documentation of his back symptoms, although he reported them, while other doctors did not include notations of his foot symptoms, just his back symptoms. He said that it is very subjective; people tend to write only what they see, and because the numbness relates to a nerve that they cannot see, they question it. He said he has explained his symptoms since the beginning: the pain in the back of his left leg, the tingling in his three toes and the weakness in his big toe. He pointed to the intake form from his chiropractor dated February 11, 2015, which notes symptoms including a shooting, burning sensation, and also tingling and weak leg muscles. The Appellant said he was feeling shooting pain to his left leg and tingling in his toes in the first 2 to 3 months after the First MVA, but around February or March 2015 the numbness in his toes became worse and debilitating.

Counsel questioned the Appellant regarding his statement in his direct testimony that he had not experienced any back pain prior to the First MVA. Counsel pointed to a report from [Doctor 4], a colleague of [Doctor 3], dated February 8, 2019, which states that the Appellant's history "traces back to mild intermittent low back pain in his [age]". The Appellant was firm in stating that this was not correct. He said if he mentioned intermittent low back pain, it would have been in relation to the First MVA; he did not say anything about his [age]. However, he did not disagree with the rest of [Doctor 4] report. Counsel also questioned the Appellant regarding a notation in his physiotherapist's chart note from December 6, 2014, which states "prior R low back/hip injury (1995)". The Appellant said it was hard for him to recall, but he did many sports, and

probably had a strain type of injury, on his right side, when he was doing exercises. The Appellant said he firmly denied that he had lower back problems prior to the First MVA. He never took any medication or had any treatments for his lower back prior to the First MVA.

The Appellant was questioned about his recent flare of back pain due to gardening. He acknowledged that it normally does flare up as a result of activity, including gardening and shoveling. Prior to the recent flare, it was getting much better. He was receiving monthly massage therapy. He had some pain but it was manageable; however, some activities are always difficult, such as going up and down the stairs to vacuum.

**Evidence for MPIC:**

MPIC relied on several HCS medical reports, reports from other health care providers and case managers' notes on the Appellant's file. In addition, MPIC called one of its HCS consultants, [Doctor 5], to testify at the appeal hearing.

**Dr. MacKay:**

As indicated, [Doctor 5] is a medical consultant for MPIC's HCS team. In that capacity, he reviewed the Appellant's file and provided HCS reports dated September 2, 2015, February 26, 2018 and June 10, 2019.

He described his education and training in sports medicine, which is an offshoot of family practice, and includes a focus on musculoskeletal issues, with the emphasis on an active approach and trying to promote exercise. In his clinical practice, he sees patients with a variety of conditions; lower back pain is the most common condition. He has been a consultant with MPIC since 1996. Since that time, he has conducted many forensic file reviews. In preparing his

opinions, he reviews the medical reports in the claim file, considers the examinations done by the professionals involved in the appellants' care and the results of the treatment, and provides an opinion to the case manager. He was qualified as an expert in sports medicine, having experience in forensic file review.

[Doctor 5] reviewed his report dated September 2, 2015. He opined that as a result of the First MVA, the Appellant had sustained a cervical and upper back strain, also referred to as a WAD 2 injury (whiplash associated disorder, category 2). With this type of WAD 2 injury, there are soft tissue injuries to the neck and upper back. WAD 2 is the diagnosis used in the absence of damage to the bony structure. There would be no structural or neurological issues, but there may be pain and loss of range of motion. He remains of the view that WAD 2 is the correct diagnosis. As well, he is of the opinion that the multilevel disc degeneration shown on the Appellant's MRI of June 16, 2015 was not caused by the First MVA, although it is possible that the MVA adversely affected the Appellant's pre-existing problems involving the lumbar spine to the extent that symptoms developed. He noted that the Appellant's presentation at the Victoria Hospital immediately following the First MVA was not in keeping with a significant injury, but rather the findings were non-specific, which is in keeping with a minor event. The multilevel degeneration shown on the MRI did not develop as a result of one event, particularly a minor event.

The documentary evidence reflects that the Appellant's lower back symptoms were not present immediately following the First MVA. At the [text deleted] Hospital, he reported upper back symptoms, which is the neck and shoulders. It was not until a few days later that the Appellant reported lower back pain, which is farther down the spine. This is what was reported to his chiropractor in February 2015. If symptoms do not develop until two or three days after an

MVA, that reflects a minor injury, with symptoms that should resolve very quickly. The most common cause of spinal pain is idiopathic, in other words, having no known cause.

[Doctor 5] said that the wedge compression findings at T12 and T7 could not be from the First MVA, firstly because they were not supported by the mechanism of injury, and secondly because they were not confirmed by later radiology. [Doctor 1] report confirmed that the T7 fracture was not likely to be the source of the Appellant's pain. [Doctor 5] further drew a distinction between an incident that causes an alteration of the spine, effecting or enhancing structural changes to it, as compared with an incident that causes an irritation of the spine, which is a temporary, less significant injury that does not effect any structural changes. He said that no acute structural changes were identified to the Appellant's spine immediately following the First MVA or in subsequent imaging; his pre-existing condition was not permanently altered. The Appellant's underlying degenerative changes, which are common and took years to form, make him more vulnerable to back pain; however, he would have developed back issues over time regardless of the MVAs. He has had various perturbations over the years. [Doctor 5] could not identify anything from the MVAs that rendered him more susceptible to this than he was prior to the MVAs. At some stage, degenerative issues catch up to people and symptoms result.

He reviewed his reports dated February 26, 2018, and June 10, 2019 in the context of the Appellant's request that MPIC fund the medications Vimovo and Lyrica. He explained that Vimovo is an anti-inflammatory drug, which he presumed was prescribed for the Appellant's back symptoms, while Lyrica is a medication for neuropathic symptoms. He was of the opinion that neither medication was medically required in the management of an MVA-related medical condition. [Doctor 5] noted that they were prescribed several years after the First MVA, so it was hard to relate the need for those medications to that MVA. With respect to Vimovo, he

acknowledged that there were two subsequent MVAs, and that those could have increased the Appellant's back symptoms. However, there is not enough documentary evidence about those MVAs and the Appellant's presentation immediately after them for [Doctor 5] to conclude that the medication was required due to those MVAs.

[Doctor 5] further reviewed his two reports, in the context of the Appellant's left leg radiculopathy symptoms. He explained that radiculopathy involves a spinal nerve that creates change. The symptoms are sensory loss, pain into a certain region of the leg (for L5 it would be the lower leg and top of foot), and tingling (sensation of pins and needles), but he noted (on redirect) that these must be accompanied by clinical findings of myotomal deficits (muscle weakness) or dermatomal deficits (abnormal sensation). There can be other reasons for symptoms that seem to reflect nerve impairment, such as myofascial issues or referred pain, but these would not support a diagnosis of radiculopathy due to the absence of the clinical findings noted above.

He referred to [Doctor 2]'s report from September 2015, which indicated that there was no radiculopathy at that time. [Doctor 5] said it was therefore not possible to opine that the Appellant developed a radiculopathy as a result of the First MVA. Although the June 2015 MRI had shown an L4-L5 disc extrusion, a further MRI of the Appellant's lumbar spine dated January 25, 2017, showed resolution. There was still some narrowing, so there was potential to cause irritation, but the L5 root was not compressed or displaced at that time. [Doctor 5] opined that while the Appellant exhibited some symptoms, they were not neuropathic in origin. He noted that [Doctor 3], in his report from June 2017, stated that the Appellant had the residue of having had a left L5 radiculopathy, but it was resolving. The electrophysiology tests were normal. [Doctor 5] said that it is common for radiculopathy to resolve; in fact, it does resolve in the vast majority of cases, although sometimes there is a residue of neuropathic weakness. He noted that

[Doctor 4], in his report from February 2019, felt that there was a radiculopathy at that time based on clinical findings of leg weakness. [Doctor 5] was of the view that the Appellant must have subsequently developed a radiculopathy some time after the assessment by [Doctor 3] in June 2017. In his view, the Second and Third MVAs did not factor significantly into the Appellant's presentation. He noted that the physiotherapy discharge report from June 2018, after the Second MVA, noted tingling in the Appellant's left great toe, but indicated that the neurological examination was normal.

In any event, [Doctor 3] provided a further report in September 2019, in which no deficits were noted. Therefore, any radiculopathy found by [Doctor 4] in February 2019 had resolved by September 2019. Further, in the September 2022 report from the Appellant's physiotherapist, the Appellant's neurological examination was normal, and there was no evidence of clinical deficits. [Doctor 5] opined that based on his review of the evidence, the Appellant is no longer exhibiting symptoms of radiculopathy. In the absence of a diagnosis, it is hard to relate the Appellant's radiculopathy to a particular event. Because the radiculopathy that he did experience at one point in time was not permanent, he would not be entitled to a permanent impairment award. On redirect, [Doctor 5] opined that the clinical findings that supported the diagnosis of radiculopathy for a period of time did not support a causal relationship to any of the MVAs. He noted that the most common form of lumbar radiculopathy is not the result of a specific event.

On cross-examination, [Doctor 5] was questioned regarding his determination of the significance of an MVA, and whether this determination was impacted by the cost of repairs. He said that he looks at pictures of the vehicle post-MVA to assess the structural damage and estimate the force the person was exposed to. In the Appellant's First MVA, he was driving a large truck, the frame

was not altered, and the vehicle was drivable after the MVA, which led [Doctor 5] to conclude that the impact was minor.

[Doctor 5] was asked to comment on the Victoria Hospital assessment from the First MVA. He said that in his view, this assessment appeared to be thorough; it indicates the reason for the Appellant's attendance, the results of several assessments that were done, and other documents were provided that add to the clinical picture. [Doctor 5] agreed that getting a proper medical history is very important. He said that the chart notes provided by the Appellant's general physician did not appear to be very thorough. While they recorded complaints, they did not always reflect assessments or clinical findings. However, [Doctor 5] said that he was able to come to his conclusions based on the reports of other specialists who had seen the Appellant and provided reports.

The Appellant pointed out that his back symptoms developed subsequent to the First MVA and he questioned [Doctor 5] as to why he could not make a finding of causation. [Doctor 5] said that the Appellant had degenerative changes prior to the MVA, which did not develop from a single event. Although the First MVA could have caused these changes to become symptomatic for a period of time, it would not have led to lifelong pain. The degenerative changes could have caused him pain or symptoms in the absence of any of the MVAs; there was no evidence to support that any of the MVAs caused a structural change to his spine. The Appellant pointed to a letter dated April 1, 2016, from his general physician, which stated that his back pain was due to the First MVA. [Doctor 5] responded that the letter contained no evidence to support the statement and no documented clinical findings; in his view, it was not a good opinion.

[Doctor 5] was asked to explain the conflicting diagnostic imaging of the Appellant's back. He noted that two x-rays done shortly after the First MVA identified different wedge compressions in the Appellant's thoracic spine of uncertain age, which could have been there for years. These were was not a likely result of the MVA. A subsequent x-ray, in November 2016, did not identify any compression fractures in the thoracic region, nor did an MRI in January 2017. In [Doctor 5] opinion, based on the totality of the evidence, there were no fractures of the Appellant's spine caused by the MVAs. He pointed out that although the Appellant's chiropractor referenced a possible L4 compression fracture, this was not supported by the diagnostic imaging; in fact, the imaging excludes such a fracture.

The Appellant questioned [Doctor 5] regarding the numbness in his toes, which [Doctor 3] stated in his report from June 2017 was likely to be permanent. [Doctor 5] said that in his report, [Doctor 3] made no neurological findings, and there was no correlation of the Appellant's symptoms to the MVAs. He acknowledged that there was an indication that the Appellant may have had a radiculopathy at some stage, but when he saw [Doctor 3] in June 2017, there was no nerve impairment. As well, his initial symptoms following the First MVA were not consistent with radiculopathy. The most common cause of lumbar radiculopathy is idiopathic. [Doctor 5] agreed with [Doctor 4] findings in February 2019 that the Appellant at that time had legitimate findings of radiculopathy, but said that was a new finding, and was temporary, because it was not present later. He said further that Lyrica was not medically required for a condition caused by any of the MVAs. Lyrica may be helpful in minimizing symptoms, i.e. medically beneficial, but not medically required, because there is no cause and effect relationship between the diagnosis and the MVAs.

[Doctor 5] was asked about his reliance on reports by physiotherapists, and their findings of normal neurological examinations. He agreed that neurologists had greater training and expertise in this area than physiotherapists; however, he noted that all health care professionals are trained to conduct basic neurological examinations, and should be able to identify neurological concerns. If they say a neurological examination is normal, he would take it at face value.

**Submission for the Appellant:**

The Appellant submitted that he was doing his best to represent himself in his appeal, and to take care of his body both before and after the MVAs. He noted that MPIC did not always accurately record what he told them. As well, the [text deleted] Hospital assessment did not reflect the symptoms that he reported on the day of the First MVA. He also expressed dismay that [Doctor 5] was critical of the chart notes of his general physician. He noted that he was not responsible for what was written in the chart notes, or for the interpretations of his health care providers. In his reply, he also pointed out that [Doctor 5] did not examine him, but provided his opinion based only on a review of documentary evidence. He submitted that [Doctor 5] opinion should be given less weight than the opinions of the health care providers who examined and treated him over the course of time. As well, he submitted that the neurological examinations conducted by neurologists should be given greater weight than those conducted by physiotherapists.

Addressing his entitlement to further physiotherapy treatment, the Appellant pointed out that [Doctor 4], in his September 2015 report, recommended that the Appellant should continue with physiotherapy treatment to address his low back pain. In his reply, he noted that [Doctor 6], in a letter dated November 29, 2016, also recommended physiotherapy for his lower back pain. He submitted that if a specialist recommends the treatment, this means it is medically required. He noted that the Internal Review decision of September 28, 2015 had approved funding for

additional physiotherapy treatment, but the BAU had only approved five further treatments. When funding for these treatments ran out, he continued treatment using his wife's insurance. Unfortunately, the physiotherapist concluded that he reached a plateau and he was eventually discharged to home exercises. In his reply, he submitted that reaching a plateau did not mean that he was good, just that he had reached a certain point; he was not going to get any better, and he was not going to get any worse.

The Second and Third MVAs exacerbated his injuries. He received further physiotherapy treatments after those MVAs. He also went for massages for pain relief. His health care providers recommended that he get a TENS machine for home use. MPIC approved a two-month home rental of a TENS machine after the Second and Third MVAs. Because MPIC would only approve a rental of the machine, he purchased his own machine, which he has found very helpful to minimize pain and maintain his functionality. He said that it is very hard for him, at this point, to say what more could be done for his back. He has to be careful how he does things, because his back has been left vulnerable after the three MVAs. Doing gardening this June increased his symptoms and he required further treatment. He still goes for physiotherapy treatment, once every two weeks, and pays for it through private insurance.

The Appellant also submitted that he had no complaints of lower back pain prior to the First MVA. He pointed to the chart notes of his general physician, which, in 30 pages of notes prior to the MVA, did not reflect any complaints of back pain prior to the date of the First MVA. As well, his former family physician, from [province], provided a letter indicating that he had never treated him for any prior lower back problems. While [Doctor 5] said that the degeneration reflected in the diagnostic imaging did not result from a single event, the Appellant argued that here, there was a single event, namely the First MVA. His back pain started on that day.

His general physician, [Doctor 6], prescribed Vimovo for the Appellant's back pain, which started after the First MVA. His doctor also provided samples of Lyrica to him for a long period of time and then prescribed it to him. The doctor considered that his radicular/neuropathic symptoms and pain would be reduced by the Lyrica, which they are. He depends on the medications for relief of his chronic pain.

The Appellant addressed his radicular symptoms of numbness and tingling, mainly on his left leg, hip and buttocks. He pointed out that the June 2015 MRI showed an L4-L5 disc extrusion, which had not been identified prior to the First MVA. He noted that [Doctor 3], in his report from June 2017, confirmed that the Appellant did have some resolving issues with radiculopathy. He also found that the numbness in the Appellant's toes was likely to remain permanent. Although the doctor did not find any major problems with nerve conduction on that day, the Appellant noted that [Doctor 3] was not able to see pain, as pain is a subjective symptom. [Doctor 3] later treated the Appellant with injections in his left hip to reduce the pain there, which were helpful. However, the numbness in his left leg continues to the present time. He is able to manage the symptoms to some extent with medication, the TENS machine, massage therapy and physiotherapy.

The Appellant submitted that his lower back pain and radicular symptoms started with the First MVA. The pain and symptoms continue to this day. As a result, he has to think about how he does things and change his lifestyle and activities to prevent exacerbations. Sometimes it is very hard to control the pain. He has a chronic problem, and he needs compensation for the damages caused by the MVAs.

**Submission for MPIC:**

Counsel for MPIC briefly reviewed the issues under appeal as outlined above. He noted that the onus is on the Appellant to establish his entitlement to benefits.

Addressing the Appellant's entitlement to physiotherapy treatment after October 6, 2016, counsel pointed out that MPIC accepted the Appellant's injuries from the First MVA as being cervical and upper back strain, as well as lumbar strain and mechanical back pain (WAD 2). MPIC's HCS physiotherapy consultant, in a report dated September 10, 2015, opined that the appropriate injury category for a WAD 2 injury is Category 1 (24 treatments). The Appellant was initially provided with funding for Category 1 treatment. Based on the Internal Review decision dated September 28, 2015, MPIC authorized five further physiotherapy treatments, and the Appellant sought treatment with a second physiotherapist, whom he continued to see even after MPIC ceased funding. The Internal Review decision dated December 21, 2016, which is the subject of the present appeal, authorized funding by MPIC of physiotherapy treatment up to October 6, 2016. It is MPIC's position that further physiotherapy treatment beyond that date would not be medically required.

Counsel pointed out that the Internal Review decision dated December 21, 2016 stated:

> In order to be considered "medically required", additional physiotherapy would have to be considered essential for the treatment of your accident-related condition (that meet accepted standards of practice) with measurable and sustained improvement. Treatment which provides only short-term, symptomatic relief does not meet this test.

A report dated March 9, 2015 from the Appellant's first physiotherapist noted that the Appellant "has had moderate improvement in symptoms, but has been plateaued over the past 4-6 weeks." He was discharged from that physiotherapy program within a few weeks thereafter. The

physiotherapy discharge report from the second physiotherapist, dated October 3, 2016, stated that the Appellant had plateaued and was discharged to a home program. MPIC's HCS physiotherapy consultant provided a further report dated October 4, 2016, in which he reviewed the chart notes from the Appellant's general physician. He confirmed his earlier opinion that the appropriate injury category for a WAD 2 injury was Category 1.

Although the Internal Review decision of December 21, 2016 predates the Second and Third MVAs, the parties agreed that those MVAs could be considered for the purposes of determining the Appellant's entitlement to further physiotherapy treatments after October 6, 2016 because the Appellant said that those MVAs exacerbated his symptoms. MPIC funded 24 physiotherapy treatments after the Second MVA. The physiotherapist's chart notes from five days after the Second MVA indicate that the Appellant was diagnosed with a WAD 2 injury: cervical and lumbar sprains/strains and dural tissue irritation. The chart notes further indicate that at the time of discharge on November 7, 2017, primarily myofascial issues remained. The physiotherapist encouraged self-massage and stretching, and recommended a home TENS unit, which MPIC funded for two months. The chart notes also reflect that the Appellant aggravated his condition with shoveling, and was able to resolve to baseline quickly. Counsel pointed out that this type of perturbation is what [Doctor 5] said is typical of the Appellant's degenerative condition. There is no evidence that the therapist requested further treatment.

MPIC funded 25 physiotherapy treatments following the Third MVA. The discharge report from the treating physiotherapist, dated June 25, 2018, indicates a diagnosis of lumbar sprain/strain and injury Category 1. It states that the Appellant's condition was much improved, and he was provided with exercise instruction. Again, a TENS unit was recommended, and MPIC funded this for two months. There is no evidence that the therapist requested further treatment.

Counsel submitted that although [Doctor 2] had recommended physiotherapy in September 2015, all of the Appellant's other health care providers ultimately recommended self-management for his symptoms, in the form of stretching, exercises and other techniques. The Appellant did provide a physiotherapy recommendation from June 2022; however, he said that his need for physiotherapy at that time arose due to an incident of gardening. Counsel submitted that this was not related to the MVAs because it was too far removed from them; rather, it was another example of how the Appellant's pre-existing back condition could be rendered symptomatic through activities of daily living. Counsel also referred to AC-18-042, in which the Commission stated that in determining whether additional physiotherapy treatments are medically required, there must be objective medical evidence supporting the requirement for treatment. He submitted that there is insufficient objective medical evidence to support the medical requirement for further physiotherapy treatment beyond what has already been provided by MPIC.

Further, counsel submitted that no MVA injury has been identified which would account for the Appellant's back pain so long after the MVAs. [Doctor 5] looked at the mechanism of the MVAs, and noted that the Appellant's lower back pain was not reported immediately following the First MVA. He said that if the injury had been significant, it would have had a much quicker onset. Dr. MacKay also noted, in his review of the diagnostic imaging, that although the First MVA could have aggravated the Appellant's pre-existing degenerative back condition, rendering it symptomatic for a period of time, he could not identify a permanent alteration to the Appellant's spine that had occurred as a result of the First MVA. He reviewed the documentation from the Second and Third MVAs, and could not conclude that they had done anything beyond further irritating the Appellant's spine.

Counsel submitted that it is not reasonable to conclude that an MVA which did not cause any acute injury could cause continuing back pain. The Appellant continued to work and carry on with his activities of daily living, all of which could cause back pain. Further, counsel noted that in spite of the Appellant's testimony, there is documentary evidence that he had experienced back pain prior to the First MVA. His physiotherapist's chart note from December 6, 2014, indicates that he had a prior right low back/hip injury from 1995. There is also a statement in [Doctor 4] report that the Appellant has a history of low back pain in his forties and fifties. Accordingly, on the basis of the medical opinion of [Doctor 4], who did not find a structural back injury caused by the MVAs, and primarily because there is no medical requirement for further treatment, counsel submitted that the Appellant is not entitled to funding for further physiotherapy treatments.

The Appellant's entitlement to funding for the medication Vimovo was then addressed by counsel. It is MPIC's position that there was a temporary irritation to the Appellant's pre-existing degenerative back condition caused by each of the MVAs. This may have caused his condition to become symptomatic for a period of time after each MVA, but the pain would not be ongoing and should have resolved. Vimovo was first prescribed to the Appellant on December 30, 2016. [Doctor 5], in his report dated February 26, 2018, opined that this medication was not prescribed due to the First MVA at that time. The Appellant's condition was resolving due to the physiotherapy treatment that he had received. Further, the medication was prescribed to the Appellant before the Second MVA, so it could not be considered to have been prescribed as a result of that MVA.

Counsel also addressed the Appellant's entitlement to funding for the medication Lyrica. It is MPIC's position that the Appellant did not suffer an L5 lumbar radiculopathy caused by any of

the MVAs. [Doctor 2], in his report from September 2015, found no radiculopathy at that time. [Doctor 3], in his report of June 28, 2017, found that the Appellant had the residue of having had a left L5 radiculopathy. The Appellant had some residual numbness in his left toes, but he did not have radicular pain at that time. In his report dated February 26, 2018, [Doctor 5] concluded that the Appellant did not exhibit signs of lumbar radiculopathy at the time of his examination by [Doctor 3]. He could not attribute the residual radiculopathy mentioned by [Doctor 3] to the First MVA, because there had been no clinical findings following that MVA to support a radiculopathy.

In his report dated June 10, 2019, [Doctor 5] noted that when the Appellant was seen by [Doctor 4], on February 8, 2019, that doctor made clinical findings that the Appellant had an L5 radiculopathy. [Doctor 5] concluded that the Appellant's radiculopathy developed some time after he was first seen by [Doctor 3] on June 28, 2017. Counsel pointed out that the Appellant was noted to have a normal neurological examination by his physiotherapist on June 25, 2018 (with tingling noted in the left great toe). As well, [Doctor 5] noted that in [Doctor 3] subsequent report of September 2019, there were no findings of radiculopathy, and so it must have resolved by that time. Further, the Appellant was noted to have a normal neurological examination by his physiotherapist in September 2022. Counsel noted that [Doctor 5] testified that radiculopathy can be present and then resolve. He submitted that any radiculopathy that the Appellant did have was not caused by any of the MVAs.

Further, counsel submitted that there was no period when radiculopathy was present and when Lyrica was prescribed to the Appellant, which would establish a causal connection between the need for Lyrica and an MVA. The first MVA was on December 1, 2014. The Appellant's general physician first gave him a sample of Lyrica on February 13, 2017. The Second MVA was on

June 25, 2017. Three days later, [Doctor 3] found that the Appellant had no radicular symptoms, but he had the residue of a resolving L5 radiculopathy. Counsel submitted that based on [Doctor 5] opinion, this radiculopathy cannot be causally related to the First MVA because there were no clinical findings to support it until the Appellant's visit to [Doctor 4] in February 2019. The Third MVA was on February 1, 2018. The only documentary evidence with respect to that MVA is the physiotherapist's discharge report dated June 25, 2018, but this indicates a normal neurological examination. In any event, even if the Appellant could establish that he suffered a radiculopathy caused by an MVA, MPIC submits, based on [Doctor 5] opinion, that Lyrica may be beneficial, but it is not medically required.

Counsel also submitted that, as indicated above, the documentary evidence reflects that any radiculopathy suffered by the Appellant was not permanent. [Doctor 5] testified that radicular findings could be idiopathic and often resolve, and that is most likely what occurred here. Counsel submitted that the evidence does not support a finding that the Appellant is entitled to a permanent impairment benefit with respect to an L5 radiculopathy in relation to the MVAs. [Doctor 5] was qualified as an expert in sports medicine, with experience in file review. Counsel pointed out that [Doctor 5] opinions are the only ones on file with respect to the medications and permanent impairment, and should be preferred. Counsel submitted that the Appellant's appeal should be dismissed.

**Discussion**:

The onus is on the Appellant to establish, on a balance of probabilities, the following:

1. That he is entitled to funding from MPIC for further physiotherapy treatment after October 6, 2016, as it relates to the injuries sustained in the MVAs;

2. That he is entitled to funding from MPIC for the medications Vimovo and/or Lyrica related to the injuries sustained in the MVAs; and
3. That he is entitled to a permanent impairment benefit as a result of the injuries sustained in the MVAs.

In making our decision, as set out below, we have thoroughly reviewed all of the reports and documentary evidence filed in connection with this appeal. We have given careful consideration to the testimony of the witnesses and to the submissions of the Appellant and of counsel for MPIC. We have also taken into account the provisions of the relevant legislation and the applicable case law.

1. Entitlement to Funding for Further Physiotherapy Treatment

Funding for physiotherapy expenses is governed under subsection 136(1) of the MPIC Act (set out above), which provides for "the reimbursement of expenses incurred by the victim because of the accident", including, in paragraph 136(1)(a), "paramedical care". Subsection 5(a) of the Expense Regulation (above) provides that MPIC shall reimburse physiotherapy expenses "when care is medically required". Accordingly, in order to be entitled to funding for further physiotherapy treatment, the Appellant must establish, on a balance of probabilities, that such treatment would be medically required treatment directed towards an injury sustained in one or more of the MVAs.

The Appellant is seeking further physiotherapy treatment for his lower back pain. The parties did not agree on the nature of the Appellant's MVA injuries, nor did they agree as to whether further physiotherapy treatment after October 6, 2016 would be medically required.

*MVA Injury*

The Appellant argued that he suffered a lower back injury in the First MVA, which was aggravated by the Second and Third MVAs. MPIC disputed this, and argued that the Appellant's injuries from the First MVA were cervical and upper back strain, as well as lumbar strain and mechanical back pain. It is MPIC's position that the Appellant did not suffer an alteration to his back caused by the MVAs. Rather, MPIC argued that the Appellant had a pre-existing degenerative back condition, and there was a temporary irritation to that condition caused by each of the MVAs.

The Appellant testified regarding his back pain. He stated that he had no lower back pain prior to the First MVA, and therefore believed that he suffered an acute back injury in the First MVA. He acknowledged that the assessment from the [text deleted] Hospital did not record lower back pain, but he said that the nurse did not record everything that he told her. The chart notes from his general physician from a visit of December 4, 2014, do record "pain to right side neck and right side lowe[r] back". Low back pain is also recorded in his general physician's chart notes from a visit of December 22, 2014.

In support of his position, the Appellant relied on a letter from his general physician dated April 1, 2016, which stated, in full, "[Appellant's] back pain is due to a motor vehicle accident in Dec 01/2014." This letter, which was written almost 18 months after the First MVA, did not provide any evidence or clinical findings to support the opinion given. The physician's chart note from that date states simply "in for the refills, doing same, nothing new." We therefore assign little weight to this letter.

The Appellant also referred to the diagnostic imaging, and submitted that it was supportive of his position. However, a review of the imaging reports reveals that, while they reflect the Appellant's degenerative condition, they do not appear to show acute changes. An x-ray on December 1, 2014, of his cervical, lumbosacral and thoracic spine noted the following impression: "I do not see any convincing evidence of an acute process within the surveyed regions." It did identify a wedge compression at T7, "likely of longstanding". A subsequent lumbosacral x-ray on February 17, 2015, did not show a wedge compression at T7, but did show one at T12, "of indeterminate age". A later x-ray of the thoracic region on November 22, 2016 showed no compression fractures. An MRI of the Appellant's lumbar spine on June 16, 2015, showed "multilevel degenerative disc disease", with a disc extrusion at L4-L5. A subsequent MRI on January 25, 2017 of the Appellant's thoracic and lumbar spine showed that the L4-L5 disc extrusion had resolved (although the possibility of L5 root irritation remained). No thoracic wedge compressions were identified.

[Doctor 5], in his testimony, noted that the documentary evidence reflects that the Appellant's lower back symptoms were not present immediately following the First MVA. At the Victoria Hospital, where in [Doctor 5] opinion a thorough assessment appears to have been done, the Appellant reported upper back symptoms, which is the neck and shoulders. It was not until a few days later that the Appellant reported lower back pain, which is farther down the spine. [Doctor 5] opined that if symptoms do not develop until two or three days after an MVA, that reflects a minor injury, with symptoms that should resolve quickly.

[Doctor 5] also reviewed the diagnostic imaging and opined that it did not establish that any acute structural changes were caused to the Appellant's spine by the MVAs; his pre-existing degenerative condition was not permanently altered. He said that if the Appellant had suffered an

acute injury in the First MVA, it would have had a quicker onset. [Doctor 5] also stated in his report dated September 2, 2015, that "It is possible that the [First MVA] adversely affected pre-existing problems involving the lumbar spine to the extent that symptoms developed." [Doctor 5] confirmed in his testimony that, based on his review of the documentation from the Second and Third MVAs, a similar irritation could have occurred for a period of time after the Second and Third MVAs as well. However, he could not identify anything from the MVAs that rendered the Appellant more susceptible to back issues than he would have been prior to the MVAs.

The panel accepts the testimony of the Appellant that he is suffering from lower back pain. We do understand the Appellant's conviction that the First MVA was the cause of a structural lower back injury; however, there is no medical evidence supporting his position. Rather, the only medical evidence directly addressing causation of a lower back injury is from MPIC's HCS medical consultant, [Doctor 5]. We find that he had the opportunity to review all of the medical reports, assessments and reports of interventions on the Appellant's file and was thorough and comprehensive in his analysis, and we accept his evidence. [Doctor 5] was of the opinion that there was no alteration to the Appellant's spine caused by the MVAs, although he was also of the opinion that each of the MVAs likely caused an irritation to the Appellant's degenerative back condition for a period of time.

Based on the evidence of [Doctor 5], we find that the Appellant has not met the onus of establishing, on a balance of probabilities, that he suffered a structural lower back injury caused by any of the MVAs. Also based on the evidence of [Doctor 5], we find that Appellant has met the onus of establishing, on a balance of probabilities, that there was a temporary irritation to his pre-existing degenerative back condition caused by each of the MVAs.

*Medical Requirement*

Based on our finding that there was a temporary irritation to the Appellant's pre-existing degenerative back condition caused by each of the MVAs, the next issue to consider is whether further physiotherapy after October 6, 2016 would be medically required. In AC-18-042, a recent decision referred to by counsel for MPIC, the Commission held that in determining whether additional physiotherapy treatments are medically required, the weight of the objective medical evidence must support the requirement for treatment.

The Appellant attended for physiotherapy treatment following the First MVA. His physiotherapist provided a report dated March 9, 2015, after 20 of the 24 treatments funded by MPIC had been provided. As indicated above, the physiotherapist noted that the Appellant had plateaued over the past 4 to 6 weeks. He did request an extension of treatments based on the T12 compression fracture identified on imaging. Further treatments were denied by MPIC based on [Doctor 5] opinion that the compression fractures were not caused by the MVA. However, subsequently, on October 9, 2015, MPIC authorized five further physiotherapy treatments to address the Appellant's ongoing lumbar symptoms. The Internal Review decision dated December 21, 2016 authorized reimbursement by MPIC of physiotherapy expenses up to October 6, 2016.

The Appellant's second physiotherapist provided a discharge report dated October 3, 2016, which stated: "Plateaued. Achy w/ overuse. No functional limitations. d/c [discharged] to home program." An invoice from the Appellant's second physiotherapist indicates that 32 treatments were provided between October 19, 2015 and September 16, 2016. (Although this invoice was issued directly to the Appellant, the Appellant was entitled to reimbursement from MPIC pursuant to the Internal Review decision noted above.)

The Appellant pointed to the recommendation for physiotherapy made by [Doctor 2], in his September 16, 2015 report, as supporting his position that further physiotherapy treatment would be medically required. However, we note that following [Doctor 2] report, the Appellant received 32 further treatments as set out above (ultimately funded by MPIC). There is no subsequent report from [Doctor 2] indicating his opinion as to the Appellant's further need for physiotherapy beyond the additional treatments provided.

The Appellant also referred to a letter from [Doctor 6], dated November 29, 2016, addressed "To Whom it May Concern", which recommended physiotherapy and massage therapy, to "Evaluate and treat re: chronic LBP secondary to MVA with underlying OA, some L leg radicular component." This is the only medical evidence supporting the Appellant's position that one of his health care providers recommended further physiotherapy treatment after funding by MPIC for such treatment was concluded.

Following both the Second and Third MVAs, the Appellant was discharged from physiotherapy to a home exercise program. The chart notes of the Appellant's physiotherapist for his last visit following the Second MVA, on November 7, 2017, state: "Primarily myofascial issues remain, encourage self massage, and stretching. Patient has completed program. Would potentially benefit from home TENS unit for self-management." Similarly, the discharge report from the Appellant's physiotherapist following the Third MVA, dated June 25, 2018, states that the Appellant's condition was much improved, and he was provided with exercise instruction. A TENS unit was recommended for home use. There is no evidence that either of these physiotherapists requested further treatment after the allotted sessions funded by MPIC were completed.

The Appellant himself said that it is very hard for him to say what more could be done for his back. He acknowledged that he does have perturbations of his symptoms depending on his activity level. For example, in June 2022, he experienced an exacerbation due to gardening, following which he went for physiotherapy treatment. A report from the physiotherapist dated September 13, 2022, states that a home exercise program was provided.

[Doctor 5], in his report dated September 2, 2015, noted that the Appellant's MVA injuries of cervical and upper back strain, including any adverse impact on the Appellant's pre-existing lumbar spine condition to the extent symptoms developed, would be considered WAD 2. MPIC's HCS physiotherapy consultant, [Physiotherapy 1], provided a report dated September 10, 2015, in which he said that for a WAD 2 injury, Category 1 physiotherapy (24 treatments) would be appropriate, and physiotherapy treatment beyond that would not be considered medically required. [Physiotherapy 1] provided a further report dated October 4, 2016, in which he confirmed that the diagnoses of lumbar strain and mechanical back pain would not qualify for treatment beyond Category 1 physiotherapy. He reiterated, "Treatment beyond Category 1 would not be considered medically required."

As indicated above, the letter from [Doctor 6] dated November 29, 2016, is the only objective medical evidence supporting the requirement for further physiotherapy treatment. As noted above, the Appellant's second physiotherapist provided a discharge report dated October 3, 2016, which noted that the Appellant had reached a plateau in his treatment, had no functional limitations, and had been discharged to a home program. This is consistent with all of his subsequent treating physiotherapists. Apart from [Doctor 6], all of the Appellant's health care providers recommended home exercises and self-management techniques such as self-massage, stretching and the use of a TENS machine for pain control. Further, MPICs HCS physiotherapy

consultant, [Physiotherapy 1], opined that for a WAD 2 injury, physiotherapy treatment beyond Category 1 physiotherapy (24 treatments) would not be considered medically required.

Considering all of the medical evidence, the panel finds that the weight of the objective medical evidence does not support the medical requirement for further physiotherapy treatment. As a result, we find that the Appellant has not met the onus to establish, on a balance of probabilities, that funding from MPIC for further physiotherapy treatment after October 6, 2016, is medically required.

2. Funding for Vimovo and Lyrica

Funding for medication expenses is governed under subsection 136(1) of the MPIC Act (set out above), which provides for "the reimbursement of expenses incurred by the victim because of the accident", including, in paragraph 136(1)(d), "expenses as may be prescribed by regulation". Section 38 of the Expense Regulation (above) provides that MPIC shall reimburse medication expenses where the medication was "required for a medical reason resulting from the accident". Accordingly, in order to be entitled to funding for Vimovo and/or Lyrica, the Appellant must establish, on a balance of probabilities, that such medication would be medically required for an injury sustained in one or more of the MVAs.

a) Vimovo

*MVA Injury*

The Appellant testified that he requires Vimovo to treat his lower back pain. As noted above, the panel has found that there was a temporary irritation to the Appellant's pre-existing degenerative back condition caused by each of the MVAs. Therefore, the next issue to consider is whether

Vimovo was medically required for the treatment of that irritation, in respect of any of the MVAs,

*Medical Requirement*

The only medical evidence from any of the Appellant's health care providers respecting Vimovo is found in the chart note of his general physician from December 30, 2016. In that note, which is two years subsequent to the First MVA, but prior to the Second MVA, it is recorded that the Appellant was there for "review of back pains". The most recent x-ray report, which showed no compression fractures, was also reviewed. The physician "suggested trial [of] Vimovo". The chart note also records the Appellant's "problem" as "mechanical back pain with underlying OA". There is no medical evidence from the Appellant's health care providers with respect to Vimovo following the Second or Third MVA.

[Doctor 5] testified that the irritation to the Appellant's spine following each MVA was a minor, temporary injury, with symptoms that should resolve quickly. He further said that Vimovo was prescribed several years after the First MVA, so it was hard to relate the need for Vimovo to that MVA; by that time, any MVA-related irritation should have resolved. In his report dated February 26, 2018, [Doctor 5] opined that Vimovo was "not medically required in the management of a MVC-related medical condition." The Appellant's low back pain was secondary to his underlying degenerative back condition. [Doctor 5] also testified that while the Appellant likely suffered further irritations to his condition following the Second and Third MVAs, there is not enough documentary evidence about those MVAs for him to conclude that Vimovo was medically required in the management of his condition following those MVAs.

The panel finds that [Doctor 5], in his testimony and in the preparation of his reports, had the opportunity to review all of the medical reports, assessments and reports of interventions on the Appellant's file and was thorough and comprehensive in his analysis, and we accept his evidence. Therefore, we find that the Appellant has not met the onus of establishing, on a balance of probabilities, that Vimovo was medically required to treat the temporary irritation to his pre-existing degenerative back condition caused by the MVAs.

As a result, we find that the Appellant has not met the onus to establish, on a balance of probabilities, that funding from MPIC for the medication Vimovo is medically required.

b) Lyrica

The Appellant testified that he requires Lyrica to treat his left L5 radicular pain and symptoms, which he said were the result of a radiculopathy caused by the First MVA. MPIC disputes that the Appellant suffered a left L5 radiculopathy caused by any of the MVAs. Therefore, that is a preliminary issue that must be determined. Once that is addressed, and if it is determined that the Appellant suffered a radiculopathy caused by an MVA, then the next issue to consider would be whether Lyrica was medically required to treat the Appellant's left L5 radicular pain and symptoms, in respect of any of the MVAs.

*MVA Injury*

As indicated, the parties disagree with respect to causation of an L5 radiculopathy. In his testimony, [Doctor 5] said that in order to establish radiculopathy, which involves a spinal nerve (here, L5), symptoms must be accompanied by clinical findings of myotomal deficits (muscle weakness) or dermatomal deficits (abnormal sensation). He noted that there can be other reasons

for symptoms that seem to reflect nerve impairment, such as myofascial issues or referred pain, but these would not support a diagnosis of radiculopathy due to the absence of these clinical findings. [Doctor 5] testimony was not challenged on this point, and we accept it.

The Appellant testified that he experienced left L5 radicular pain and symptoms of pain in the back of his left leg and tingling in his toes immediately following the First MVA on December 1, 2014. The numbness in his toes became much worse in February and March, 2015. In support of his position that his radiculopathy was caused by the First MVA, the Appellant relied on the June 28, 2017 report of [Doctor 3], which found that the Appellant had the residue of a radiculopathy and that the numbness in his toes was likely to remain permanent. He also pointed to the June 16, 2015 MRI, which showed an L4-L5 disc extrusion that had not been identified prior to the First MVA.

The panel has reviewed the documentary medical evidence, and we note that there is no medical report from any of the Appellant's treating health care providers that states that he suffered a radiculopathy that was caused by an MVA. Two health care providers who treated the Appellant did find evidence of radiculopathy, at different times: [Doctor 3], in his June 28, 2017 report, found that the Appellant had "the residuum of having had a left L5 radiculopathy", and [Doctor 4], in his February 8, 2019 report, found that the Appellant had "legitimate findings of left L5 radiculopathy". However, neither of those doctors stated in their reports that the Appellant's radiculopathy was caused by an MVA.

In contrast, the evidence of [Doctor 5] was that any radiculopathy suffered by the Appellant was not caused by an MVA. He testified that the most common cause of lumbar radiculopathy is idiopathic, having no known cause. He said further that radiculopathies resolve in the vast majority of cases. Based on [Doctor 2] September 16, 2015 report, which found no evidence of

radiculopathy, [Doctor 5] was of the opinion that the Appellant did not develop a radiculopathy as result of the First MVA. He acknowledged that in [Doctor 3] June 2017 report there was an indication that the Appellant may have had a radiculopathy at some stage, but [Doctor 3] found that it was resolving at that time, and the electrophysiological tests were normal. [Doctor 3] made no neurological findings, and he made no correlation of the Appellant's symptoms to the First MVA.

[Doctor 5] pointed out that the January 15, 2017 MRI showed that the L4-L5 disc extrusion shown on the June 16, 2015 MRI had mostly resolved. There was still some narrowing, but the L5 root was not compressed or displaced at that time. He opined that while the Appellant exhibited some symptoms, they were not neuropathic in origin. In [Doctor 5] view, the Second and Third MVAs did not factor significantly into the Appellant's presentation. He agreed with [Doctor 4] findings, in his February 8, 2019 report, that the Appellant at that time had legitimate findings of radiculopathy, but [Doctor 5] said that was a new finding, which was temporary and subsequently resolved. [Doctor 5] stated in his report dated June 10, 2019:

> Presently the claim file does not contain evidence indicating [Appellant] examination, following the incident in question [First MVA], revealed positive nerve tests or consistent myotomal and/or dermatomal dysfunction. It is difficult to comprehend how a L5 myotomal weakness (as noted by [Doctor 4]) developed after an event that took place over four years previously when assessments performed before [Doctor 4] exam did not identify myotomal weakness or clinical findings in keeping with an active radiculopathy.

He opined that the clinical findings that supported the diagnosis of radiculopathy for a period of time did not support a causal relationship to any of the MVAs.

The panel has reviewed the documentary medical evidence, and finds it to be supportive of the opinion of [Doctor 5], as follows:

- There is no record of the Appellant reporting any left L5 radicular symptoms to any of his health care providers immediately following the First MVA, although he did report various other symptoms, including initially neck pain, upper back pain and mild tingling to fingers (Victoria Hospital, December 1, 2014), and subsequently lower back pain (general physician chart notes, December 4 and 22, 2014). The first record of radicular-type symptoms appears in a February 11, 2015 intake form of the Appellant's chiropractor. Similarly, symptoms of "tingling and numbness, aching shooting pain, and burning in his low back, buttock and posterior legs bilaterally (left > right)" are recorded in a report from the Appellant's physiotherapist dated March 9, 2015. However, the accompanying therapy report from the physiotherapist records a normal neurologic examination.

- This normal neurologic examination is consistent with other examinations of the Appellant following the First MVA: a February 9, 2015 chart note from the Appellant's general physician records that lower limb strength was 5/5, there were no neurological signs, no weakness in lower limbs and sensation in lower limbs was normal; a March 26, 2015 report from [Doctor 1], sports medicine specialist, records that "dermatomes, myotomes and deep tendon reflexes were normal and symmetric"; and the September 16, 2015, report from [Doctor 2], neurosurgeon, states "I could not detect any obvious sensorimotor deficit at the lower extremities. […] I cannot detect any obvious signs of frank ongoing radiculopathy."

- One year later, a physiotherapy progress report dated September 16, 2016 records that "SLR [straight leg raise]" was negative, and myotomes were normal. A few months later, on November 28, 2016, the chart note of the Appellant's general physician records the first reference to radicular symptoms in those records, identifying a subjective complaint of "radicular symptoms to the left leg". The only objective measurement is "SLR positive left".

- Three days following the Second MVA, the Appellant was seen by [Doctor 3], a physiatrist with a specialty in neurophysiology, who provided a report dated June 28, 2017 (as noted above). While the report notes that the Appellant's right foot and right hand symptoms arising from the Second MVA were not investigated, any left L5 radicular issues arising from the Second MVA (or earlier) would have been assessed in the testing done by [Doctor 3]. The results of his report are noted above. A few months later, a chart note from the Appellant's physiotherapist dated October 31, 2017, which was one week prior to discharge after 24 treatments following the Second MVA, records "unremarkable" myotomes and "lower leg and thigh normal sensation."

- Subsequent to the Third MVA, a report from the Appellant's physiotherapist dated June 25, 2018, which was provided upon discharge after 25 treatments following the Third MVA, records a normal neurologic examination, noting tingling in the left great toe. Seven months later, the February 8, 2019 report from [Doctor 4], a physiatrist, identifies that the Appellant had legitimate findings of left L5 radiculopathy, confirmed both clinically and with MRI findings (as indicated above). Subsequently, a September 9, 2019

> report from [Doctor 3] records that "power is grade 5 and there is no dermatomal deficit." A September 13, 2022 report from the Appellant's physiotherapist records that the Appellant's neurological examination was normal.

The panel finds that [Doctor 5], in his testimony and in the preparation of his report, had the opportunity to review all of the medical reports, assessments and reports of interventions on the Appellant's file and was thorough and comprehensive in his analysis, and we accept his evidence. Based on the evidence of [Doctor 5] and the supporting medical evidence, we find that the Appellant has not established, on a balance of probabilities, that he suffered a left L5 radiculopathy that was caused by any of the MVAs.

*Medical Requirement*

As indicated, we have found that the Appellant has not established that a left L5 radiculopathy was an injury that was caused by any of the MVAs. Based on the legislation referred to above, this precludes a finding that Lyrica would be medically required to treat any left L5 radicular pain and symptoms.

As a result, we find that the Appellant has not met the onus to establish, on a balance of probabilities, that funding from MPIC for the medication Lyrica is medically required.

3. Entitlement to a Permanent Impairment Benefit

Subsection 127(1) of the MPIC Act provides a permanent impairment ("PI") benefit to "a victim who suffers permanent physical or mental impairment because of an accident". Schedule A to the PI Regulation lists permanent deficits that may have been caused by an accident.

The Appellant is seeking a PI benefit for his left L5 radiculopathy. MPIC does not dispute that Schedule A to the PI Regulation contains a category for such an impairment (Division 2, subdivision 4, table 2.1); rather, the dispute is regarding the Appellant's entitlement to a PI benefit under this provision. Pursuant to the legislation, in order to be entitled to a PI benefit for L5 radiculopathy, the Appellant must establish, on a balance of probabilities, that he suffered a left L5 radiculopathy, that it was caused by an MVA, and that it was permanent.

As noted above, we have found, based on the medical evidence, that the Appellant has not established, on a balance of probabilities, that he suffered a left L5 radiculopathy that was caused by any of the MVAs. This precludes a finding that the Appellant suffered a permanent impairment "because of an accident", which is required under the legislation for entitlement to a PI benefit.

As a result, we find that the Appellant has not met the onus to establish, on a balance of probabilities, that he is entitled to a PI benefit in respect of a left L5 radiculopathy.

Conclusion

As indicated above, the panel finds as follows:

1. That the Appellant has not met the onus to establish, on a balance of probabilities, that funding from MPIC for further physiotherapy treatment after October 6, 2016, is medically required;
2. That the Appellant has not met the onus to establish, on a balance of probabilities, that funding from MPIC for the medications Vimovo and Lyrica is medically required; and
3. That the Appellant has not met the onus to establish, on a balance of probabilities, that he is entitled to a permanent impairment benefit in respect of a left L5 radiculopathy.

**Disposition:**

Accordingly, the Appellant's appeal is dismissed, and the Internal Review decisions dated December 21, 2016 and November 8, 2018 are therefore upheld.

Dated at Winnipeg this 15th day of December, 2022.

**JACQUELINE FREEDMAN**

**LORNA TURNBULL**

**SANDRAOAKLEY**