Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-18-042

PANEL:	**Jacqueline Freedman, Chair** **Leona Barrett** **Linda Newton**
APPEARANCES:	**[Text deleted] (the "Appellant") was self-represented; Manitoba Public Insurance Corporation ("MPIC") was represented by Anthony Lafontaine Guerra.**
HEARING DATES:	**February 7, 8 and 9, 2022.**
ISSUES:	**Whether the Appellant is entitled to funding from MPIC for further physiotherapy treatment after December 17, 2017.**
RELEVANT SECTIONS:	**Paragraph 136(1)(a) of The Manitoba Public Insurance Corporation Act (the "MPIC Act") and subsection 5(a) of Manitoba Regulation 40/94.**

AICAC NOTES: THIS DECISION HAS BEEN EDITED TO PROTECT THE APPELLANT'S PRIVACY AND TO KEEP PERSONAL INFORMATION CONFIDENTIAL. REFERENCES TO THE APPELLANT'S PERSONAL HEALTH INFORMATION AND OTHER PERSONAL, IDENTIFYING INFORMATION HAVE BEEN REMOVED.

Reasons For Decision

Background:

The Appellant was injured in a motor vehicle accident on December 20, 1999 (the "MVA"). She suffered injuries as a result of the MVA, including soft tissue injuries to her neck, back and left shoulder, along with headaches and dizziness. She received treatments pursuant to the Personal Injury Protection Plan ("PIPP") provisions of the MPIC Act, including physiotherapy treatment.

In a February 22, 2006 decision, the Commission determined that the Appellant's vestibular condition, cervical vertigo, was caused by the MVA. The Commission's decision further provided that the Appellant would be entitled to reimbursement for treatment expenses that she had incurred, which included physiotherapy treatment.

MPIC reimbursed the Appellant for the physiotherapy expenses that she had incurred, and continued to fund physiotherapy treatments thereafter for several years.

On July 31, 2017, the [Appellant's physiotherapist # 1], submitted a report requesting funding for further physiotherapy treatment. This request was reviewed by the case manager, and the medical information was reviewed by MPIC's Health Care Services ("HCS") physiotherapy consultant. The case manager issued a decision dated October 16, 2017, which states, in part, as follows:

> Following a review of the medical information in collaboration with our Health Care Services Team on August 24, 2017, we are no longer able to fund physiotherapy treatments effective immediately and any further treatment is elective. […]
>
> The noted medical reports since February 26, 2006, including the Health Care Services opinions of December 11, 2012 and most recently August 24, 2017, do not objectively identify an improvement in your overall condition after 723+ treatments received to the extent you are able to function at a higher level for an injury that took place 18 years ago. This form of supervised in clinic care as describe[d] by [Appellant's physiotherapist # 1] is not considered medically required and can be performed at home.

The case manager's decision provided the Appellant with two months of physiotherapy treatments, to December 17, 2017, in order to wean off and participate in a home program. The Appellant disagreed with the decision of the case manager and filed an Application for Review. The Internal Review decision, dated March 26, 2018, upheld the case manager's decision. It provides, in part, as follows:

> Coverage for treatment benefits is governed by Section 5 of Regulation 40/94. Coverage is only available where the care is "medically required".

> MPI's Physiotherapy Consultant has reviewed your claim file on several occasions with regards to the medical requirement of continued physiotherapy treatment. The physiotherapy consultant provided an opinion based on the balance of probabilities, that there is no indication further physiotherapy treatment is deemed "medically required" within the meaning of the legislation. The consultant opined your "condition *would be considered at maximum medical improvement. The motor vehicle accident occurred in 1999 – approximately 18 years ago. The physiotherapy treatment appears to be focused on symptom relief. The clinic notes do not indicate ongoing physiotherapy assessment nor do they reflect any significant improvements in condition*".
>
> […]
>
> Based on the totality of the medical information on file, there is no objective medical information supporting that further physiotherapy treatment would be deemed "medically required" within the meaning of PIPP legislation and directly related to the accident of December 20, 1999.
>
> There is sufficient evidence to support the decision under review and no basis has been shown for interfering with the decision [of] October 16, 2017. I am therefore confirming the case manager's decision and dismissing your Application for Review.

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

Issue:

The issue which requires determination on this appeal is whether the Appellant is entitled to funding from MPIC for further physiotherapy treatment after December 17, 2017.

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:

- That the Appellant has not met the onus to establish, on a balance of probabilities, that further regular physiotherapy treatment after December 17, 2017, is medically required. As such, the Appellant is not entitled to funding (reimbursement) from MPIC for the regular physiotherapy

treatments that she has received from the [Appellant's physiotherapy clinic] since December 17, 2017; and

- That the Appellant has met the onus to establish, on a balance of probabilities, that a vestibular assessment and treatments (as recommended) by a physiotherapist trained to provide advanced vestibular treatments are medically required. As such, the Appellant is entitled to funding from MPIC for such assessment, and for any such recommended treatments.

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 advance of the appeal hearing, on January 26, 2022, a Case Conference was held with the parties, to clarify the issue under appeal. One matter discussed was the Commission's prior decision of February 22, 2006. The parties confirmed that there was no dispute with the Commission's finding that the Appellant's cervical vertigo was caused by the MVA.

Also discussed at the Case Conference on January 26, 2022, was the issue of "supportive care" as it related to the physiotherapy treatment that the Appellant received in the past and was seeking in the appeal. The definition of "supportive care" that the Commission has applied in past cases was reviewed with the parties (see page 31 below). The Commission's letter to the parties, dated January 27, 2022, summarizes the discussion that followed:

> Mr. Lafontaine Guerra confirmed, based upon the above definition, that he completely agreed that this case is about "supportive care" and further agrees that MPIC has historically proceeded on the basis of funding supportive care to [the Appellant]. MPIC has interpreted the reports from messrs [the Appellant's physiotherapists #1 & #2] as providing supportive care to [the Appellant]. [The Appellant] stated that she agreed with this positon, as well.

> I advised that the Commission considered obtaining a further report from [the Appellant's physiotherapy clinic], in response to the final HCS report of [MPIC's physiotherapist], which of course would delay the hearing. Mr. Lafontaine Guerra commented that the file documentation is clear that [the Appellant's] physiotherapy care has been in the form of supportive care, which has been commented upon by Messrs. [the Appellant's physiotherapist #1], in particular at Tab # 442. MPIC would not be surprised, and in fact anticipated, that [the Appellant's physiotherapist #2] would testify to supportive care at the hearing. MPIC opposed a delay to the hearing.
>
> [The Appellant] agreed that she will call [Appellant's physiotherapist #2] to address the issue of supportive care. She confirmed her understanding that the issue of her ongoing physiotherapy treatments is based on the fact that she has reached maximum therapeutic benefit. She will testify to how the ongoing physiotherapy helps her manage her dizziness and pain, which she relates to her cervical vertigo. [The Appellant] did not feel it necessary to obtain a further report and did not wish to delay her hearing.

The hearing proceeded on that basis.

Opening Statements:

After concluding discussions of the preliminary matters, the parties were then invited to give opening statements. The Appellant did not make an opening statement. Counsel for MPIC briefly stated MPIC's position, which will not be summarized here, as it was reflected in MPIC's submission, below.

Legislation:

The relevant provisions of the MPIC Act are as follows:

> **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;
>
> […]

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 "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;

[…]

Evidence for the Appellant:

The Appellant relied on numerous medical reports from her health care providers in support of her appeal. She also testified at the hearing, along with her husband and her treating physiotherapist, [Appellant's physiotherapist #2].

The Appellant:

As indicated, the Appellant testified and was cross-examined at the hearing of her appeal.

She said that prior to the MVA, which occurred when she was [Text deleted] years old, she was healthy and strong, and could handle her job as a [text deleted]. As a consequence of the MVA, she suffered intense whiplash. She did not get better after treatment with her first physiotherapist, [Appellant's physiotherapist #3], and she was not able to return to work; in fact, she got worse by April, 2000. She then went for a reconditioning program to [Appellant's rehabilitation clinic], from

May to August, 2000. However, the more conditioning she did, the worse she felt, and her dizziness increased. At that time, the only thing that made her feel better was the treatment she received from the physiotherapist there, [Appellant's physiotherapist #4]. However, she was still not able to return to work and was looking for answers. Having in mind that the physiotherapist at [the Appellant's rehabilitation clinic] had helped, she looked for another physiotherapist, and she had an assessment by [Appellant's physiotherapist #1] in October, 2000. He became her treating physiotherapist and continued to treat her until his death in late 2021, when his practice was taken over by, [Appellant's physiotherapist #2].

The Appellant noted that she has a cervical vestibular disorder and said that physiotherapy treatment allows her to live with this disorder. She described her symptoms as including headaches, dizziness, upper back and left shoulder swelling, postural changes, back pain, muscle spasms, left arm pain, TMJ and jaw pain, with the primary source of pain being the left side of her neck. There are times when she finds it difficult to cope because of the pain, dizziness and headaches. These symptoms can affect her ability to function and perform her activities of daily life, and can vary depending on her activities. If she does more physically demanding tasks, like cleaning her house and lifting heavy groceries or shoveling snow, her symptoms will worsen. However, the Appellant noted that inactivity is not the answer, because staying in bed all day would only make her worse. She does exercises, as well as stretching, and does walk around her house. She does not want to walk too far in case she needs help, because she is often alone as her husband is away [text deleted].

The physiotherapy treatment that the Appellant receives, previously from [Appellant's physiotherapist #1] and now from [Appellant's physiotherapist #2], relieves her headaches and dizziness, and takes away the pain in her upper back, shoulder, TMJ area and behind her left ear. After the physiotherapy treatments, she feels better. The headaches, dizziness and upper back pain

are never really gone entirely, but they are relieved sufficiently such that she can live her life. Prior to a physiotherapy treatment, her clothing often feels tight and she is sitting in a stiff and uncomfortable position in her car. When she leaves the treatment, her clothing feels more comfortable and she can change the position of her seat in the car because she has more strength. The Appellant said that the physiotherapy treatment can even improve her hearing, although her hearing condition is not related to the MVA.

The Appellant noted that during the COVID pandemic, there was a two-month lockdown when she was not able to go for physiotherapy treatment. During that period of time, her husband did some massage for her, and she utilized some heat and ice treatments at home, so that she could cope. However, by the end of those two months, she was "all but bedridden". Her husband had to drive her to the clinic because she was so dizzy. It took one or two treatments before she felt any difference, and then she started to feel better again. The Appellant would prefer not to have to go for physiotherapy treatments, but when she is in pain, she knows that she will be sick if she does not go. She said that she knows that she will feel better after the treatment.

The Appellant said that she tries not to take medication for her headaches and pain, because it causes difficulty for her digestive system. She does take some Tylenol 3 pills, but tries to limit their use. She prefers to manage her pain by going for physiotherapy treatment.

The cross-examination of the Appellant briefly covered the Appellant's education, family circumstances, and pre-MVA employment, as well as the circumstances of the MVA. The Appellant was also questioned regarding subsequent accidents that she was involved in following the MVA, including one on January 9, 2002, when her vehicle went off the track in a car wash, one on July 1, 2004, when her vehicle was hit on the driver's side, and one on April 21, 2014, when her vehicle's

rear door was hit. The 2004 accident resulted in a new injury, to her jaw, with consequent TMJ symptoms. Other than that, the subsequent accidents did not result in new injuries; they did, however, exacerbate the condition already existing from the MVA.

Counsel questioned the Appellant regarding the physiotherapy treatment she received from [Appellant's physiotherapist #3 and Appellant's physiotherapist #4]. She said that while she initially found [Appellant's physiotherapist #3's] treatment to be of some benefit, in retrospect certain things he did were detrimental. He was starting to push her to do more things than she was able to do. Weights and strengthening exercises were making her feel worse. She said [Appellant's physiotherapist #3's] began to question whether she was suffering from a disc protrusion. She preferred the physiotherapy treatment she received at [the Appellant's rehabilitation clinic] from [the Appellant's physiotherapist #4], which made her feel better, and which she characterized as comfort physiotherapy. It involved resistance, traction, mobilization, massage, heat and ice. Other portions of the reconditioning at [the Appellant's rehabilitation clinic] involved strength training, including lifting and pushing, and using a truck simulator. Although her experience with [the Appellant's physiotherapist #4] was more positive than her experience with [the Appellant's physiotherapist #3], she felt that her condition did not improve after her program at [the Appellant's rehabilitation clinic], but rather worsened.

The Appellant was asked why she went to seek treatment with [the Appellant's physiotherapist #1] if physiotherapy had not improved her condition. She said that she wanted to seek a second opinion. She was looking to see if there was a treatment that could help her, because at that point she was only 10 months post-MVA. She sought an opinion from [the Appellant's physiotherapist #1] and also from a chiropractor, and decided to seek treatment from [the Appellant's physiotherapist #1]. She had felt better from the physiotherapy treatment at [the Appellant's rehabilitation clinic], and reasoned that

perhaps additional physiotherapy treatment would improve her condition. She explained that [the Appellant's physiotherapist #1]. performed mobilizations, traction, and resistance treatments to her neck and upper back that had not been done by the other therapists, as well as a traction resistance movement behind her left ear. These provided very good relief for her.

Counsel questioned the Appellant regarding the frequency of her physiotherapy treatments since funding was terminated by MPIC as of December 17, 2017. The Appellant explained that prior to the COVID pandemic, she was seeing [the Appellant's physiotherapist #1] once or twice per week. Since the onset of the pandemic, frequency has been reduced to once every two weeks, which is the bare minimum that she requires. The longest period that she went without treatment was during the two month period that the clinic was closed in March and April, 2020, during the pandemic lockdown. Otherwise, there have been occasional periods over the years when she has gone on a 10 to 12 day driving trip with her husband. In those cases, she would plan the trip to make sure she would have a physiotherapy treatment on the Friday before departure and again immediately on return home, so she could only miss one week of treatment. The relief provided by the physiotherapy treatment can last from one to two days, or up to 5 to 6 days, depending on what she does. When asked if she had considered consulting with another physiotherapist, about the possibility of another regime, to see if she could get better relief, the Appellant said she would consider anything other than medication, if it would give her relief, even if it was not physiotherapy.

Counsel questioned the Appellant regarding her statement that one of the benefits of physiotherapy treatment is that it allows her to reduce her medications. She said that in saying this, she was referring to opiates, pain medications that can be addictive and detrimental to her body. She does take Tylenol 3, but prefers to try to use naproxen or Tylenol Arthritis, to avoid gastric irritation. She now requires acid reflux medication due to the effect that these medications have had on her. Her use of Tylenol 3

has gone up since the onset of the pandemic, when her frequency of physiotherapy treatment decreased. In addition, when she was not able to access physiotherapy during the lockdown, her use of Tylenol 3 further increased. Prior to the pandemic, the Appellant estimated that she was using Tylenol 3 two to three times per month. Since the onset of the pandemic, she estimates that she is now using it once or twice per week. During the period of lockdown, she was using it twice to three times per week.

The Appellant was questioned regarding her visit to [the Appellant's physician] at the [Text deleted] Clinic in late 2009, who had recommended trigger point needling. She said she was surprised, when reading the indexed file, to find that it had been intended that she return for a follow-up visit, as that had not been communicated to her. Her recollection of the appointment with [Appellant's physician] is that he told her that things had been left for a very long time, and although he could do the treatment, it could make her worse.

Counsel questioned the Appellant regarding the psychological treatments that she received from [Appellant's psychologist]. The Appellant said that she didn't find the treatments necessary, because she did not have depression and still doesn't. She agreed that she believed her problem to be physical and not psychological, and that is why she discharged herself from his care.

[Appellant's husband]:

[Text deleted] is the Appellant's husband. He testified and was cross-examined at the hearing.

He said that he has seen firsthand the benefits that the Appellant receives from her physiotherapy treatments with [the Appellant's physiotherapist # 1]. Before she goes for a physiotherapy treatment, there is a certain level of rigidity to her muscles, her left shoulder gets swollen, her eyes go chalky

grey and she gets quiet. Occasionally, the pain will be so significant that it causes vomiting. When she comes home from a physiotherapy treatment, she is much more mobile, and she is more open emotionally. He has previously seen [the Appellant's physiotherapist #1] perform a movement from behind to reset her muscles. During the pandemic, [the Appellant's husband] personally has become her masseuse. He estimates that the Appellant gets 3 to 4 days' benefit from a physiotherapy treatment. He knows that the Appellant does not want to become dependent on medication.

On cross-examination, [the Appellant's husband] confirmed that he has seen the Appellant increase her medication use when she was not able to access physiotherapy treatment. He explained that when she is without treatment, she will tell him that she is not feeling well, and the pain is building up, and then she will take some pain killers. If he is at home, he will massage her. The medication, specifically Tylenol 3, will help her sleep. Since the onset of the pandemic, her use of Tylenol 3 has increased, since it has been harder to go for physiotherapy treatment.

[Physiotherapist #2]:

[Physiotherapist #2] is the Appellant's treating physiotherapist. In addition to his testimony at the appeal hearing, he provided a report (co-authored with [the Appellant's physiotherapist #1]) dated August 19, 2020. Also forming part of the documentary evidence were prior reports and chart notes prepared by [the Appellant's physiotherapist #1], who had been the Appellant's primary treating physiotherapist until the time of his death.

[The Appellant's physiotherapist #2] described his education and experience. He has a Bachelors of Medical Rehabilitation (physical therapy) from the University [text deleted], as well as a Masters in Clinical Sciences (manual and manipulative therapy) from the University [text deleted]. His Masters

research project involved exercises for mechanical neck disorders. He was qualified as an expert in physiotherapy, with a specialty in exercises for mechanical neck disorders.

[The Appellant's physiotherapist #2] has been providing physiotherapy treatment to the Appellant over the last three years. The Appellant had provided to [the Appellant's physiotherapist #2] the definition of "supportive care". He described his practice, and said based on the definition, it struck him that approximately 80% of his practice would be supportive care patients, in that he treats numerous patients on an intermittent or recurrent basis for things such as chronic knee and hip conditions, and plantar fasciitis. With respect to the treatment of the Appellant, it is fairly routine. When she attends for a treatment, he does a biomechanical assessment. He then performs treatment, including manual therapy, massage, joint work, myofascial release, cupping, and stretching. He will also advise her regarding what she could do at home to maintain the gains she achieves from the treatment.

He said that the Appellant requires physiotherapy treatment on a biweekly basis to maintain management of her symptoms. Reflecting on the definition of "supportive care", he said he would equate the physiotherapy treatments that she receives to a pain management regime. She has "micro-doses" of improvement from the treatment. Without treatment, she suffers small deteriorations, such as increases in headaches and dizziness. The physiotherapy treatments then improve her condition. There are certain things the Appellant can do at home to decrease her symptoms, and he has taught the Appellant's husband to do some things for her, but there are other things that [he] does in the clinic that the Appellant cannot do herself, such as mobilizations. He would not be providing those treatments to her if she could do them herself at home.

On cross-examination, [the Appellant's physiotherapist #2] was questioned regarding the material that had been provided to him for review in advance of the hearing. He confirmed that the Appellant

had only provided to him the most recent HCS report, authored by [MPIC's physiotherapist], dated April 15, 2021. He also confirmed that the Appellant has been a patient of the [the Appellant's physiotherapy clinic] since the fall of 2000. She currently attends approximately once every two weeks, although if she is too dizzy she may cancel an appointment. Aside from the closure during the pandemic lockdown for approximately six weeks, there were no other pandemic restrictions at the clinic.

Counsel questioned [the Appellant's physiotherapist #2] regarding what type of assessments he performs on the Appellant at each visit. With regard to whether he does an assessment of the Appellant's range of motion or other physical signs in connection with her performance of home exercises, [the Appellant's physiotherapist #2] said that he sometimes does that. Assessments are not done at every visit. A typical visit involves asking the Appellant to list her complaints, and doing a biomechanical assessment such as lifting her arm or leg. He does not do measurements, although if MPIC were to ask him to do that he could. In his view, on a day-to-day basis there is not much use in taking measurements. If her arm did not go up, then he would do the treatment that is necessary to address that and see if he could make it better. Regarding specific treatment, he performs mobilization on the Appellant, which is a hands-on technique on her spine, moving one bone on another. Occasionally he performs traction, which involves a mechanical machine to effect spinal decompression. Other manual therapy includes myofascial release, cupping and massage. He acknowledged that the use of heat and ice were treatments that the Appellant could perform herself. She has been given exercises to perform at home, and he will typically give her one thing to think about until the next treatment.

[The Appellant's physiotherapist #2] agreed that vertigo is complicated. He was of the view that cervical vertigo is something that is within the scope of practice of many physiotherapists. In the

Appellant's case, it is believed that her vertigo is affected to a large degree by her neck function. Neck related vertigo comes from the four discs at the very top of the neck, and this can be addressed by myofascial release. It is a mechanical issue, involving miscommunication between the eyes, ears and neck, and so he would treat the neck muscles. Counsel questioned [the Appellant's physiotherapist #2] as to whether he would assess the Appellant's vertigo symptoms, such as vision, dizziness or balance issues. [The Appellant's physiotherapist #2] said although he has a reasonable understanding of these issues because he was exposed to them, along with vestibular issues, during his education, he is not qualified to test vision or come up with solutions.

Counsel questioned [the Appellant's physiotherapist #2] regarding whether the Appellant had reached maximum medical improvement. He said that that was not a definition he would use, because the Appellant receives micro-doses of improvement in pain and range of motion from treatment. While he would not expect her to fully recover, he does believe he can prevent deterioration. He was also asked about the concept of supportive care. [The Appellant's physiotherapist #2] said he had not seen that definition before, but he liked it. He agreed that the term is not used in physiotherapy, but said he would talk instead about maintenance or compensation treatment for a chronic issue. He said his role would be to try to do what he could for the patient. Eighty percent of his patients would fall into this maintenance or supportive care category. He has been practising for 15 years, and it is not uncommon that a patient would be treated for that length of time.

[The Appellant's physiotherapist #2] was asked whether there was any documented assessment of the Appellant's condition immediately before and immediately after the pandemic lockdown. He acknowledged that there was no such assessment; [the Appellant's physiotherapist #1's] chart notes were perhaps not as thorough as they could have been after 40 years in practice. Similarly, there are no details in the chart notes regarding the specific medication(s) which the Appellant may be able to

reduce due to physiotherapy treatment. [The Appellant's physiotherapist #2] acknowledged that he relied on the Appellant regarding this information.

In response to the question of why he felt the Appellant's condition would deteriorate in the absence of treatment, [the Appellant's physiotherapist #2] said that he can feel the difference in her neck muscles and joints after they have been worked on. He can see the difference in her ability to move and in her muscle tension. He cannot interpret how much vertigo she has, but he believes that the neck treatments are helping.

[The Appellant's physiotherapist #2] agreed that the Appellant should remain active, but was firm that she would deteriorate without his physiotherapy treatment. He acknowledged that the benefits from his treatments are short-term, but was firm that there are benefits, which he called micro-doses of improvement.

[The Appellant's physiotherapist #2] agreed that the Appellant's injury is chronic. However, he did not agree that physiotherapy treatment would be inappropriate for somebody with chronic pain. In his view, the patient should be able to direct their own care. He was not of the view that the Appellant had any dependence issues, but he agreed that if one of her other treating practitioners were of that view, he would like to be made aware and would take it into consideration.

Counsel asked [the Appellant's physiotherapist #2] if the Commission were to find that supportive care was required, whether he would recommend any additional assessments. [The Appellant's physiotherapist #2] said that it would be possible to assess the Appellant, possibly annually, by such measures as a pain scale and a neck disability index assessment. He also suggested that it may be helpful to have the Appellant assessed by someone who specializes in eye tracking. In response to

the question of whether there would be anything that he could do related to the Appellant's vertigo, [the Appellant's physiotherapist #2] responded that he could test her cervical range of motion and the strength of her neck muscles. If she reached a point where her neck was "good", she would likely no longer require treatment from him.

Evidence for MPIC:

In addition to numerous HCS medical reports and case managers' file notes on which MPIC relied, MPIC called as a witness one of its HCS consultants, [MPIC's physiotherapist].

[MPIC's physiotherapist]:

[MPIC's physiotherapist] is a physiotherapy consultant for MPIC's HCS team. In addition to his testimony at the appeal hearing, he reviewed the Appellant's file and provided HCS reports dated December 11, 2012, August 24, 2017, October 23, 2018 and April 15, 2021. Prior to his engagement as a physiotherapy consultant with MPIC's HCS department, [MPIC's physiotherapist] also conducted a functional physical assessment of the Appellant at the request of MPIC and provided a report dated May 8, 2006.

[MPIC's physiotherapist] described his education and experience. He has a Bachelors of Medical Rehabilitation (physical therapy) from the University [text deleted], and has taken several continuing education courses since that time. He has been a practising physiotherapist for 24 years, and presently works at [Text deleted], a multidisciplinary clinic and fitness facility. [MPIC's physiotherapist] has been a physiotherapy consultant with MPIC since 2010. Since that time, he has conducted many forensic file reviews, in which he conducts a review of the entire file, including medical and non-medical documents, in order to determine whether treatment is warranted. He was qualified as an expert in physiotherapy and in forensic document review.

He described cervical vertigo, which he said is a vestibular disorder that is associated with neck pain and cervicogenic dizziness. Although he has taken courses on vestibular treatment, treating cervical vertigo is not part of his clinical focus. He does treat BPPV (benign paroxysmal positional vertigo), which is a different kind of dizziness, caused by a mismatch of perception of head movement; the main treatment for BPPV is a repositioning manoeuvre. Cervical vertigo is associated with a neck disorder, and it is possible that by treating the neck issues, the dizziness could resolve as the neck improves. If symptoms persist, the next logical step would be to add vestibular treatment. While he doesn't personally provide those vestibular treatments, he knows what they are and would refer a patient to practitioners that provide them. In reviewing the treatments provided to the Appellant by [the Appellant's physiotherapist #1], and [the Appellant's physiotherapist #2], and recommended for her by them, it appears that they are solely treatments to the Appellant's neck, and not vestibular treatments. [MPIC's physiotherapist] noted one report in 2007 in which [the Appellant's physiotherapist #1] mentioned a Hallpike's test, but apart from that he did not see any vestibular assessments performed by either [the Appellant's physiotherapist #1] or [the Appellant's physiotherapist #2]. He noted that there was reference in the Appellant's home regime to balance and proprioceptive exercises, which are vestibular exercises.

[MPIC's physiotherapist] reviewed the concepts of active and passive treatment, explaining that in the acute stage, which is immediately post-MVA, when there might be some swelling, there is a role for passive treatment (such as ultrasound, heat, cold pack, massage, mobilizing the joint) to calm things down. After the acute stage, then there should be a move to more active treatment, which is asking the patient to do something, typically exercise. With BPPV for example, the physiotherapist teaches the patients how to do the manoeuvre themselves. There can still be some passive treatment, but if things are not better by three months, then the patient should go back to the physician, because by the time the patient reaches six months, the condition would be chronic. [MPIC's physiotherapist]

said that maximum medical improvement means that you would not expect that any further treatment would result in any further positive changes to the patient's condition. In the Appellant's case, certainly her symptoms have persisted, and in some cases have gotten worse, and there does not seem to be any documentation of objective findings of improvement.

"Supportive care" is a chiropractic term and while [MPIC's physiotherapist] is somewhat familiar with it, he is of the view that it does not have a solid foundation as it pertains to physiotherapy. He could not explain why a patient's neck would be expected to deteriorate in the absence of in-clinic care, because he could not identify the mechanism by which this would occur. If he had treated someone, and then discharged them, and then there was a problem several years later, he would suggest that it was not due to the initial injury but rather due to a lack of use, in other words a lack of being active.

In the Appellant's case, a primary reason that he could not identify why her condition would deteriorate in the absence of treatment, was because there were no physical findings identified in the chart notes. There were no objective measures identified before and after treatment, no physical assessment findings and no findings regarding vertigo or dizziness; the focus in the chart notes is on the report of symptoms. [MPIC's physiotherapist] was of the view that while the Appellant may have experienced some positive effects of the treatment she received from [the Appellant's physiotherapist #1 & #2], this could be attributed to the contextual effect of treatment. For example, there is a relaxation effect with manual therapy, but this is short term and the patient returns to baseline within a few hours. With chronic pain, you can no longer rely on the symptoms to tell an accurate story. The patient should remain active.

While the Appellant suffers from dizziness aside from her pain, it does not appear that either [the Appellant's physiotherapist #1 or Appellant's physiotherapist #2], specifically addressed her dizziness. While it is true that in the vast majority of vestibular issues, the patient can be treated by addressing the neck issues, if it is not working, the patient should be referred for vestibular treatment. In the Appellant's case, she is not getting any sustained benefit from the neck treatment, and so there should have been a referral to someone who specializes in vestibular therapy.

[MPIC's physiotherapist] said that if the Appellant's physiotherapy treatment does allow her to reduce her medication intake, then he would consider that the treatment would be reasonable. However, he said that there is a difference between treatment that is reasonable and treatment that is "medically required". In his view, a medically required treatment is "a treatment that's agreed to be required for the condition that will resolve it". Here, the Appellant has said that the treatment she receives from [the Appellant's physiotherapist #2] will not resolve her condition.

He noted that supportive care may not be appropriate where its risks outweigh its benefits, for example in situations of dependence or somatization. He referred to a report from [the Appellant's psychologist] dated August 9, 2000, which identified possible diagnoses of somatization disorder and dependent personality disorder for the Appellant. He said that if he had been the Appellant's treating therapist who knew this, he would have kept this in mind. It may continue to be a concern, as the Appellant stopped going for psychological treatment. [MPIC's physiotherapist] was concerned that the risks of physiotherapy treatment outweighed the benefits. He said that continuing to treat the Appellant with no sustained improvement may be feeding into a mental health condition, which is potentially harmful.

On cross-examination, [MPIC's physiotherapist] confirmed that his review was restricted to documents on MPIC's file. He noted that the Appellant's general physician did not send his chart notes to MPIC, and so he did not have an opportunity to review them. He confirmed that he did not contact [the Appellant's physiotherapist #1 or physiotherapist #2] to review the matter with them.

In response to questions from the panel, [MPIC's physiotherapist] confirmed that he has provided treatment to patients even after they have reached maximum medical improvement. He drew a distinction between those treatments being at the patient's choice, rather than at his requirement.

Submission for the Appellant:

The Appellant submitted that when she gets physiotherapy treatment, she feels better. Although it does not "fix" her, it helps her live her life. There are mobilizations and other treatments performed by [the Appellant's physiotherapist #2] that she could not do by herself.

She noted that the panel heard evidence from two physiotherapists, but only [the Appellant's physiotherapist #2] had actually treated her. [MPIC's physiotherapist], on the other hand, had not treated her, but had only reviewed paperwork. Although [MPIC's physiotherapist], referred to a report from [the Appellant's psychologist] dated August 9, 2000, and said this raised a concern regarding some psychological issues, the Appellant was concerned that if he was forensically going through all of the documents, he failed to refer to the same doctor's subsequent report dated May 9, 2001, 10 months later. On page 2 of that report, [the Appellant's psychologist] noted that the Appellant was not suffering from clinical depression, anxiety disorder or mental disorders at that time. Further, he stated that since she had been emotionally stable, there was no need for regular psychological services at that point. Given that [MPIC's physiotherapist] did not refer to this later

report from [the Appellant's psychologist] the Appellant raised the question as to what else he may have omitted in his review.

The Appellant pointed out that MPIC did not do everything possible to assist her to return to her pre-accident condition. For example, [the Appellant's physiotherapist #3] had raised the possibility of a thoracic disc injury/protrusion, and [the Appellant's psychologist] had raised the possibility of MRI investigation to determine the source of her neck pain, but the case manager told her that MPIC would not pursue that, as reflected in a file note dated September 13, 2000. The Appellant also pointed out that although MPIC paid for her physiotherapy treatments from 2010 to 2017, they did not send her for any other treatment. She was not aware that [The Appellant's physician] at the [text deleted] Clinic had wanted her to return for follow-up.

She submitted that she is someone who takes responsibility for her own health care. She goes to her general practitioner for annual physicals, and she goes to her hearing doctor regularly with respect to her congenital hearing problem. She knows that she has to be active, and she takes responsibility for this by eating healthy, exercising and staying active at the highest level she can on any given day. She is also responsible with her medications. The Appellant said that although she could have taken opiate medications to deal with her pain, she chose not to. She has made the effort to lose 60 pounds in the last five years; she was previously overweight and recognized that it was unwise to carry excess weight. Losing 60 pounds was a smart choice and she noticed the difference that it made to her back and neck. Another active choice that she makes is to go to physiotherapy. [The Appellant's physiotherapist #2] does not call her and tell her she needs to come in; rather, she decides when to go for treatment. She goes for treatment when she is at her worst, or when she knows that she is getting to her worst, although she has had to cancel when she is too dizzy. The physiotherapy treatments help her; they make her feel better, and help her to reduce her reliance on medication.

The Appellant submitted that the panel should put more weight on the evidence of [the Appellant's physiotherapist #2] than on the evidence of [MPIC's physiotherapist], because [the Appellant's physiotherapist #2] has training in cervical issues and has treated her for years. He was able to speak specifically to the treatment that she received. She submitted that she requires long-term supportive physiotherapy, and that she benefits from such treatment. The Appellant submitted that both parties had agreed that supportive care was the issue in front of the panel, and MPIC had been funding physiotherapy treatments for her on this basis for 17 years.

Submission for MPIC:

Counsel for MPIC provided oral argument at the hearing, as well as a written submission, which was appreciated.

He noted that in order for the Appellant to be entitled to reimbursement for expenses incurred for physiotherapy treatment, the expenses must have been incurred to treat an injury caused by the MVA, and the treatments must be "medically required". Counsel acknowledged that in the present appeal, the issue is entitlement to additional "supportive" physiotherapy care. However, he submitted that the evidence of [MPIC's physiotherapist] was that the term "supportive physiotherapy care" is not recognized within the physiotherapy profession. The evidence of [the Appellant's physiotherapist #2] was that he was not familiar with the term. There was no authoritative text, article or study in front of the Commission to confirm the recognition or existence of "supportive physiotherapy care". The term "supportive care" comes from the chiropractic field, and although the Commission has, in the past, applied that chiropractic term in appeals where reimbursement was sought for supportive physiotherapy treatment, counsel submitted that it was not proper to transplant concepts from one discipline to another without sufficient evidence to support its appropriateness. Counsel encouraged the Commission to reconsider whether it is appropriate to apply the supportive care test to requests

for additional physiotherapy treatments. He argued that without evidence that supportive physiotherapy care is an accepted practice in the physiotherapy profession, a treatment plan proffered as such cannot be "medically required".

If the Commission does determine to retain its practice of applying the supportive care test to an analysis of whether further physiotherapy treatment is medically required, counsel noted that there are established criteria which the Appellant must meet to satisfy the onus upon her of showing that supportive physiotherapy treatments would be medically required. He submitted that the Appellant cannot meet that onus.

Counsel conducted an extensive review of the documentary evidence before the panel. He noted that prior to starting her treatment with [the Appellant's physiotherapist #1], the Appellant had sought treatment initially with [the Appellant's physiotherapist #3], who she felt pushed her to do more than she was comfortable doing. She was subsequently treated at [the Appellant's rehabilitation clinic] by [the Appellant's physiotherapist #4], who discharged her due to a lack of progress. When the Appellant's treatment with [the Appellant's physiotherapist #1] was initially approved by MPIC in 2000, it was intended to be on a short-term basis; MPIC ultimately terminated funding for such treatment on February 26, 2002. Counsel pointed out that the Commission, in its decision of February 22, 2006, dealt both with the entitlement to income replacement indemnity ("IRI") benefits and the funding for treatment expenses. The decision centred primarily on causation, with the Commission relying on the opinion of the Appellant's treating otolaryngologist, [text deleted] to find that the Appellant's cervical vertigo was caused by the MVA. On that basis, the Commission awarded the Appellant both IRI benefits and reimbursement for treatment expenses. There was no specific discussion about whether physiotherapy treatments were medically required.

Subsequent to the Commission's 2006 decision, [the Appellant's otolaryngologist] met with MPIC's medical consultant, [MPIC's physician #1], and the case manager, on July 13, 2006, to discuss the Appellant's condition. [MPIC's physician #1] then followed up with a letter to summarize the matters discussed at the meeting, noting that [the Appellant's treating otolaryngologist] was of the opinion that the Appellant had plateaued with regard to her response to supervised care and that any further care would not likely result in any additional functional gains. He submitted that although [the Appellant's treating otolaryngologist] subsequently wrote, on October 17, 2006, that "if she continues to see benefit from ongoing physiotherapy, I would be inclined to support an ongoing physiotherapy or massage therapy program", this letter must be viewed in light of his prior comments to [MPIC's physician #1]. In a letter dated December 12, 2006, [the Appellant's treating otolaryngologist] noted that the Appellant had no new clinical issues, but he would refer her to the [Text deleted] Clinic regarding her cervical pain.

Counsel submitted that MPIC has taken every opportunity to promote the Appellant's functional independence. He argued that conversely, the actions of others have promoted the opposite. He submitted that since very early on, [the Appellant's physiotherapist #1] had encouraged the Appellant to become dependent on his physiotherapy treatment. On December 18, 2006, [MPIC's physician #1] provided an opinion, noting that although [the Appellant's physiotherapist #1] was of the view that regular physiotherapy was required in order for the Appellant to remain functional, his reports did not contain any information suggesting that his objective assessments of the Appellant identified improvement in her overall condition, or information suggesting that the treatments resulted in functional gains. He stated that "It is my opinion treatment cannot be viewed as being medically required if it is based solely on subjective reporting of the individual receiving the treatment."

MPIC's medical director at the time, [MPIC's physician #2], subsequently reviewed the file to determine whether a reasonable remedial physiotherapy treatment plan could be considered during the Appellant's transition to [Text deleted] Clinic treatment. [MPIC's physician #2], stated in his report, dated July 19, 2007, that the Appellant was likely to have reached maximum medical improvement, and that "it is difficult to conclude that any in-clinic physiotherapy is medically required". Notwithstanding this, the case manager provided the Appellant with an entitlement of up to two physiotherapy treatments per week while she awaited assessment from the [Text deleted] Clinic.

The Appellant saw [the Appellant's physician] at the [Text deleted] Clinic on October 8, 2009. She determined not to pursue trigger point needling treatments. MPIC determined to begin slowly concluding physiotherapy treatments, in consultation with [the Appellant's physiotherapist #1]. The case manager did consult with [the Appellant's physiotherapist #1], who expressed his opinion, as recorded in a file note dated December 12, 2013, that the Appellant "is never going to get better", although she was "kept stable with treatment". The case manager issued a decision letter on February 25, 2013, which provided that the Appellant was not entitled to receive any further funding for supervised physiotherapy care, but that MPIC was prepared to fund a treatment plan designed to wean her off treatments over the next year.

In April, 2014, the Appellant was involved in another accident, which aggravated her MVA injuries. This delayed weaning her off of physiotherapy treatments. [The Appellant's otolaryngologist] provided a report dated January 9, 2015, which stated that "I have seen no change in her overall vestibular function in the last several years". [The Appellant's physiotherapist #1] provided a report (received by MPIC on July 31, 2017) indicating that "Therapy in clinic helps to keep her at her highest level of function and able to continue to exercise. […] As per my chart notes one can see that [the

Appellant] always feels better after treatment and she is able to function to the best of her ability." [MPIC's physiotherapist] reviewed the file and provided an opinion dated August 24, 2017. It was noted at this point that the Appellant was receiving treatments three times per week and had received approximately 723 treatments to date. [MPIC's physiotherapist] noted that [the Appellant's physiotherapist #1] had identified symptoms that the Appellant was experiencing, but not objective findings. In [MPIC's physiotherapist]'s view, additional physiotherapy treatment would not be considered medically required.

[MPIC's physiotherapist] provided another report dated October 23, 2018. He reviewed the July 31, 2017, report provided by [the Appellant's physiotherapist #1] and noted that "[the Appellant's physiotherapist #1] provided nothing in the way of any form of assessment findings." He opined that the primary way to maintain function is to be active, including performing a prescribed home exercise program on a regular basis. He concluded: "Based on a lack of any objective sustained improvement in the claimant's findings, which again do not appear to have been assessed, physiotherapy treatment would not be considered medically required."

[The Appellant's physiotherapist #2] did not challenge the submission that [the Appellant's physiotherapist #1]'s chart notes lacked consistent reporting of physical examinations. Counsel submitted that without any records of examinations or assessments, it is not possible to review or substantiate the conclusions that [the Appellant's physiotherapist #1] reached in his reports. Counsel also noted that the Appellant was required to accept a total withdrawal of in-clinic physiotherapy treatment in the two-month lockdown that followed the onset of the pandemic. Despite this, [the Appellant's physiotherapist #2] could not provide any objective assessment of functioning for the period before and after the lockdown. In other words, he was not able to assess the impact of the withdrawal other than that the Appellant resumed her request for treatment when it was over. Counsel

acknowledged that her request was not unreasonable. As [MPIC's physiotherapist] testified, he occasionally has patients of his own who return after the completion of treatment to request further consultation or treatment. Counsel submitted that the difference is that these requests are not required to treat the condition, and it is the patient themselves who determined the need, not the physiotherapist.

Counsel acknowledged the Appellant's argument that her physiotherapy treatments allowed her to decrease her reliance on medication. He submitted that there is no objective support for the Appellant's testimony on this point. In their report dated August 19, 2020, [the Appellant's physiotherapist #1 and #2] state that "she also has abdominal discomfort she believes comes from her ongoing medical regime […] [the Appellant] is quick to point out that the less physio care she's receiving the more she relies on medications". The Appellant testified that she increased her use of Tylenol 3 during the pandemic, and particularly during the lockdown. She testified that this medication is hard on her digestive system, and she would like to avoid using it as much as possible. Counsel submitted that there is no medical evidence in the indexed file that links the Appellant's use of Tylenol 3 medication to any gastric problems. As well, the available medical evidence supports that the Appellant's medication prescriptions remain consistent; there is no demonstrable link between the use of physiotherapy and the consumption of medication. Further, although [MPIC's physiotherapist] testified that it would be reasonable for a patient to utilize physiotherapy as a means of reducing their consumption of medication, that alone does not render physiotherapy treatment a medical necessity. Counsel argued that there is a difference between treatments that are needed and those that are wanted.

[MPIC's physiotherapist] reviewed the file and provided a further report dated April 15, 2021. He noted that any benefits that the Appellant received from the treatment provided by [the Appellant's

physiotherapist #1 and #2] appear to be short-term. He was of the view that these benefits were more likely the results of the "non-specific effects" of treatment, which he described as the effect arising from the patient's response to receiving care from a recognized health practitioner in a therapeutic ritual. He noted in his report that some of these effects have been identified as patient expectations, conditioned response, reward systems and changes in emotional states. [MPIC's physiotherapist] opined that the best way to remain functional would be to continue to engage in functional activities, including a home exercise program. In his view, "the focus on things like manual therapy would only serve to reinforce the notion that there is a problem "in the tissues"". He remained of the opinion that further physiotherapy treatment was not medically required. Counsel noted that when [MPIC's physiotherapist] was asked to consider the next steps in the treatment of the Appellant, he indicated that given her ongoing complaints of vertigo and dizziness, the Appellant could be referred for a vestibular assessment and treatment by a physiotherapist trained to provide advanced vestibular treatments, if required. [The Appellant's physiotherapist #2] agreed that assessing and treating vestibular dysfunction was not his specialty. Instead, the treatments that the Appellant has received from him (and previously, from [the Appellant's physiotherapist #1]), and that he proposes to continue providing, consists of regular passive physiotherapy treatments of the Appellant's neck, designed to relax the area and temporarily improve range of motion and muscle tone. [The Appellant's physiotherapist #2] noted that he had no way of determining whether his techniques were addressing the Appellant's vertigo other than the subjective reports he received from her. The Appellant has confirmed repeatedly that any improvements are limited. She testified that her headaches, dizziness and neck pain are never really gone, although they are made more manageable through these treatments.

Counsel submitted that the Appellant has become dependent on the supervised in-clinic treatment received from [the Appellant's physiotherapist #1 and #2]. This concern over dependency was raised

by her treating clinical psychologist, [the Appellant's psychologist], in his report dated August 9, 2000, in which he stated that "Dependency behaviour should not be encouraged. The time-limited but supportive therapy focus should prove helpful in changing her attitudes about herself and in alleviating aspects of her depressive and anxiety symptoms." [the Appellant's psychologist] provided a subsequent report dated May 9, 2001, in which he recommended no need for regular psychological services at that time. Counsel submitted that [the Appellant's psychologist] did not retract his previous concerns regarding the need to avoid encouraging dependency behaviour. He submitted that there is no evidence that [the Appellant's psychologist] would have supported the long-term in-clinic treatments provided by [the Appellant's physiotherapist #1 and #2], and argued that the available evidence indicates that when the Appellant was given psychological tests, the conclusion was that any type of supportive therapy should be time-limited. He submitted that this should be taken into account when assessing whether the risks of continued physiotherapy treatment outweigh the benefits. As well, [the Appellant's physiotherapist #2] acknowledged that information from a treating medical professional that warned of dependent behaviour would be relevant to any treatment plan.

Applying the test for "supportive care" to the above facts, counsel submitted that the Appellant has failed to meet the test, as follows:

1. The Appellant has not established that her cervical vertigo will progressively deteriorate when treatment is periodically withdrawn. There is a complete absence of any objective assessment of the Appellant's condition, and there was no objective assessment done prior to and subsequent to the two month pandemic lockdown period. In AC-05-137, the Commission denied a request for supportive care where the objective evidence of deterioration following a discontinuation of the treatment was inadequate.
2. The Appellant has not established that active and passive modalities of treatment were actively pursued, nor has she established that alternative care options were considered and

attempted. Counsel submitted that while there is evidence of extensive treatment and rehabilitation, there is also evidence that questions whether the Appellant is effectively using active treatments to avoid deconditioning. The Appellant herself noted that she did not find the physiotherapy techniques designed to "push her to do more" to be beneficial. There is also evidence that no advanced vestibular assessment was conducted and that the Appellant refused a trial of trigger point needling. As a result, the Appellant has not established that supportive care is the only logical next step.

3. The Appellant has not established that the risks of supportive care do not outweigh its benefits. Counsel submitted that although one possible benefit of supportive physiotherapy may be reduced reliance on pain medication (a potential benefit that is not objectively established), the more significant issue is whether the physiotherapy care that the Appellant receives promotes dependency and/or reinforces improper notions of her condition. There is evidence that a psychologist who treated the Appellant warned against encouraging a dependency situation. But this is exactly what [the Appellant's physiotherapy clinic] has done.

Counsel submitted that as a result, further supportive physiotherapy care is not medically required, and MPIC is not obligated to reimburse the Appellant for any treatments received after December 17 2017. The appeal should therefore be dismissed.

Counsel provided the Commission with alternative positions, in the event that the Commission is satisfied that the Appellant would benefit from ongoing supportive physiotherapy. If the Commission is concerned about the risk of dependency, counsel submitted that the Commission may allow the appeal but add as a condition of any entitlement to funding, that the Appellant be independently reassessed by a psychologist to determine whether the dependency concerns are adequately addressed by the further use of the proposed treatment plan. If the Commission is not concerned about the risk

of dependency, counsel submitted that entitlement should still be limited by the Commission with respect to future entitlement to supportive physiotherapy treatments, by requiring that the Appellant be assessed by a physiotherapist, with certain specific initial requirements, followed by annual reassessment.

Discussion:

The onus is on the Appellant to establish, on a balance of probabilities, that she is entitled to funding from MPIC for further physiotherapy treatment after December 17, 2017. Under paragraph 136(1)(a) of the MPIC Act (set out above), expenses may be reimbursed by MPIC where they are "incurred by the victim because of the accident". Under subsection 5(a) of the Regulation (also as set out above), the expense must be reimbursed "when care is medically required". There does not seem to be a dispute here with respect to whether the expenses were incurred because of the accident, in that both parties accept the finding in the Commission's decision of February 22, 2006, that the Appellant's cervical vertigo was caused by the MVA, and it is that condition in respect of which she sought physiotherapy treatment. The dispute here is whether such treatment was, and continues to be, medically required. The onus is therefore on the Appellant to show, on a balance of probabilities, that further physiotherapy treatment is medically required.

In making our decision, as set out below, the panel has carefully reviewed all of the 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.

Application of the Test for Supportive Care

As indicated earlier in these Reasons, under the heading "Preliminary and Procedural Matters", this appeal proceeded on the basis that the physiotherapy treatment at issue would be addressed by both parties on the basis of the concept of "supportive care" physiotherapy treatment.

As noted by counsel for MPIC, the phrase "supportive care" arises from the Clinical Guidelines for Chiropractic Practice in Canada, which provide as follows:

> Supportive Care: Treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain this benefit and progressively deteriorate when there are periodic trials of withdrawal of treatment. Supportive care follows appropriate application of active and passive care including rehabilitation and lifestyle modifications. It is appropriate when alternative care options, including home-based self-care, have been considered and attempted. Supportive care may be inappropriate when it interferes with other appropriate primary care, or when the risk of supportive care outweighs its benefits, i.e., physician dependence, somatization, illness behaviour, or secondary gain.

In prior cases, this Commission has accepted the above wording, and applied that wording as a test to assist in the determination of whether certain physiotherapy treatments were medically required (see, for example, AC-06-07 and AC-08-132).

In AC-08-132, the Commission described the difference between supportive care physiotherapy treatment and regular or ongoing care treatment, as follows:

> […] The Commission notes that the purpose of supportive care is different from treatment directed towards obtaining maximum medical improvement. The tests for these two types of care are quite different. The criteria for supportive care do not require a progress towards maximum medical improvement in the Appellant's underlying condition; that is the test for regular or ongoing care which seeks to achieve maximum medical improvement. Supportive care is meant to address ongoing symptoms where the patient has reached maximum medical improvement but failed to sustain this benefit. […]

We note that in accepting the above-quoted definition of "supportive care", the Commission accepted that the meaning of the phrase "medically required" contained in subsection 5(a) of the Regulation encompasses not only physiotherapy treatments that direct a patient towards maximum medical

improvement, but also treatments that prohibit deterioration once maximum medical improvement has been reached.

In argument, counsel for MPIC submitted that it was not proper to transplant concepts from one discipline to another without sufficient evidence to support the appropriateness of doing so. Counsel encouraged the Commission to reconsider whether it is appropriate to apply the supportive care test from the chiropractic field to requests for additional physiotherapy treatments. In contrast, the Appellant submitted that both parties had agreed that supportive physiotherapy care was the issue in front of the panel, and that MPIC had been funding physiotherapy treatments for her on this basis for 17 years.

The panel has considered this issue, taking into account the positions of the parties, and in particular the evidence of the two physiotherapists who testified. [the Appellant's physiotherapist #2]'s evidence was that although the term "supportive care" is not used in physiotherapy, he would talk, instead, in terms of maintenance or compensation for a chronic issue. He said that approximately 80% of his practice consists of patients treated on an intermittent or recurrent basis for chronic conditions. [MPIC's physiotherapist]'s evidence was that the term "supportive care" does not have a solid foundation as it pertains to physiotherapy. He did say, however, that he occasionally has patients of his own who return after the completion of treatment to request further consultation or treatment.

While we acknowledge the submission of counsel for MPIC that there is no authoritative text, article or study in front of the panel to confirm the recognition or existence of the phrase "supportive care" in physiotherapy, the panel is concerned that the parties not lose sight of the ultimate issue here, which is whether or not further physiotherapy treatments, regardless of the label applied to them, are medically required. Whether or not the phrase "supportive care" is well-known in the field of

physiotherapy is not the issue; the issue is whether the concept that has been accepted by this Commission is one that exists in the physiotherapy field.

In the circumstances of this case, based on the testimony of [the Appellant's physiotherapist #2] and [MPIC's physiotherapist] that the phrase "supportive care" is not a phrase that is known in the physiotherapy field, the panel is prepared to accept the argument of counsel for MPIC, that it may not be appropriate to continue to apply to physiotherapy the above-quoted definition (and test) of "supportive care" from the chiropractic field, without further authority. This matter can be re-evaluated by the Commission at a later date, as may be necessary.

However, although the panel has determined not to apply the definition for "supportive care" from the chiropractic field in this case, that does not mean that the Commission has determined that physiotherapy treatment that is provided on an intermittent or recurrent basis even after an appellant has reached maximum medical improvement can *never* be medically required. On the contrary, the evidence of both [the Appellant's physiotherapist #2] and [MPIC's physiotherapist] was that they both provide treatment to patients on an intermittent or recurrent basis after they have reached maximum medical improvement ([the Appellant's physiotherapist #2] to a significant degree, [MPIC's physiotherapist] only occasionally). As noted above, the Commission has previously accepted that the meaning of the phrase "medically required" contained in subsection 5(a) of the Regulation encompasses not only physiotherapy treatments that direct a patient towards maximum medical improvement, but also treatments that prohibit deterioration once maximum medical improvement has been reached. The labeling, or non-labeling, of this second type of treatment as "supportive care" physiotherapy treatment does not change the fact that such treatment *can be* considered to be medically required. That remains true, regardless of the label. In any given case, based on the evidence, an appellant would have to establish, on a balance of probabilities, that such

physiotherapy treatment *is* medically required. All that has changed is that this panel will not apply the test for "supportive care" that was based on language arising from the definition found in the Clinical Guidelines for Chiropractic Practice.

Whether Further Physiotherapy Treatments are Medically Required

The evidence of the Appellant was clear and unequivocal that she is of the view that she derives a benefit, although short-term, from the physiotherapy treatment that she has received since December 17, 2017. When she had to go without physiotherapy treatment for the two-month pandemic lockdown period, she said that her condition deteriorated, and she had to increase her reliance on Tylenol 3 medication. The Appellant also testified that in her view, physiotherapy treatment allows her to avoid taking stronger medications such as opiates.

In summary, the Appellant's evidence was that she requires physiotherapy treatment in order to maintain her quality of life. However, the determination of whether such treatments are medically required cannot depend solely on the subjective reporting of the Appellant. An analysis of whether physiotherapy treatment is *medically* required within the meaning of subsection 5(a) of the Regulation also necessarily involves an analysis of the medical evidence.

[The Appellant's physiotherapist #2] testified that the Appellant has "micro-doses" of improvement from the physiotherapy treatment that he provides. He expressed the opinion that without physiotherapy treatment, she suffers small deteriorations, such as increases in headaches and dizziness. The physiotherapy treatments then improve her condition. This view is reflected in the report that he co-authored with [the Appellant's physiotherapist #1], dated August 19, 2020, which states as follows:

> […] We can pick away at things that help her restore balance/equilibrium, reduce incidence and severity of headaches, improve her range of motion and strength, all of which results in an improved quality of life and function for [the Appellant]. What we find is that we can objectively help improve articular mobility, muscle tension and the like through a combination of manual therapy, exercise prescription and maintenance of certain focused exercises depending on what comes up as well as some in clinic modalities. Even if for short periods it greatly enhances [the Appellant's] life and reduces the burden of medicating.
>
> Do we ever think there will be a day where [the Appellant] will feel she no longer benefits from our care, likely not. The nature of her injuries and findings are somewhat permanent, however we stay optimistic that we can and do maintain a higher quality of life with less pain than [the Appellant] would have without physiotherapy and our care.

On cross-examination, however, [the Appellant's physiotherapist #2] acknowledged that the chart notes of his physiotherapy clinic do not contain an objective assessment or record of these improvements. The entries in the chart notes provided from his physiotherapy clinic focus primarily on the Appellant's symptoms and the treatments provided, but do not contain any objective measurements before or after treatment; rather, the results are reflected narratively with comments such as "good, +ve relief" (June 2, 2017) or "good results" (June 5, 2017), for example. He said that on a day-to-day basis, he does not see much use in taking measurements. On the contrary, when asked, [the Appellant's physiotherapist #2] agreed that there were several types of assessments that could be done to track the Appellant's progress, such as a pain scale index, neck disability index, and assessments of her cervical range of motion and muscle strength, but he has not done any of these assessments to date. There was no documented assessment of the Appellant's condition immediately before or immediately after the pandemic lockdown, which appears to have been the longest time that she went without physiotherapy treatment. Nor were there any details in the chart notes regarding any specific medication(s) which the Appellant may be able to reduce due to physiotherapy treatment. [The Appellant's physiotherapist #2] acknowledged that he relied on the Appellant regarding this information. He said that it would be helpful for the Appellant to be assessed by someone who specializes in eye tracking. He cannot assess how much vertigo she has, but he is treating the cervical

vertigo by treating her neck. He does not assess the Appellant's other vertigo symptoms, such as vision, dizziness or balance issues.

[MPIC's physiotherapist]'s evidence was that in the absence of objective measurements before and after treatment, it was difficult to make a determination as to why the Appellant would deteriorate without treatment. In his report dated October 23, 2018, he stated as follows:

> […] In reviewing the chart notes, there does not appear to be any documentation of regular physical examination. The structure of the notes consistently is a description of the claimant's symptoms that day, and then a listing of the various treatment modalities utilized. There is little or no mention of monitoring or progression of any exercises or program […] While there is often reference to "good result" or "+ve relief" in the chart notes, it can only be assumed that this is in reference to some subjective symptom modulation, as again there is no indication that any physical examination was documented. While there is repeated report of symptoms of dizziness and nausea, there is nothing in the notes to document specific vestibular testing or assessment.

[MPIC's physiotherapist] said that while it is true that in the vast majority of vestibular issues, the patient can be treated by addressing the neck issues, if neck treatment is not working, the patient should be referred for vestibular treatment.

In his report dated April 15, 2021, [MPIC's physiotherapist] noted that the most appropriate diagnosis at this time for the Appellant would be chronic pain. He reviewed the August 19, 2020, report provided by [the Appellant's physiotherapist #1 and #2], and stated as follows:

> […] While the physiotherapists suggest that treatment can objectively improve signs of mobility and muscle tension, it would appear that any of these reported benefits would be short-term. This writer would suggest that these temporary improvements in the claimant's signs and symptoms would more likely be due to non-specific effects of treatment.
>
> […]Non-specific effects are sometimes referred to as contextual effects, or as a meaning response. As the experience of pain is complex and multi-factorial, so too is the patient's response to treatment. Any time a conscious person receives care from a recognized health practitioner in a therapeutic ritual, there will always be non-specific effects of that intervention. This may be affected by the demeanour of the clinician, the amount of eye contact, [and] the nature of the communication, etc. Some of these effects have been

> identified as patient expectations, conditioned response, reward systems, changes in emotional states, etc. […]

[MPIC's physiotherapist] said that if that were the case that the physiotherapy treatment did allow the Appellant to reduce her medication intake, then he would consider that the treatment would be reasonable, but not, in his view, medically required.

The panel has considered the testimony of the Appellant in light of the medical evidence provided by [the Appellant's physiotherapist #2] and [MPIC's physiotherapist], both oral and documentary, as well as the other documentary medical evidence in front of the panel. The panel accepts the testimony of the Appellant that she derives a short-term benefit from the regular physiotherapy treatment that she receives from [the Appellant's physiotherapist #2]. However, there is no objective documentary medical evidence in support of her position. As noted above, there is no documentary medical evidence to support the contention made by the Appellant and by [the Appellant's physiotherapist #2] that the condition of the Appellant would deteriorate in the absence of physiotherapy treatment. While [the Appellant's physiotherapist #2] acknowledged that numerous assessments of the Appellant could have been made, none were in fact made. As well, there is no medical evidence before the panel to support the Appellant's contention that her use of physiotherapy treatment allows her to decrease her consumption of medication; there is no demonstrable link between the use of physiotherapy and the consumption of medication.

On the issue of further regular physiotherapy treatment, the panel preferred the evidence provided by [MPIC's physiotherapist] to that of [the Appellant's physiotherapist #2]. The panel finds that [MPIC's physiotherapist], 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. The report provided by [the Appellant's physiotherapist #2], co-

authored with [the Appellant's physiotherapist #1],, is not comprehensive in its analysis. Nor did [the Appellant's physiotherapist #2] have an opportunity to review any of the prior medical documents on the Appellant's file. We accept [MPIC's physiotherapist]'s evidence and opinion on the issue of further regular physiotherapy treatment.

Based on all of the evidence, we find that the Appellant has not met the onus to establish, on a balance of probabilities, that further regular physiotherapy treatment after December 17, 2017, is medically required.

Having said that, both [the Appellant's physiotherapist #2] and [MPIC's physiotherapist] testified that the Appellant should be referred for further assessment and physiotherapy treatment (as recommended) due to her ongoing vestibular issues. This treatment would be of a different kind than that currently provided by [the Appellant's physiotherapist #2]. As noted above, [the Appellant's physiotherapist #2] said that it would be helpful for the Appellant to be assessed by someone who specializes in eye tracking. He does not assess the Appellant's other vertigo symptoms, such as vision, dizziness or balance issues. [MPIC's physiotherapist] recommended that ongoing complaints of vertigo and dizziness should be referred for a vestibular assessment and treatment by a physiotherapist trained in that area. The panel accepts the evidence of [MPIC's physiotherapist] and [the Appellant's physiotherapist #2], who agreed on this point, that further assessment and physiotherapy treatment is required for the treatment of the Appellant`s ongoing vestibular issues. We find that the Appellant has met the onus to establish, on a balance of probabilities, that such further vestibular assessment and treatment are medically required. We note that both physiotherapists indicated that this would not be regular physiotherapy, but rather assessment and treatment provided by a physiotherapist trained to provide advanced vestibular treatments.

Conclusion

In summary, weighing all of the evidence, the panel finds as follows:

- That the Appellant has not met the onus to establish, on a balance of probabilities, that further regular physiotherapy treatment after December 17, 2017, is medically required. As such, the Appellant is not entitled to funding (reimbursement) from MPIC for the regular physiotherapy treatments that she has received from the [Appellant's physiotherapist #1] Physiotherapy Clinic since December 17, 2017; and

- That the Appellant has met the onus to establish, on a balance of probabilities, that a vestibular assessment and treatments (as recommended) by a physiotherapist trained to provide advanced vestibular treatments are medically required. As such, the Appellant is entitled to funding from MPIC for such assessment, and for any such recommended treatment.

Disposition:

Accordingly, the Appellant's appeal is allowed to the extent indicated above.

The Internal Review Decision dated March 26, 2018, is hereby:

1. Varied, to provide that the Appellant shall be entitled to funding from MPIC for a vestibular assessment and for treatments (as recommended) by a physiotherapist trained to provide advanced vestibular treatments; and
2. Upheld, with respect to the Appellant's entitlement to funding (reimbursement) from MPIC for further regular physiotherapy treatment after December 17, 2017.

The matter is hereby returned to MPIC's case manager, for implementation.

The Commission shall retain jurisdiction in this matter and if the parties are unable to agree on the amount of funding, either party may refer this issue back to the Commission for final determination.

Dated at Winnipeg this 25th day of April, 2022.

JACQUELINE FREEDMAN

LEONA BARRETT

LINDA NEWTON