Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an appeal by [the Appellant]
AICAC File No.: AC-96-52

PANEL:	**Mr. J. F. Reeh Taylor, Q.C. (Chairperson)** **Mr. Charles T. Birt, Q.C.** **Mrs. Lila Goodspeed**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') represented by** **Mr. Keith Addison** **the Appellant, [text deleted], attended the hearing by telephone conference call and was also represented by her sister, [text delted];**
HEARING DATE:	**March 7th, 1997**
ISSUE(S):	**1. Termination of coverage for chiropractic treatment - whether justified;** **2. Termination of coverage for massage therapy - whether justified;** **3. Claim for reimbursement of expenses for personal care assistance; and** **4. Whether Appellant entitled to payment for entire cost of new bed.**
RELEVANT SECTIONS:	**Sections 132 and 136(1) of the MPIC Act, and Sections 5, 8 and 10(1)(d)(iii) of Regulation 40/94**

AICAC NOTE: 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

THE FACTS:

On December 5th, 1995, the Appellant, [text deleted], was sitting in the back of [text deleted] automobile driven by her brother-in-law, [text deleted], which was hit from behind while stopped at an intersection. In fact, the [text deleted] was the foremost of four vehicles; the first three were stopped when the fourth ran into the third, and so on. [the Appellant] was not wearing a seatbelt. She testified that she had been sitting upright but that, coincidentally with the collision, "everything went black" for a split second and she then found herself slumped down in the back seat. She says that the collision threw her forward, that her right knee hit the back of the front seat, resulting in discomfort in her lower back, knees, hip, neck and head. She also complained of having no feeling in her arms and legs. None of the evidence suggests that there was any direct impact upon her torso, neck or head, and [the Appellant] herself denies any exterior trauma to her chest.

At the time of the motor vehicle accident ('MVA') [the Appellant], who was fifty-seven years of age at the time, was being driven to the Winnipeg International Airport for her return home, after visiting her sister, [text deleted]. She lives in Nova Scotia, was not employed outside the home, but was caregiver for her husband who has suffered a cerebral vascular accident or intracranial bleeding in 1986. [Appellant's husband] appears to require a significant amount of care, although we were told that he is 'able to ambulate with aides'.

The only prior medical conditions of which we were made aware are these:

(a) marked obesity - her physician puts her at about [text deleted] hundred pounds, although she asserts that she is now only a few pounds either side of [text deleted] hundred;

(b) bi-lateral patella femoral syndrome - a dysfunction of the knees which pre-dated her MVA and which, amongst other things, makes it difficult for [the Appellant] to complete certain exercises which might, if performed, be beneficial; and

(c) an admission to hospital in 1994 for chest pain. [The Appellant] explains that she had been shovelling snow, felt chest pain and was admitted to the emergency department at her local hospital. She believes, although is not sure, that she was 'diagnosed with arrhythmia', and says that she was discharged from hospital later that same day. She adds that she took herbal remedies for some few weeks thereafter, and that the trouble did not reoccur.

[The Appellant] was taken by her sister and brother-in-law to the emergency department at [hospital #1] immediately after the accident. She was examined by [Appellant's ER doctor] who diagnosed a 'cervical and lumbar strain secondary to a motor vehicle accident'. He advised her not to fly for two to three days and prescribed Naproxen. Despite that advice, she elected to fly homeward that same day, staying overnight in [text deleted]; she was anxious to return to her husband who, during her absence, was being cared for by their daughter.

Upon her return home to [text deleted], Nova Scotia, she attended upon her family physician, [text deleted], who saw her on December 19th, 1995 and spoke with her on the phone on January 3rd, 1996. Between the latter date and January 27th, 1997, [the Appellant] was examined and treated by [Appellant's doctor] and by [text deleted] (her chiropractor), on numerous occasions, a detailed assessment of her physical abilities, disabilities and domestic limitations was performed by a qualified occupational therapist with the [rehab clinic] and she participated in six

weeks of a work hardening program there in April and May of 1996.

More significantly, when [the Appellant] attended upon [Appellant's doctor] on January 26th of 1996, she complained that she had a sore back, shoulders and left arm and central chest pains. Those central chest pains become significant in light of what follows.

[The Appellant] presented herself on July 5th, 1996 at the outpatient's department of the [hospital #2] in [Nova Scotia], complaining of chest pains. An X-ray was taken which revealed considerable cardiac enlargement but, after staying in the hospital for 4 ½ hours she was given some anti-inflammatory medicine and sent home without any mention being made to her of the heart enlargement. [The Appellant] had seen [Appellant's doctor] about a week prior to that hospital visit, as well as in February of 1996. On both occasions she complained of chest pains but [Appellant's doctor] felt that her problem might be angina, for which he gave her some medication which, she says, had no noticeable effect. [Appellant's doctor] had examined her again in March of 1996, when he records that she did complain of a sore central chest and of "retrosternal chest discomfort".

[The Appellant] next presented herself at the emergency department at the [hospital #2] in [Nova Scotia] on December 12th, 1996, complaining of chest pain and breathing difficulties. A further chest X-ray showed gross enlargement of the cardiac silhouette, although no evidence of cardiac failure. Once again, she was sent home without treatment.

[The Appellant] was seen again in the emergency room at the hospital on December 23rd, 1996, complaining of weakness and shortage of breath. She was found to be in atrial fibrillation. She was seen by an internal medicine specialist, [text deleted], and a surgeon, [text deleted]. They diagnosed a pericardial effusion with cardiac tamponade. On that same day, [the Appellant] underwent open pericardial drainage performed by [Appellant's surgeon], who drained about 1 litre of serosanguineous fluid. Sundry analyses of that fluid disclosed no particular infection or disease; the appropriate tests were all negative. [The Appellant's] symptoms of chest pain and shortness of breath resolved almost immediately after the drainage and, during a followup visit with [Appellant's surgeon] about six weeks later, [the Appellant] remained asymptomatic.

We have described, at greater length than usual, the series of events in which [the Appellant] was complaining of chest pains in the months following her MVA, resulting in the surgical procedure required to drain her pericardial effusion. All of her own medical advisors have expressed the view, in one way or another, that this particular problem had its origins in her motor vehicle accident, while MPIC's medical consultant expresses the view that such a cause was most unlikely in the absence of blunt trauma to the chest wall. We therefore referred that facet of of this appeal to [text deleted], a cardiovascular and thoracic surgeon whose is head of the section of cardiac surgery at the [hospital #3] and cardiac surgery program director at the [text deleted]. [independent cardiovascular and thoracic surgeon's] considered opinion, after reading the entire medical file related to [the Appellant] and after researching the available literature, is contained in his letter to this Commission of May 26th, 1997 which reads, in part, as follows:

"**Commentary**

I will make a few points which pertain to [the Appellant's] case:

1. Accidents which include deceleration are well known to cause injuries of the heart and the thoracic aorta without any direct blow to the chest. This is because these mobile structures continue to move forward within the chest while the whole body suddenly stops. Any such injury to any intrapericardial structure can cause a traumatic (bloody) pericardial effusion.

2. If a traumatic pericardial effusion goes unrecognized it can lead to a state called chronic effusive pericarditis. This consists of a chronically and gradually enlarging accumulation of inflammatory fluid within the pericardial sac which can be remarkably subtle symptomatically and long in duration before the diagnosis is finally made.

3. My opinion, based upon the available information, is that [the Appellant's] clinical course was consistent with the diagnosis of posttraumatic chronic effusive pericarditis. In the face of the normal panel of blood tests referred to by [Appellant's surgeon] there still could be other very uncommon causes of a chronic, bloody pericardial effusion such as tuberculous or malignant pericarditis. Often those diagnoses can only be made with microbiological and pathological examination of a sample of pericardium obtained at the time of surgical drainage and no such tissue was obtained. It is, however, inconceivable that [the Appellant] would have recovered from those lethal diseases without other treatment.

Opinion

In my opinion it is possible that the motor vehicle accident of December 5th, 1995 was the cause of [the Appellant's] large pericardial effusion which was surgically drained on December 23rd, 1996."

We accept the opinion of [independent cardiovascular and thoracic surgeon], which clearly supports the views expressed by [the Appellant's] own medical consultants. This finding will be referred to later, in the context of the third facet of [the Appellant's] claim.

Turning, now, to the several aspects of the appeal now before us:

1. **Chiropractic Treatment**

MPIC had been paying for [the Appellant's] chiropractic treatments, which had commenced approximately three weeks following her MVA. In a letter of January 3rd, 1996 her physician, [text deleted], had indicated that he believed that chiropractic treatment and deep muscle massage therapy for two to four weeks "should see her on the road to recovery". Her chiropractor, [text deleted], having treated her three times per week over a one month period, re-examined her on January 24th of 1996 when [the Appellant] reported that "everything had lessened". That is to say, her headaches had lessened, the "twitch" of her face and the small of her back felt better; her knees and between her shoulder area also felt better and, in general, she was more comfortable although she had trigger point tenderness of the right quadratus lumborum muscle and the semilunar cartilage of both knees were still tender medially. [Appellant's chiropractor] felt that she would continue to progress, and undertook to re-examine her again at the end of February of 1996. That report from [Appellant's chiropractor] bears date February 6th, 1996; we do not appear to have had any further report from him.

After a very full assessment by an qualified occupational therapist at the [rehab clinic], [the Appellant] was also assessed by [Appellant's physiotherapist], PT, MCPA, CAT (c) on April 1st of 1996. He noted that "massage has been conducted with this lady since December 1995. This type of passive treatment will make this lady feel better, and it will probably reduce the soft tissue symptoms of her neck and back. It will not, however, remove the symptoms of a soft tissue condition this lady possesses". [Appellant's physiotherapist's] report went on to say that, considering the length of time that she had had massage, it should have had better results than had been the case in removing her symptoms. For that reason, he said, he could not recommend a continuation of that type of treatment. [Appellant's physiotherapist's] report also noted that 20 sessions of chiropractic treatment where the patient admits that he is unsatisfied would demonstrate that chiropractic treatment was also not working.

Based upon the foregoing reports and advice, MPIC advised [the Appellant] by telephone and by letter, on April 4th of 1996, that massage and chiropractic treatments would cease to be paid for by MPIC as of April 7th, but that she was to begin her rehabilitation or work hardening program on April 8th.

We can find no good reason to disagree with that decision on the part of MPIC.

2. **Termination of Massage Treatments**

For the reasons noted above in connection with the termination of payments for chiropractic treatments, we are of the view that MPIC's decision to quit those payments was

correct. We note, also, the view expressed by [text deleted], MPIC's chiropractic consultant, that [the Appellant] had gone beyond the time when further benefit might be expected to flow from continued chiropractic or massage therapy, or both.

3. **Reimbursement of Expenses for Personal Care Assistance**

As was noted earlier in these Reasons, [the Appellant] devotes a large portion of her time and energy in the care of her disabled husband. True, she has had some domestic assistance that is paid for from other sources, but she is still alone with her husband at various times of the day and all night, when her physical limitations have made it very difficult indeed for her to cope with the demands of those tasks. MPIC started paying [the Appellant] $294.00 a week for caregiver benefits, following a detailed assessment of her needs by the [rehab clinic]. The last such payment that she received from MPIC covered the period from May 3rd to May 17th of 1996, MPIC having decided to terminate those payments as of the latter date. [The Appellant's] undisputed evidence was that she did not become aware of that decision until some three weeks later. It was also MPIC's view that any continuing home care needs on the part of [the Appellant] were related to her pericardial effusion which, as noted above, the insurer did not feel stemmed from the MVA. Since we have concluded that the MVA was, indeed, the most probable cause of the pericardial effusion, it follows that the caregiver weekly indemnity needs of [the Appellant] also stemmed from that same accident. A careful reading of all of the available evidence persuades us, firstly, that there was a patent inequity in terminating that flow of income to [the Appellant] three weeks before notifying her of the decision to do so and, secondly, that she had to pay an additional two weeks for home care assistance out of her own pocket after the expiry of that

first three weeks. In other words, we find that she is entitled to be paid for five weeks caregiver weekly indemnity and, since the amount of that weekly indemnity seems to have been increased from the earlier figure of $294.00 to $302.00, she is entitled to a total of $1,510.00.

4. **Payment for Cost of New Bed**

The situation, in this context, is a comparatively simple one. [The Appellant] had complained to her physician and to her chiropractor that the waterbed upon which she had been sleeping was not giving her the kind of rest and relaxation that she felt she should expect; she felt sore and stiff upon waking up in the morning. She asked them whether she would be better advised to use a firm mattress and they both agreed that this was, indeed, a wise thing to do. She purchased a brand new bed at a total cost, including taxes, of $783.75. Of this sum, MPIC has reimbursed her for $375.00 - approximately half. Section 10(1) of Regulation 40/94 gives MPIC the discretion to pay for "medically required beds, equipment and accessories" when, in the opinion of the Corporation, it is necessary or advisable to do so for the rehabilitation of the victim. Here, too, we have concluded that, even though the suggestion that a new bed with a firm mattress emanated from [the Appellant], the fact is that both her physician and her chiropractor concurred in that suggestion and felt that it was medically desirable. At the same time, however, we express the view that the life expectancy of that new bed and its beneficial effects will far exceed the length of time that it will take (or, perhaps, has already taken) for [the Appellant] to reach pre-accident status. We do not believe that the insurer should be required to pay for benefits beyond that time frame, and we therefore find that the amount already paid by MPIC was reasonable under the circumstances.

DISPOSITION:

MPIC shall pay [the Appellant] the sum of $1,510.00, by way of caregiver weekly indemnity, to cover the five weeks from May 18th to June 22nd, 1996, both inclusive. To the extent, if any, that the cost of medical reports prepared by [the Appellant's] medical and chiropractic advisors and used in support of her appeal have not already been paid for by MPIC, that should be done, along with [independent cardiovascular and thoracic surgeon's] fee for the preparation of his report of May 26th, 1997.

In all other respects, the decisions of MPIC's Acting Review Officer are confirmed.

Dated at Winnipeg this 12th day of June 1997.

J. F. REEH TAYLOR, Q.C.

CHARLES T. BIRT, Q.C.

LILA GOODSPEED