Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-09-016

PANEL:	**Mr. Mel Myers, Q.C., Chairperson** **Mr. Paul Johnston** **Dr. Sheldon Claman**
APPEARANCES:	**The Appellant, [text deleted], was represented by Mr. Ken Kalturnyk of the Claimant Adviser Office;** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Terry Kumka.**
HEARING DATES:	**November 2, November 24 and November 30, 2011**
ISSUE(S):	**1. Entitlement to further Income Replacement Indemnity benefits beyond July 2008.** **2. Entitlement to reimbursement for expenses associated with the surgery of July 24, 2008.**
RELEVANT SECTIONS:	**Sections 110(1)(a) and 131 of The Manitoba Public Insurance Corporation Act ('MPIC Act') and Section 5(a) of Manitoba Regulation 40/94**

AICAC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE PERSONAL HEALTH INFORMATION OF INDIVIDUALS BY REMOVING PERSONAL IDENTIFIERS AND OTHER IDENTIFYING INFORMATION.

Reasons For Decision

[The Appellant] was involved in a motor vehicle accident on October 18, 2006. At the scene of the motor vehicle accident, the Appellant initially reported right shoulder pain. The Emergency Room record noted tenderness along the lower cervical and thoracic spine.

The Appellant reported that for three or four days after the motor vehicle accident she felt sore and she returned to work the next day. She commenced to receive chiropractic treatment on October 24, 2006 at which time it was documented that the symptoms included right-sided neck pain, right shoulder pain, scapular pain, and headache and lower back pain.

On October 3, 2008 [Appellant's Doctor #1], the Appellant's physician, provided a report to MPIC which indicated:

1. "The medical records on file show that [the Appellant] visited the [text deleted] Clinic on June 16th, 2006 with neck pain and weakness in the arm due to excessive spring yard work and cleaning. An xray was taken on June 27th, 2006 which showed no focal right posterolateral disc protrusion indenting the right anterolateral aspect of the thecal sac. She was diagnosed with bursitis in June 2006.
2. On October 5th, 2006, was seen by [Appellant's Doctor #2] in reference to a swelling of her left elbow. Diagnosis later confirmed left elbow bursitis.
3. On October 18, 2006 while in a motor vehicle accident another xray was taken at [Hospital #1] showing mild degenerative disc space narrowing at C5-6."

The X-ray taken prior to the motor vehicle accident did not disclose the mild disc narrowing at C5-C6 level. Neither the X-rays taken before and at the time of the motor vehicle accident disclosed an osteophyte complex at the C5-C6 level.

After the motor vehicle accident the Appellant received chiropractic treatments at which time it was documented that the symptoms included right sided neck pain, right shoulder pain, back pain, right scapular pain, headache and right low back pain. The Appellant further reported that

upon initially receiving chiropractic care she was slowly improving, but after approximately two to three weeks she began to notice an increase in pain in the neck and top of her shoulders.

In a letter dated April 24, 2007 to [Appellant's Doctor #2], [Appellant's Orthopaedic Surgeon] reported that having regard to the Appellant's complaints of neck pain, right shoulder pain and occasional paresthesia to the right arm, he suggested a CT scan be obtained and referred the Appellant to [Appellant's Neurologist] in [Manitoba].

[Appellant's Neurologist] examined the Appellant on March 23, 2007. [Appellant's Neurologist] indicated that the reason for the neurological examination was related to the Appellant's right hand numbness. Upon examination he confirmed by nerve conduction studies that he found the Appellant was suffering from a right carpal tunnel syndrome. [Appellant's Neurologist] advised that the Appellant should be treated conservatively with night time wrist splinting since her symptoms came on quite recently. He further stated that if conservative treatment was not satisfactory, after a reasonable period of trial, decompression of the right carpal tunnel should be considered.

[Appellant's Neurologist] also stated:

> "Her right shoulder and neck pain is not the reason for this neurological consultation. Presently, I am unable to demonstrate any radicular signs from her cervical spine. She had MRI scan of the cervical spine done today, ordered by [Appellant's Doctor #2]. The radiologist informed me that the MRI scan is normal except for a large posterior disc osteophyte complex at C5-C6, extending from the left to the right neural foramen which is also narrowed. There is also some apparent displacement of the spinal cord posteriorly. Presently, there are no spinal cord signs. If her neck and shoulder pain should persist despite adequate conservative treatment, then [Appellant's Doctor #2] should make a referral to a spinal surgeon of her choice and I shall leave this to her. The MRI findings have nothing to do with her right hand parestesia, which is unquestionably due to a carpal tunnel syndrome." (underlining added)

[Appellant's Neurologist] wrote to MPIC on June 10, 2007 enclosing a copy of his report of March 23, 2007 and further stated:

> "The reason for that neurological consultation is a right carpal tunnel syndrome which has nothing to do with her motor vehicle accident. She also has neck and shoulder pain but that was not the reason for that consultation." (underlining added)

The Appellant was again seen by [Appellant's Orthopaedic Surgeon] who recommended a right carpal tunnel decompression. [Appellant's Orthopaedic Surgeon] wrote to MPIC on July 23, 2007 advising that a decompression was performed on June 27, 2007.

On August 2, 2007 the case manager wrote to the Appellant in response to her request for reimbursement of expenses relating to her recent carpal tunnel surgery. The case manager indicated that based on information received from [Appellant's Neurologist] the Appellant's carpal tunnel syndrome was not causally related to the motor vehicle accident.

The Appellant was referred by MPIC to [Independent Physiatrist], to conduct an independent medical examination. [Independent Physiatrist] provided a report dated September 12, 2007 and stated:

1) She had no prior work injuries including any fractures and that she had not previously reported being symptomatic in the neck, shoulder or back.
2) In respect of the Appellant's history, he stated:

   for 3-4 days after the MVA she felt sore. She returned to work the next day. She reported starting chiropractic care, and had the impression of slowly improving. However, in approximately 2-3 weeks she began to notice increasing pain in the neck and the top of the shoulder. She reported that the chiropractor continued treatment, but felt

that there was potentially a torn tendon or pinched nerve, which led to having an MRI scan performed in March 2007.

3) She reported on specific questioning that she also noticed that a number of months later she began to notice stiffening developing of the right arm at the shoulder. She was taken off work by her attending practitioner in April 2007, and advised to rest. However, she reported there did not appear to be any improvement in symptoms with rest.
4) She has pain present intermittently in her neck, top of the shoulders, and right arm. She reported that at times with avoiding some activities there are minimal symptoms.
5) She notes that the symptoms are variable, at times greater, and she noticed that increased activities usually cause increased symptoms in the areas.
6) She has pain 7 days/week, usually between 4-8 hours/day on average. The pain can occur at night time regularly.
7) Her pain on a Visual Analog Scale of 0 – 10 (with 10 being severe) as the worst pain being 8/10; the least pain as being 6/10; the average pain as being 7/10.
8) She could get neck stiffness, which is variable.
9) She was also having further symptoms including fatigue, which she felt was related to her difficulty with sleeping.
10) The overall severity of her pain was reported as being severe, and that she has difficulty tolerating the symptoms when they occur.
11) In terms of specific activities and how they affect her pain symptoms, she reported:
    a) Sitting usually increases her symptoms as does standing, usually after 3 – 4 hours.
    b) Both of these increase the symptoms across the shoulders and neck.
    c) No change in her symptoms with walking.
    d) With lying down there is some increase in her neck and shoulder symptoms, but usually after several hours.

e) Movements such as bending forwards and backwards usually increase symptoms in the neck and shoulder after 10 – 20 minutes.

f) Usually there is an immediate increase in pain in the neck, shoulder and arm with lifting.

12) Her forward flexion was within normal limits of the neck. She had limited extension with a restriction of approximately 50%. "There was also some restriction of neck rotation to the right, slight to the left. Lateral bending to the left was within normal limits; to the right there was some mild restriction."

13) She also had marked limitation of bending on the right side with discomfort with movements of the top of the right shoulder, especially with lateral bending on the left and rotation to the left.

14) She also had discomfort on the right side of her neck and tenderness in the mid-cervical region.

15) There was also tenderness in the infraspinatus region as well as the medial scapular soft tissues on the right.

16) The Appellant's shoulder movement also showed restriction in the range with the scapula fixed.

17) She was adversely affected by the pain in her neck and shoulder, and that she was unable to wash windows, vacuum, wash floors or do any major cleaning and that she required help in respect of these activities.

18) She was unable to do her prior activities of golfing, curling, fishing and walking longer distances. She also reported that she had difficulty with frequent lifting and carrying of lighter weights and pushing/pulling moderate weights, or lifting/carrying heavier weights.

<u>The Appellant also advised [Independent Physiatrist] of the MRI scan to her cervical spine of March 23, 2007 which indicated that there was not much space between the C4-5 and C6-7</u>

vertebral bodies of the neck and also that there was a large posterior disc osteophyte complex at C5-6.

The Appellant further advised [Independent Physiatrist] that:

1. She had been working two part-time jobs prior to the motor vehicle accident and advised that she worked at [text deleted] (6-10 hours per week) primarily as relief.
2. She worked part-time as a [text deleted] in the [text deleted] for approximately 10 hours per week on average.
3. She did work following the motor vehicle accident until April when she noticed gradually increasing arm symptoms and difficulty with lifting her right arm and as a result her doctor took her off work duties in April 2007 and she had not been back at work since that time.

In his report, [Independent Physiatrist] described conducting a neurological examination and concluded that he suspected a right frozen shoulder. He further stated that:

1. There was no evidence on file of any neurological involvement related to the motor vehicle accident and that there were some minor symptoms which appeared to be related to a likely pre-existing bilateral carpal tunnel syndrome.
2. There was also no evidence of any cervical nerve root irritation, irritability or any neurological involvement on the current examination.
3. Any investigations of the Appellant's right shoulder at the current point appeared to be for conditions that likely developed subsequent to the motor vehicle accident as the file documentation did not initially suggest any significant difficulty with shoulder or neck range of movement.

[Independent Physiatrist] further stated:

> "...The current clinical examination suggests the likely presence in addition of a frozen shoulder. Frozen shoulder is typically of spontaneous onset, it can occur spontaneously unrelated to any trauma, with higher incidence in middle-aged women. Although in some frozen shoulders the adhesive capsulitis was initiated with a strain to the rotator cuff. (underlining added)
>
> The claimant has been protecting range of movement of the right shoulder and was advised to rest movements, and this appears to have delayed recovery from what appears to be some soft tissue irritability of top of the shoulder and lateral neck on the right side. From the history, this could have had onset when the claimant rotated to the right while having the secondary rear-end collision."

[Independent Physiatrist's] report was reviewed by [MPIC's Doctor #1], Medical Consultant with MPIC's Health Care Services. [MPIC's Doctor #1] disagreed with [Independent Physiatrist's] assessment in respect of the Appellant's frozen right shoulder. She concluded that, having regard to the Appellant's consistent complaints of her right shoulder symptoms from the motor vehicle accident, her neck and arm problems were the cause of the frozen shoulder rather than the frozen shoulder being the cause of the neck and arm problems. In arriving at this conclusion, [MPIC's Doctor #1] indicated that [Independent Physiatrist] did not take into account the consistent complaints made by the Appellant in respect of her neck, arm and shoulder following the motor vehicle accident.

At the request of [Appellant's Doctor #2], the Appellant's family physician, she was referred to [Appellant's Neurosurgeon] who practised in [Saskatchewan]. [Appellant's Neurosurgeon] saw the Appellant on January 18, 2008 and stated that he had examined the Appellant and noted that the Appellant may have a small disc protrusion with an osteophyte at the C5-6 level. He noted that she was also developing a mild right frozen shoulder which was augmenting or increasing her pain. He further stated:

> "I think we need to review this C5-6 disc lesion a little more carefully with thin cuts and therefore I plan to repeat the MRI here in [Saskatchewan]. Once these results become available, I can then let you know whether or not any surgery is indicated for this lesion."

[Appellant's Neurosurgeon] wrote to the Appellant's physician and concluded that she had a frozen shoulder. In his letter he stated:

> "Investigation Reviewed:
> X-rays of her Cervical Spine showed a block vertebra at C5-6 level.
>
> An MRI was done on February 23rd/08, which showed a cervical disc protrusion at C5-6 on the right.
>
> APPRAISAL:
> This lady has pain in her neck with radiation down into her right upper limb, which is secondary to a C5-6 Right Disc Protrusion.
>
> PLAN:
> For this, she will require excision of the C5-6 disc and interbody fusion.
>
> For her Right Frozen Shoulder, she will require Physiotherapy..."

[Appellant's Neurosurgeon] further stated that after advising her of the risks of surgery, the Appellant indicated she wished to proceed with the surgery.

On July 24, 2008 [Appellant's Neurosurgeon] carried out the disc surgery on the Appellant and in a report to MPIC dated October 8, 2008; [Appellant's Neurosurgeon] noted that besides the presence of a large osteophyte, the Appellant had an element of soft tissue disc protrusion causing root compression. [Appellant's Neurosurgeon] further indicated that it was anticipated that the Appellant would make a good recovery.

In a note to file the case manager noted that she had spoken with the Appellant on August 19, 2008 when the Appellant indicated that was unable to return to work as a [text deleted] and as a [text deleted]. The Appellant indicated that she intended to return to work as a [text deleted] in the fall term.

In a memo to file the case manager indicated that she had spoken to the Appellant on September 15, 2008 and advised her that the surgery performed on her neck on July 24, 2008 was not related to the motor vehicle accident.

[MPIC's Doctor #2] reported to the case manager in an Interdepartmental Memorandum that he reviewed the file on September 16, 2008 and stated:

1. "The medical evidence does not establish a cause/effect relationship between the incident in question and the diagnosed C5-C6 osteophyte that required surgical management;
2. The medical evidence does not support the opinion that [the Appellant] requires a gym membership in order to manage the medical conditions arising from the incident in question.

The information used in formulating the first conclusion is as follows:

1. <u>Documentation of pre-existing neck pain and arm weakness two days prior to the incident in question</u>;
2. Documentation of osteoarthritic changes involving the facet joints and narrowing involving the left C6-7 neuroforamen on x-rays performed two days prior to the incident in question;
3. Absence of documentation indicating any acute changes were noted involving [the Appellant's] cervical spine following the incident in question;
4. Documentation of neck pain and bilateral shoulder pain in the absence of any objective medical evidence of associate radiculopathy;
5. Documentation indicating [the Appellant's] neurologic examination was normal aside from mild changes associated with carpal tunnel syndrome that did not develop as a direct result of the incident in question.

<u>It is my opinion the medical evidence indicates [the Appellant] might have exacerbated a pre-existing condition (i.e. neck pain that might be associated with the degenerative changes and C5-6 osteophyte) as a result of the incident in question. The medical evidence does not indicate the motor vehicle incident resulted in an enhancement of [the Appellant's] pre-existing neck condition</u>." (underlining added)

<u>Case Manager's Decision:</u>

The case manager wrote to the Appellant on September 19, 2008 based on [MPIC's Doctor #2's] report of September 6, 2008 and advised her that:

1. the surgery performed by [Appellant's Neurosurgeon] on July 24, 2008 was not as a result of the motor vehicle accident injuries; and
2. the gym membership purchased by her would not be considered a medical necessity as a result of the motor vehicle accident injuries.

The case manager stated that based on Section 110(1)(a) of the MPIC Act, the Appellant's entitlement to IRI ended effective September 15, 2008.

Application for Review:

On October 1, 2008 the Appellant made an application for review of the case manager's September 18, 2008 decision. The Appellant stated:

> "I found wrong dates on my reports as well as medical evidence stating that I was not to see the doctor two days prior to the motor vehicle accident for pre-existing neck pain and arm weakness but, for L elbow bursitis. MRI shows C5-6 disc protrusion. This was caused by the jolt I received from the accident. I should be reimburst (sic) for all my medical expenses related to the surgery I needed on July 24, 2008." (underlining added)

On October 3, 2008 [Appellant's Doctor #1], the Appellant's physician, wrote to MPIC and stated that an X-ray prior to the motor vehicle accident did not disclose any mild degenerative disc space narrowing at C5-C6. An X-ray taken on the date of the accident of October 18, 2006 did show a mild degenerative disc space narrowing at C5-C6. [Appellant's Doctor #1] further stated:

> "March 23, 2007, the first MRI was done in [Manitoba]. Conclusion: There is a large posterior disc asteaphyte complex extending from left of the midline across to the right neutral foramen displacing the spinal cord posteriarly and narrowing of the right neutral foramen.
>
> On February 23, 2008 another MRI was done at [text deleted]: Conclusion at the C5-6 level there is a focal right posterolateral disc protrusion.
>
> The medical reports support that the injury sustained in the motor vehicle accident on October 18, 2006 contributed to the disc protrusion at the C5-6 level.

[The Appellant] should be reimbursed for all medical expenses including: prescriptions, travel expenses, parking, hotel accomodations (sic) as well as a meal.

Also for wages she paid out to hire a person to do all her housework while recuperating from the July 24th, 2008 surgery." (underlining added)

On October 8, 2008 [Appellant's Neurosurgeon] sent a letter to MPIC and stated in part:

> "When seen by me on January 18th/08, she did have positive neurological signs by way of reduction of neck movement, minimal weakness of her right biceps muscle with a depressed biceps jerk. Her right shoulder did show some evidence of a partial Frozen Shoulder which, I thought, was a carryover from her previous right shoulder injury of June/06.
>
> She was investigated by doing X-rays of the Cervical Spine which showed a block vertebra at C4-5 with degeneration one level down at C5-6. An MRI was repeated in [Saskatchewan] on February 23rd/08, which confirmed the presence of a focal right posterolateral disc and osteophyte protrusion, indenting the right anterolateral aspect of the thecal sac. Armed with the above positive radiological evidence and her clinical findings, C5-6 right disc surgery was advised and was carried out on July 24th/08; at the time of surgery, besides the osteophyte, she did have an element of soft tissue disc protrusion, as well at this level, causing root compression. Following surgery, her right upper limb pain has disappeared.
>
> COMMENTS:
>
> Thus, this lady did have a pre-existing degenerative disc disease at the C5-6 level which, I believe, could have been partially accelerated due to the block vertebra higher up at C4-5. The car accident, I believe, has played an exacerbating role and possibly also caused a smaller disc of soft tissue at the same level where a hard osteophyte had been present, making this level symptomatic and resulting in root compression."

MPIC requested that [MPIC's Doctor #2] review the reports from [Appellant's Neurosurgeon] and [Appellant's Doctor #1] and the clinical notes from [Appellant's Doctor #2] and the MRI reports of March 23, 2007 and February 23, 2008. [MPIC's Doctor #2] disagreed with the medical opinions of [Appellant's Neurosurgeon] and [Appellant's Doctor #1] as to the causal connection between the motor vehicle accident and the Appellant's complaints of pain to her neck and arm weakness. In his report [MPIC's Doctor #2] confirmed that the neck pain and arm weakness occurred not in June 2006 but two days prior to the motor vehicle accident.

> "From an objective standpoint, the file does not contain information indicating [the Appellant] presented with radicular findings until assessed by [Appellant's Neurosurgeon] in January 2008. Information obtained from the file indicates that prior to this date [the Appellant] was assessed by a neurologist and physiatrist both of which did not identify any objective clinical findings of a radiculopathy or a spinal cord lesion.
>
> One might speculate that all of [the Appellant's] neck and shoulder symptoms are a byproduct of the bony and disc changes identified at the C5-6 level and that the motor vehicle incident resulted in aggravation of the changes and the later development of a radiculopathy. Even though this scenario is possible, it is not medically probable based on the absence of documentation indicating [the Appellant] did not present with radicular findings until sometime in the latter part of 2007 which was well after the incident in question.
>
> Information obtained from the above noted reports does not indicate acute changes occurred to [the Appellant's] cervical spine as a result of the incident in question that in turn jeopardized a pre-existing condition to the extent a radiculopathy developed sometime after the incident in question."

Internal Review Officer's Decision:

The Internal Review Officer's Decision of January 15, 2009 dismissed the Appellant's Application for Review on the issue of whether she was entitled to further IRI benefits and other expenses and whether the surgery scheduled on July 24, 2008 was a result of the motor vehicle accident injuries. After briefly reviewing a history of the claim, the Internal Review Officer relied on [MPIC's Doctor #2's] memorandums of September 16, 2008 and November 28, 2008 which indicated that from an objective standpoint the file did not contain any information indicating that the Appellant had presented with radicular findings until she was assessed by [Appellant's Neurosurgeon] in January 2008.

The Appellant filed a Notice of Appeal on January 30, 2009.

On September 30, 2010 [Appellant's Neurosurgeon] wrote to the Claimant Adviser Office in reply to his letter of September 20, 2010 which enclosed [MPIC's Doctor #2's] opinion of November 24, 2008. [Appellant's Neurosurgeon] stated:

"Many thanks for your letter of September 20th/10. The opinion note of [MPIC's Doctor #2] dated November 24th/08, on Page 2, para 1, line 3 states; "as noted in my September 16th/08 interdepartmental memorandum, this opinion was based on documentation of pre-existing neck pain and arm weakness two days prior to the incident in question. Upon further review, this is not correct in that the reporting of the neck pain and the arm weakness was noted in June/06 and not two days prior to the incident in question." I could not confirm that this patient saw any physician two days prior to the alleged accident. On talking to the patient, she also vehemently denies that she ever saw anyone two days or one week prior to the accident and hence I do not know where [MPIC's Doctor #2] got this information." (underlining added)

[Appellant's Neurosurgeon] requested a copy of the medical records on which [MPIC's Doctor #2's] statement was based.

[Appellant's Neurosurgeon] was provided with the relevant medical reports by the Claimant Adviser and in a letter dated November 22, 2010 he stated that:

1. As a result of the motor vehicle accident, the Appellant "did develop immediate pain to the right side of her neck and top of her right shoulder and the scapular region...
2. The documentation by the Emergency Department of the hospital on the day of impact, on arrival to the Emergency Centre, does record, "pain in the right shoulder posteriorly while moving the shoulder, localized pain in the lateral trapezius region and tenderness along the cervical spine, especially at C-7/T-1 region.
3. It is also a fact that the claimant followed up with the chiropractic treatments in October/06 and, during this time frame, it was documented that her symptoms included right-sided neck pain, right shoulder pain, right scapular pain, headaches and right lower back pain. With respect to her cervical area, the chiropractor noted the range of movement being limited and tenderness was noted related to her right shoulder and the neck (extract taken from the HCS Review evaluation, created on November 29th/07).
4. [Independent Physiatrist], in his documentation report of September/07, in many places has recorded that the patient had reduced activity following the accident due to symptoms of neck pain, etc., and in the shoulder increased by standing, bending, etc. She also had not been able to do any swimming or lifting any amount of weight. She had not been able to tolerate some of the activities required to work in the [text deleted]. As far as his examination was concerned, [Independent Physiatrist] does document limitation of movement of the shoulder, which he claimed was secondary to the gradual development of mild frozen shoulder, right side. He also records on Page 11 of his report that her neck movements were limited by 50% in extension, some restriction of neck rotation to the right and slightly to the left. She also had marked limitation of bending on the right side with discomfort with movement on the top of the right shoulder, especially lateral bending to the left and rotation to the right (Page 11). He also found discomfort in the right side of the patient's neck, and tenderness in the mid cervical region. [Independent Physiatrist] also detected tenderness in the infraspinatus region, as well, and a bit in the

medial scapular soft tissues on the right. The shoulder movement also showed restriction in the range with the scapula fixed (Page 11-12 of the independent examiner's report).

5. With regards to the opinion of [Appellant's Neurologist], it appears that he was prefixed in his examination with the finding of carpal tunnel syndrome and, most likely, did not pay attention to the subtle signs of nerve root irritation as had been documented by myself on Page 2 of my letter dated October 6th/08. He also possibly didn't have the advantage of seeing the MRI films himself and therefore couldn't look for specifically for specific signs to correlate with the findings of the MRI.

OPINION:

1. There is little doubt that this lady started to have symptoms related to her neck and shoulder area soon after the impact. It is the impact that caused pain in her shoulder which restricted her movements which, in turn, lead to the development of a right frozen shoulder; thus, the right frozen shoulder is a direct sequel to the accident.

2. This patient does have accelerated degeneration due to a blocked vertebra at C4-5 and has an osteophyte at the C5-6 level on the right but this is certainly asymptomatic. She had no symptoms in her neck prior to the accident ([Appellant's Doctor #1's] report dated October 3rd/08 and the history obtained by [Independent Physiatrist], refer Para I, Page 2 of his report). This would indicate that the neck symptomatology was precipitated by the accident. Although the degenerative changes might have been present, they were asymptomatic and certainly, if [Appellant's Neurologist] would have looked carefully, he would have found subtle signs of root irritation, as I did.

3. ...

4. I would like to take an objection to [MPIC's Doctor #2's] notation on Page 2 of his report dated November 24th/08 that, "it is not correct the reporting of neck pain and arm weakness was noted in June/06 and not two days prior to incident in question". It is clear from the documented history that the symptoms did arise immediately after the impact and had continued to be present until her cervical disc surgery." (underlining added)

After reviewing [Appellant's Neurosurgeon's] report dated September 22, 2010, [MPIC's Doctor #2] wrote to MPIC's legal counsel on January 12, 2011 and strongly disagreed with [Appellant's Neurosurgeon] and [Appellant's Doctor #1's] medical opinions. [MPIC's Doctor #2] stated there was no documentation to support [Appellant's Neurosurgeon's] opinion and further stated:

> "The file does not contain documentation indicating radiological assessments performed shortly before the incident in question and after the incident in question identified an enhancement of a pre-existing condition as a result of the incident.

[The Appellant] was assessed by a neurologist ([Appellant's Neurologist]) and two physiatrists ([Appellant's Physiatrist] and [Independent Physiatrist]) prior to [Appellant's Neurosurgeon's] involvement in her care. At no time was she noted to have objective clinical and/or electrophysiological findings of cervical radiculopathy.

[The Appellant's] pre-motor vehicle accident medical history did include problems with neck pain and arm weakness that could have been a byproduct of underlying cervical spine pathology.

The diagnosed C5-7 osteophyte complex pre-dated the motor vehicle incident in all probability." (underlining added)

Appeal:

The relevant Sections of the MPIC Act provide:

Events that end entitlement to I.R.I.

110(1) A victim ceases to be entitled to an income replacement indemnity when any of the following occurs:

(a) the victim is able to hold the employment that he or she held at the time of the accident;

Reimbursement of personal assistance expenses

131 Subject to the regulations, the corporation shall reimburse a victim for expenses of not more than $3,000. per month relating to personal home assistance where the victim is unable because of the accident to care for himself or herself or to perform the essential activities of everyday life without assistance.

The relevant Section of Manitoba Regulation 40/94 provides:

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;
(b) when care is medically required and dispensed outside the province by a person authorized by the law of the place in which the care is dispensed, if the cost of the care

> would be reimbursed under *The Health Services Insurance Act* if the care were dispensed in Manitoba.

The appeal hearing took place on November 2, November 24, and November 30, 2011. Mr. Ken Kalturnyk from the Claimant Adviser Office appeared on behalf of the Appellant and Mr. Terry Kumka appeared on behalf of MPIC.

The issues in the appeal were entitlement to further Income Replacement Indemnity ("IRI") benefits from July 2008 and entitlement to reimbursement for expenses associated with the surgery of July 24, 2008. The Commission determined that:

1. The only issue to be initially decided by the Commission was the issue of whether or not there was a causal connection between the Appellant's complaints to her arm and neck as a result of the motor vehicle accident of October 18, 2006.
2. The issue of the payment of IRI benefits and the reimbursement of expenses would be deferred pending the Commission's decision on the issue of causation.

The Appellant testified at the hearing and stated that:

1. Prior to the motor vehicle accident she did not have a problem with her neck and arm.
2. In the month shortly before the motor vehicle accident she was diagnosed with bursitis in her left elbow which was resolved in due course.
3. After the motor vehicle accident she immediately commenced to have pain to the right side of her neck and right shoulder and back.
4. From the time of the motor vehicle accident to the time of the surgery she had continuous and significant pain to neck and shoulder which adversely affected her normal activities, including her ability to work.

5. She received chiropractic treatments after the motor vehicle which caused improvement but several weeks after the motor vehicle accident she began to notice increased pain in her neck and shoulders which continued until the disc surgery performed by [Appellant's Neurosurgeon] in October 2008 and thereafter she no longer had any pain to her neck and right shoulder.

The Appellant was cross-examined by MPIC's legal counsel and essentially confirmed the reports she made to [Appellant's Neurosurgeon].

[Appellant's Neurosurgeon], who is an experienced neurologist, resides in [Saskatchewan] and testified by teleconference. [Appellant's Neurosurgeon] is a clinical professor of neurosurgery at the [text deleted], and a member of the medical staff at the [Hospital #2], [Hospital #3], and [Rehabilitation Centre], all of [Saskatchewan]. [Appellant's Neurosurgeon] previously held the position of Chair of the Head Injury Medical Board [text deleted]. The Department of Neurosurgery, [Hospital #2], in conjunction with the Saskatchewan Neurological Association and [text deleted] have established an annual lectureship in honor of [Appellant's Neurosurgeon].

[Appellant's Neurosurgeon] is also the author of six chapters in authorized medical texts relating to his area of expertise and has published 59 scientific medical papers between [text deleted] and [text deleted] in respect of his area of expertise.

In his testimony, [Appellant's Neurosurgeon] confirmed the medical opinions provided to the Commission and stated:

1. There was probably a pre-existing small osteophyte at the Appellant's C5-C6 prior to the motor vehicle accident which was too small to show up on an X-ray.
2. On February 23, 2008 he obtained an MRI at the [text deleted] Health Region which indicated that at the C5-6 level there was a disc protrusion.
3. Prior to the motor vehicle accident the Appellant did not report any pain to her neck and arm. This pain commenced immediately following the motor vehicle accident.
4. The Appellant continued to report neck and shoulder symptoms which he interpreted as a subtle radicular sign that the trauma caused by the motor vehicle accident exacerbated the osteophyte that contributed to the disc protrusion at the C5-6 level. This resulted in an encroachment on the nerve causing compression that induced the Appellant's neck and arm symptoms.

[Appellant's Neurosurgeon] further testified that:

1. [Independent Physiatrist], in his report, correctly set out the shoulder and neck problems suffered by the Appellant after the motor vehicle accident which in [Appellant's Neurosurgeon's] view indicated subtle radicular signs.
2. [Independent Physiatrist] incorrectly concluded that the Appellant suffered a frozen shoulder which caused the Appellant to experience neck and shoulder problems.
3. As a result [Independent Physiatrist] incorrectly concluded that the Appellant's complaints were not causally connected to the motor vehicle accident.
4. Although [Independent Physiatrist] was aware of the existence of the large osteophyte complex at C5-C6 and the disc protrusion, he failed to consider the impact that the motor vehicle accident had on the osteophyte and the disc protrusion in causing the Appellant's arm and neck symptoms.

[Appellant's Neurosurgeon] further testified relative to [Appellant's Neurologist's] reports that:

1. [Appellant's Neurologist] clearly indicated that the Appellant's right shoulder and neck was not the reason for her neurological consultation and clearly indicated that the reason for the neurological examination related to the Appellant's right carpal tunnel syndrome and had nothing to do with the motor vehicle accident.
2. Concluded that [Appellant's Neurologist] did not conduct any neurological examinations to determine that there were any radicular signs from the Appellant's cervical spine.
3. Subsequent to [Appellant's Neurologist's] examination he received the MRI scan which indicated a large posterior disc osteophyte complex at C5-C6 and that there was some apparent disc displacement of the spinal cord.
4. [Appellant's Neurologist] indicated that if conservative treatment was not adequate then a referral should be made to a spinal surgeon.

[Appellant's Neurosurgeon] further testified that:

1. [MPIC's Doctor #2's] opinion on causality was based on his view that there was documentation of a pre-existing neck pain and arm weakness two days prior to the motor vehicle accident.
2. [MPIC's Doctor #2] erred in this respect since there was no documentation to establish that the Appellant was complaining of neck pain and arm weakness two days prior to the motor vehicle accident.
3. He disagreed with [MPIC's Doctor #2] that the radicular signs had not occurred until sometime in the latter part of 2007, which was well after the motor vehicle accident.
4. The Appellant's symptoms in respect of arm and neck commenced immediately after the motor vehicle accident.

5. [MPIC's Doctor #2] did not appreciate that the motor vehicle accident resulted in the exacerbation of the existing osteophyte and contributed to the disc protrusion causing a nerve compression which resulted in the Appellant's symptoms to her neck and shoulder.
6. For these reasons [MPIC's Doctor #2] erred in concluding that there was no causal connection between the motor vehicle accident and the Appellant's complaints to her neck and shoulder.

[MPIC's Doctor #2] testified on behalf of MPIC and confirmed his medical opinion that:

1. The Appellant suffered from pre-existing neck pain and arm weakness two days prior to the motor vehicle accident.
2. The medical reports did not indicate that the Appellant presented with radicular findings until after [Appellant's Neurosurgeon] assessed her in January 2008, several years after the motor vehicle accident.
3. It was only speculation that the Appellant's neck and shoulder problems were a by-product of the disc changes identified at the C5-C6 level and that the motor vehicle accident resulted in an aggravation of the changes which later developed into radiculopathy.
4. It was not medically probable, based on the absence of documentation that the Appellant did not present with radicular findings until sometime in the latter part of 2007 which was well after the incident and did not support [Appellant's Neurosurgeon's] medical opinion.
5. There was no causal connection between the Appellant's complaints to her neck and arm and the motor vehicle accident.

In a written submission, the Claimant Adviser argued that:

1. [Appellant's Neurosurgeon] had a distinguished record as a neurosurgeon and based on his considerable experience and expertise there was a pre-existing osteophyte at the C5-C6 level prior to the motor vehicle accident which was too small to show up on the X-ray.
2. [Appellant's Neurosurgeon] testified that the continuous reporting of consistent neck and shoulder symptoms which were reflected in [Independent Physiatrist's] report clearly demonstrated subtle radicular signs.
3. [Appellant's Neurosurgeon] was of the view that if [Independent Physiatrist] had done a thorough physical examination he would have found that the Appellant's complaints were well documented which would have clearly demonstrated that in his view; there were signs of radicular pain.
4. [MPIC's Doctor #1] and [Appellant's Neurosurgeon] concluded that [Independent Physiatrist] erred in concluding that the Appellant's frozen shoulder caused the problems to her arm and shoulder and as a result Appellant's complaints were not causally connected to the motor vehicle accident.
5. The Commission should not accept the opinion of [Independent Physiatrist] who ignored the subtle radicular signs in arriving at his conclusion.
6. [MPIC's Doctor #2] erred in concluding that the Appellant complained of arm and neck problems two days prior to the motor vehicle accident.
7. [MPIC's Doctor #2] acknowledged his error in his testimony.

The Claimant Adviser also submitted:

1. That [Appellant's Neurosurgeon's] view of [Appellant's Neurologist's] report should be accepted.

2. [MPIC's Doctor #2] erred in concluding [Appellant's Neurologist] had conducted a neurological examination of the Appellant's arm and neck and as a result concluded that there were no radicular signs from the Appellant's cervical spine.
3. [Appellant's Neurologist] did not report any radicular signs because he was concentrating on the Appellant's carpal tunnel symptoms.
4. There is no record in [Appellant's Neurologist's] report that indicates he conducted a neurological examination of the Appellant's arm and shoulder.
5. [Appellant's Neurologist's] reports clearly indicated that he was addressing the carpal tunnel syndrome and was not addressing the issue of the Appellant's complaints to her right arm and shoulder.

MPIC's legal counsel reviewed [MPIC's Doctor #2's] medical opinion and submitted that his opinion should be accepted. [Appellant's Neurosurgeon's] opinion should be rejected and that he was acting as an advocate, and not a medical doctor, and had no objective evidence to support his opinion and that he was merely speculating about the existence of an osteophyte at the time of the motor vehicle accident. He further submitted that [Independent Physiatrist] and [Appellant's Neurologist] both conducted neurological examinations and did not find any radicular signs and therefore their opinions should be accepted over that of [Appellant's Neurosurgeon] and [Appellant's Doctor #1].

Discussion:

The Commission finds that on a balance of probabilities there was a causal connection between the motor vehicle accident of October 18, 2006 and the Appellant's complaints of arm and neck pain.

MPIC denied the Appellant's claim in respect of causality on the basis of [MPIC's Doctor #2's] review of documentary evidence and the reports of [Independent Physiatrist] and [Appellant's Neurologist]. On the other hand, [Appellant's Neurosurgeon] who is a distinguished neurosurgeon with many years of experience dealing with problems relating to the spinal cord disagreed with [MPIC's Doctor #2] on the issue of causality. The Commission accepts [Appellant's Neurosurgeon's] opinion that [MPIC's Doctor #2] erred in arriving at his decision in respect of causality on the following grounds:

1. [MPIC's Doctor #2's] opinion that the Appellant's symptoms in respect of her arm and neck commenced two days prior to the motor vehicle accident.
2. [MPIC's Doctor #2's] reliance on [Independent Physiatrist's] opinion that the Appellant did not exhibit any radiculopathy signs and that the cause of the Appellant's neck symptoms was due to a frozen shoulder and not the motor vehicle accident.
3. [MPIC's Doctor #2's] conclusion that, as a result of neurological tests conducted by [Appellant's Neurologist], the Appellant did not suffer from any radiculopathy to the arm and neck.

Commencement of Neck Symptoms:

[MPIC's Doctor #2] erred in concluding that the Appellant complained of neck and arm pain two days prior to the motor vehicle accident. As a result he found there was no temporal connection with the Appellant's symptoms and the motor vehicle accident.

[Appellant's Neurosurgeon] disagreed with [MPIC's Doctor #2] and asserted that the Appellant's complaints of neck and arm pain arose after the motor vehicle accident and continued to be present until the Appellant's successful cervical disc surgery.

The medical documentation on the Appellant's file indicates that at the scene of the motor vehicle accident she initially reported right shoulder pain. The Emergency Room record noted tenderness along the lower cervical and thoracic spine.

The Appellant reported that for three or four days after the motor vehicle accident she felt sore and she returned to work the next day. She commenced to receive chiropractic treatment on October 24, 2006 at which time it was documented that the symptoms included right-sided neck pain, right shoulder pain, scapular pain, and headache and lower back pain.

The Commission notes that the Appellant did visit the [text deleted] Clinic on June 16, 2006 with complaints of neck pain and weakness in the arm relating to excessive spring yard work and cleaning. An X-ray taken on June 27, 2006 showed no disc protrusion and she was diagnosed at that time with bursitis. In a report to MPIC on October 3, 2008, [Appellant's Doctor #1] stated that the Appellant was seen on October 5, 2006 by [Appellant's Doctor #2] in regards to a swelling of her left elbow. This diagnosis was later confirmed to be bursitis which resolved itself.

For these reasons the Commission finds that [Appellant's Neurosurgeon] was correct in concluding that [MPIC's Doctor #2] erred in finding that the Appellant's existing neck and arm weakness commenced two days prior to the motor vehicle accident in question. The Commission accepts [Appellant's Neurosurgeon's] opinion that the Appellant's complaints did not occur until after the impact of the motor vehicle accident.

[Independent Physiatrist's] Medical Report:

[Independent Physiatrist] conducted an extensive physical examination of the Appellant and reported the Appellant's continuous complaints in respect of her neck and arm from the date of the motor vehicle accident on October 18, 2006 to the time he examined her on September 12, 2007. Notwithstanding these findings, [Independent Physiatrist] concluded that the Appellant had not initially complained in respect of her neck and shoulder but subsequently developed a frozen shoulder which was the cause of the problems to the Appellant's neck and arm.

The Commission agrees with [MPIC's Doctor #1], Chief Medical Consultant of MPIC's Health Services, who after reviewing [Independent Physiatrist's] report disagreed with his diagnosis in respect of the frozen shoulder. [MPIC's Doctor #1], having regard to the Appellant's continuous complaints of her arm and shoulder, concluded that her complaints were caused by the motor vehicle accident and that the frozen shoulder was a consequence of the neck and arm complaints.

In reviewing [Independent Physiatrist's] report, [MPIC's Doctor #1's] stated:

> "In reviewing the body of [Independent Physiatrist's] consultative report, on a balance of probability, it appears that the painful right shoulder condition has progressed to a suspected right frozen shoulder. This condition is consistent with the chronological documentation as well as the plausibility that a painful right shoulder condition stemming from the collision of October 20906 (sic) could have led to decreased range of motion and ultimately a frozen shoulder presentation that [Independent Physiatrist] identified in the September 2007 examination."

[Appellant's Neurosurgeon] agreed with [MPIC's Doctor #1's] opinion that the frozen shoulder did not cause the Appellant's symptoms to her arm and neck and that the motor vehicle accident was the cause of the arm and neck symptoms which in turn resulted in the Appellant's frozen shoulder.

The Commission agrees with [Appellant's Neurosurgeon's] opinion that although [Independent Physiatrist] found consistent complaints by the Appellant in respect of her arm and shoulder, he failed to recognize that these complaints indicated subtle signs of nerve compression. The Commission further agrees with the medical opinions of [MPIC's Doctor #1] and [Appellant's Neurosurgeon] that [Independent Physiatrist] erred in concluding that the frozen shoulder was the cause of the Appellant's arm and neck complaints.

For these reasons, the Commission finds that [MPIC's Doctor #2] erred in relying on [Independent Physiatrist's] medical report to determine that there was no causal connection between the Appellant's complaints to her arm and neck and the motor vehicle accident.

<u>Medical Report of [Appellant's Neurologist]:</u>

[MPIC's Doctor #2] relied on the report of [Appellant's Neurologist] to support his opinion that there was no causal connection between the motor vehicle accident and the Appellant's symptoms in respect of her arm and neck. The Commission agrees with [Appellant's Neurosurgeon's] opinion that [MPIC's Doctor #2] misinterpreted [Appellant's Neurologist's] report by finding that [Appellant's Neurologist] had conducted neurological tests to demonstrate that there were no radicular signs in respect of the Appellant's symptoms.

[Appellant's Neurosurgeon] correctly concluded that [Appellant's Neurologist] had explicitly stated that the right shoulder and neck pain were not the reason for his consultation and that he was only concerned with whether or not the Appellant was suffering from a carpal tunnel syndrome. [Appellant's Neurologist] specifically stated that the reason for the neurological consultation was the Appellant's right carpal syndrome and this had nothing to do with the motor vehicle accident. [Appellant's Neurologist] also stated that the Appellant had neck and shoulder

pain but it was not the reason for the Appellant's consultation. The Commission notes that an examination of [Appellant's Neurologist's] report does not indicate that he had conducted any neurological examination of the Appellant's arm and shoulder but only examined the Appellant's wrist.

The Commission agrees with [Appellant's Neurosurgeon's] statement in his report of November 22, 2010 that [Appellant's Neurologist] appeared to be pre-fixed in his examination with the finding of carpal tunnel syndrome and most likely did not pay any attention to the subtle signs of root nerve irritation being demonstrated.

The Commission therefore finds that [MPIC's Doctor #2] erred in finding that [Appellant's Neurologist] had conducted a neurological examination of the Appellant's arm and neck to determine that there was no indication of any radicular signs from the Appellant's cervical spine.

The Commission therefore agrees with [Appellant's Neurosurgeon] that [MPIC's Doctor #2] erred in his interpretation of [Appellant's Neurologist's] report that [Appellant's Neurologist] had conducted neurological examinations which demonstrated that the Appellant did not display any radicular signs in respect of her cervical spine.

For these reasons that the Commission rejects [MPIC's Doctor #2's] opinion that there was no causal connection between the motor vehicle accident and the Appellant's complaints to her arm and neck and agrees with both [MPIC's Doctor #1] and [Appellant's Neurosurgeon] that there was a causal connection in this respect.

The Commission rejects the submission by MPIC's legal counsel that the [Appellant's Neurosurgeon] acted as an advocate rather than as a medical doctor in concluding that there was a causal connection between the motor vehicle accident and the Appellant's symptoms. [Appellant's Neurosurgeon] is a distinguished neurologist with many years of experience dealing with spinal injuries. Unlike [MPIC's Doctor #2] he personally examined the Appellant on several occasions and accepted her statements that her pain to her arm and neck commenced immediately following the motor vehicle accident. The Commission finds that the medical evidence does support the Appellant's position in this respect.

The Appellant testified in a direct and unequivocal fashion in examination in chief and maintained her position in cross-examination. Unlike [MPIC's Doctor #2], [Appellant's Neurosurgeon] did have the opportunity of assessing the Appellant's credibility during his examinations of her and there was no report by him that the Appellant in any way exaggerated her injuries or was inconsistent in the history of her claim. The Commission finds that the Appellant's testimony at the appeal hearing was corroborated by the medical reports of [MPIC's Doctor #1] and [Appellant's Neurosurgeon].

[Appellant's Neurosurgeon] testified that prior to the motor vehicle accident a small osteophyte existed on the Appellant's C5-6. The initial X-ray after the motor vehicle accident did not indicate the existence of the small osteophyte on the Appellant's C5-6. However, after the motor vehicle accident, the MRI indicated a large osteophyte on the Appellant's C5-6 which [Appellant's Neurosurgeon] removed during the course of surgery. [Appellant's Neurosurgeon] testified that having regard to the size of the osteophyte that he removed from the Appellant's C5-6 when he conducted the spinal surgery, that a small osteophyte must have pre-dated the

motor vehicle accident. [MPIC's Doctor #2] agreed with [Appellant's Neurosurgeon] in his report to MPIC's legal counsel dated January 12, 2011 who stated:

> "The diagnosed C5-6 osteophyte complex pre-dated the motor vehicle incident in all probability."

The Commission further notes that the Appellant's X-ray report on October 5, 2006, prior to the motor vehicle accident did not disclose any mild degenerative disc space narrowing at C5-6 but that the X-rays taken on the date of the accident on October 18, 2006 did show a degenerative disc space narrowing at C5-6.

Based on his investigation [Appellant's Neurosurgeon] concluded that the motor vehicle accident exacerbated the osteophyte and caused the disc protrusion resulting in a nerve compression which produced pain and weakness to the Appellant's arm and neck. The Commission therefore rejects the submission of MPIC's legal counsel that [Appellant's Neurosurgeon] acted on speculation when he concluded the cause of the Appellant's pain and suffering to her arm and neck were due to the motor vehicle accident.

The Commission finds that the Appellant has established on a balance of probabilities that as a result of the motor vehicle accident, she suffered pain to her arm and shoulder which had an adverse effect to her quality of life and her ability to work. The Commission therefore allows the Appellant's appeal on the issue of causality and dismisses the Internal Review Officer's Decision of January 15, 2009 in this respect.

The Commission deferred the Appellant's appeal in respect of the payment of IRI benefits and reimbursement of expenses until a determination on the issue of causation was made. The

Commission will therefore be contacting both the Claimant Adviser Office and MPIC's legal counsel to set dates to hear the Appellant's appeal in this respect.

Dated at Winnipeg this 29th day of December, 2011.

MEL MYERS, Q.C.

PAUL JOHNSTON