Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an appeal by [the Appellant]
AICAC File No.: AC-99-19

PANEL:	**Mr. J. F. R. Taylor, Q.C. (Chairperson)** **Mrs. Lila Goodspeed** **Mr. F. Les Cox**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') represented by Mr. Tom Strutt** **[Text deleted], the Appellant, appeared on her own behalf.**
HEARING DATE:	**July 12th, 1999**
ISSUE:	**Whether Appellant entitled to continuing physiotherapy.**
RELEVANT SECTIONS:	**Section 5(b) of Manitoba Regulation No. 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:

[The Appellant] was injured in a motor vehicle accident on November 8th, 1994. She was the driver of her car that was stopped at an intersection when it was rear-ended by another car. The driver behind told her his foot had slipped off his brake pedal, rendering him unable to avoid the collision. The motor vehicle accident (MVA) occurred at 5:25 p.m. [the Appellant] attended from 6 p.m. until

8 p.m. at the emergency ward of [hospital], where she was X-rayed. The following day and on November 15th, 1994, the Appellant attended at the office of her family physician, [text deleted] who diagnosed a cervical strain due to the MVA. He prescribed physiotherapy at a frequency of 2-3 times per week for 3-4 weeks, along with Tylenol #3 and a muscle relaxant. In his report to MPIC on November 15th, 1994, [Appellant's doctor] said the Appellant was unable to resume her occupation as a telephonist at that time; he did not anticipate a permanent disability.

A short report from [text deleted] Physiotherapy of November 14th, 1994, also describes [the Appellant's] injury as cervical strain. At the Appellant's first meeting with her MPIC adjuster on November 15th, she said her common law spouse was doing the housework for both of them.

On December 13th, 1994, [Appellant's doctor] again reported that the Appellant was "unable to perform regular duties at this time." He was unsure when the disability would end. He continued to describe the injury as a cervical strain and prescribed physiotherapy for another 2-3 weeks at the rate of 2-3 times a week plus muscle relaxant medication. He did not refer the Appellant to a specialist.

[The Appellant] continued with the recommended treatment and received Income Replacement Indemnity (IRI) from MPIC, commencing from November 15th, 1994. By December 20th she was driving a car and had started on an exercise program, although complaining of pain in her right arm, her neck, upper back and both shoulders.

On January 3rd, 1995, following another discussion with the Appellant, the adjuster noted the

Appellant's healing was progressing slowly, but that her physiotherapist felt she would be able to return to work (RTW) by the end of January or early February.

[Appellant's doctor], in a letter to MPIC of February 4th, 1995, reported that he had seen the Appellant that day and that she "…has been suffering from a moderately severe cervical and trapezius muscle strain. This is worse on her right side……She had a great deal of spasm in these muscles and a decreased range of motion of her neck and right shoulder." He was of the view that these injuries were a direct result of the Appellant's MVA and that physiotherapy was the only treatment necessary. He noted improvement in her symptoms. He expected full recovery and noted that the Appellant was due to RTW on February 6th, 1995, for 4 hours per day for 2 weeks with a possible return to full time after that.

On February 22nd, 1995, [the Appellant's] adjuster at MPIC, concerned that full time RTW had not yet been achieved, and that [the Appellant] still spoke of limiting her working hours to four per day, asked [Appellant's doctor] to discuss, and to set some specific objectives for, a graduated return to full- time work.

On March 1st, [Appellant's doctor] advised MPIC that the Appellant would continue to increase her working hours to 5 hrs per day until March 10/95 and 6 hrs per day from March 11/95 to March 25/95. He also recommended a trial with acupuncture to accelerate improvement. IRI continued but was adjusted to take [the Appellant's] partial earnings into account.

On March 20th the Appellant called her adjuster to request that massage be added to her treatments; she was told that MPIC did not pay for massage treatments unless they were dispensed by a physician, chiropractor, physiotherapist or athletic therapist.

On April 6th, 1995 the adjuster wrote the Appellant for an update on her employment hours and for a supporting medical report.

A report from [Appellant's doctor] dated April 7th stated the Appellant was then capable of resuming her main occupation. He further stated that her disability had ended March 27th, although he recommended continued physiotherapy at a frequency of once a week for 4 to 6 weeks and home exercises.

MPIC terminated [the Appellant's] I.R.I. as of March 27th, 1995.

On May 2nd, 1995, [Appellant's doctor] reported to MPIC "cervical strain - condition has stabilized with physiotherapy ready for trial of discharge from physiotherapy. May need to return intermittently if strain flares up."

On August 3rd, the Appellant told her adjuster she had reached a plateau with her physiotherapy, from which she expected to be discharged on or about August 17th. She added that her progress from acupuncture was no longer benefiting her. She requested MPIC to pay for an ice pack, flat shoes, and massage therapy, and a heating pad. The ice pack and heating pad costs were approved by

MPIC.

On September 20th, 1995, the Appellant's adjuster appears to have learned that the Appellant was returning to physiotherapy because of pain that had developed since her trial discontinuance of therapy.

On December 22nd [Appellant's doctor] advised MPIC that the Appellant had "cervical strain – flareup over past 2 – 3 weeks." Physiotherapy once or twice a week for 3 – 4 weeks and a heating pad were prescribed. [Appellant's doctor] did not consider the Appellant unable to resume full duties. A moist heat pad was approved by the adjuster January 8th, 1996.

The next item of significance in the chronology of this file is a report from [Appellant's doctor] to MPIC dated August 15th, 1996 to the effect that the Appellant had cervical and lumbar strain that he classed as a Grade II whiplash associated disorder (WAD 2). He stated that [the Appellant] was not improving, was using both a cervical collar and a lumbar corset and was complaining of lower back pain radiating into the lateral aspect of each thigh; she had also reported tenderness over the ilio-tibial bands bilaterally. [Appellant's doctor] described the Appellant as 'fully functional with symptoms' and capable of 'work full duties.' The management plan that he suggested was to "maintain usual activities".

The Appellant was then referred by [Appellant's doctor] to [text deleted], a specialist in inflammatory and arthritic diseases. [Appellant's rheumatologist's] report to [Appellant's doctor] of

September 30th, 1996, after outlining [the Appellant's] medical history since her MVA, diagnosed fibromyalgia and recommended a 'Shape of Sleep' pillow, physiotherapy with emphasis on education in stretching exercises for the tensor fascia lata, plus aquacize as part of an aerobic program. He prescribed Naprosyn to relieve the Appellant's discomfort in the trochanteric bursa, noting that, if that medication proved unsuccessful, he would inject the bursa bilaterally.

[Appellant's doctor] was asked by MPIC on November 22nd, 1996 to describe a management plan for the Appellant's complaints, to include the extent of treatments prescribed, their goals, and when the conclusion of those treatments might be expected. We can see no response in the Appellant's file to this request.

A report to MPIC dated January 3rd, 1997, from [text deleted] Physiotherapy Clinic described the Appellant as having full cervical and lumbar ROM. The Appellant had reported some difficulties sitting, standing, and walking but had been able to continue curling on a weekly basis. The physiotherapist noted the Appellant still had back pain but was "managing fairly well" and the therapist intended to reduce the treatment frequency and advised the Appellant to continue her exercises.

From April 25th through November of that year, there followed several discussions and exchanges of correspondence between MPIC and the [text deleted] Physiotherapy Clinic, to which the Appellant had apparently been going about once per month for treatments as a result of what she described as 'flare-ups' resulting from activity. The purpose of those treatments was to help reduce muscle spasm

and increase the Appellant's joint mobility

MPIC paid the costs of those treatments to November 17th, 1997, and wrote to [Appellant's doctor] for an up-dated medical report. [Appellant's doctor] eventually responded that he had not seen the Appellant since August 16, 1996, that she had had no pre-accident history of back or neck trouble, that he had referred her to [Appellant's rheumatologist] who had diagnosed fibromyalgia and that [Appellant's rheumatologist] had recommended physiotherapy as an ongoing treatment. Not having seen the Appellant recently, [Appellant's doctor] declined to comment on the chronicity or prognosis of her impairment. He referred MPIC to [Appellant's rheumatologist].

In response to a December 29th, 1997, enquiry from MPIC, [Appellant's rheumatologist] reported that his working diagnosis had originally been one of fibromyalgia and trochanteric bursitis. Of numerous tests that had been performed, most showed no abnormality. One test had revealed that the Appellant's sedimentation rate was elevated, indicating an ongoing inflammatory response somewhere in her body, but with no specificity. When the tenderness in the trochanteric bursae persisted, [Appellant's rheumatologist] had suggested corticosteroid injections which would have provided relief for weeks and possible months. The plan then would have been to try and modify the mechanical factors which had produced the tight tensor facia lata. The Appellant had rejected that suggestion.

As an alternative, [Appellant's rheumatologist] dealt with the factors delaying the Appellant's recovery, her poor sleep pattern and poor aerobic conditioning. He had suggested abstention from

caffeine and the commencement of an acquasize program. He concluded that there was no immediate role for further physiotherapy except to demonstrate stretching exercises to relieve the Appellant's tensor facia lata. [Appellant's rheumatologist] stated he was unaware of any pre-existing conditions prior to her motor vehicle accident.

In this same reporting letter, dated January 8th, 1998, [Appellant's rheumatologist] concludes by saying

> "The patient does not complain of any cervical or shoulder discomfort in our recent visits. Her discomforts appear to be limited to her lower back and trochanteric bursa region. ……..I can make no temporal association of the onset of the back discomfort to the motor vehicle accident. It appears that her cervical discomfort which resulted from the accident was resolved."

MPIC then referred the most recent medical reports to its own, in-house consultant, [text deleted]. On June 15/98 [MPIC's doctor] reviewed the Respondent's personal injury file respecting [the Appellant], including [Appellant's rheumatologist's] most recent report, and concluded that her complaints then present were not related to the MVA. Based on [MPIC's doctor's] conclusions, MPIC terminated payments for the Appellant's physiotherapy treatments after June 17th, 1998.

The Appellant requested an internal review,, which was held on October 1st, 1998. The Internal Review Officer was provided with an up-dated report from [Appellant's doctor], dated August 19th, 1998. [Appellant's doctor] gives a partial history to the effect that

> Since her 1994 MVA, [the Appellant] has been attending physiotherapy and acupuncture for intermittent flare-ups of pain in her neck and shoulders which began with this 1994 MVA.

> She has also been attending [Appellant's rheumatologist] for this pain along with lower back and hip pain.

He described the Appellant as having full range of motion of her neck and shoulders but with significant tenderness and spasms of her suboccipital muscles and rhomboid muscles bilaterally. He opined that the Appellant would benefit from ongoing physiotherapy including acupuncture for her neck pain.

Since the Appellant had made reference to treatments at the [text deleted] Physiotherapy Clinic that ended in either April or May 1998, the Internal Review Officer sought and obtained a report from that Clinic dated November 4th, '98. The Appellant had originally presented with complaints of neck, shoulder, low back and buttock pain, along with episodes of severe pain and "freezing" (unable to move due to pain). When last assessed by the Clinic on March 31st, 1998, objective findings had been:

1. Lumbar range of motion – full with discomfort and forward flexion.
2. Lumbar stabilization strength gr 3+/5.
3. Tight piriformis bilateral, tender to palpation of same.
4. No neurological findings.
5. Cervical range of motion – full.
6. Muscle tightness upper traps, levator scapulae.
7. Facet dysfunction C3.
8. No neurological findings.

The report suggested that the Appellant might benefit from trigger point injection treatment and that it may provide long term relief. It was noted that the Appellant appeared compliant with a home exercise program but might require further physiotherapy 'to settle flare-ups of her symptoms'.

By way of a decision letter of January 5th, 1999, MPIC's Internal Review Officer confirmed the adjuster's decision, upon the basis that any injuries that could reasonably have been attributable to [the Appellant's] MVA had long since been repaired and that her more recent symptoms of fibromyalgia and trochanteric bursitis had not been caused by that accident. It is from this latter decision that [the Appellant] now appeals.

DISCUSSION:

There is little doubt that [the Appellant's] cervical strain was a direct result of her motor vehicle accident, but the evidence of [Appellant's doctor] in April of 1995, and certainly by August of that year, was that the Appellant's cervical strain had stabilized with her treatments.

In light of the mechanics of that accident, as described to us by the Appellant, this is about the maximum time-frame (i.e. five-to-nine months post-accident) within which one might have expected the cervical strain to have healed. [Text deleted], MPIC's in-house consultant, goes a step further and suggests that the result of that impact would have been a minor cervical strain - so minor, indeed, that he felt it would in all probability have resolved itself without therapeutic intervention. [MPIC's doctor] bases his view upon the presumption that the other vehicle had come to a complete stop, and that only then had its driver allowed his foot to slip off the brake pedal, resulting in an inconsequential collision. We are not prepared to go that far; we accept the evidence of the Appellant as to the nature of the accident, to the effect that the other car had not quite come to a complete stop

at any time prior to the collision. We are also well aware that the extent of the physical damage to a vehicle is not, of itself, necessarily a reliable indicator of the extent of the injury caused to the occupant(s) of the vehicle; that is but one factor to be considered. At the same time, the fact is that [the Appellant's] vehicle appears to have sustained minimal damage - a small dent in the rear bumper - and the other vehicle none.

[Appellant's rheumatologist], when he came to examine the Appellant in September of 1996, found that her

> 'general medical examination was unremarkable. Musculoskeletal examination revealed no evidence of peripheral joint sinovitis……normal cervical, thoracic and lumbar range of movement. She had 18:18 fibrositic tender points…..tight tensor fascia lata.'

[Appellant's rheumatologist] diagnosed fibromyalgia, resulting from referred pain from the neck and back as well as poor sleep and poor aerobic conditioning. "She does" he said, " have tight tensor fascia lata and trochanteric bursitis which is producing her leg pain."

The association of fibromyalgia with trauma has not been scientifically validated although, it has to be added, there seems to be an increasing body of anecdotal evidence pointing to at least that possibility. In [the Appellant's] case, however, despite the fact that she developed symptoms involving her neck and upper back regions following the MVA, her low back pain and fibromyalgia syndrome did not become apparent until August of 1996, some 19 months following the MVA;
The Appellant had 128 treatments of physiotherapy, many of them accompanied by acupuncture treatments and, based upon the evidence of [MPIC's doctor], we conclude that was an excessive amount of therapy for a mild, soft tissue cervical strain and ample therapy even for a moderately

severe strain.

The body of medical evidence supports the view that [the Appellant's] injury was a cervical strain that was resolved and stabilized before other areas of her body began to demonstrate pain. The systemic inflammation referred to by [Appellant's rheumatologist] is a likely cause of her most recent symptoms, but there has not been any follow-up of which we have been made aware to determine the site of that inflammation nor whether, indeed, there is such a localized site. It is also noteworthy that [Appellant's rheumatologist], in December of 1997, saw no need for continued physiotherapy except for educational purposes.

CONCLUSION:

A careful reconsideration of the totality of the evidence, including the very capable submissions made to us both by the Appellant and by counsel for the insurer, does not persuade us of the cause-and-effect relationship between the Appellant's MVA and the soft tissue problems of which she now complains. We therefore find that, although the Appellant may, perhaps, benefit from occasional physiotherapy, that modality of treatment has not been established as 'medically necessary' within the meaning of Section 5 of Manitoba Regulation No. 40/94 nor, on a reasonable balance of probabilities, have [the Appellant's] fibromyalgia and related symptoms been causally related to her MVA. It follows that her appeal must fail.

Dated at Winnipeg this 20th day of September, 1999.

J. F. REEH TAYLOR, Q.C.

LILA GOODSPEED

F. LES COX