AUTOMOBILE INJURY COMPENSATION APPEAL COMMISSION

IN THE MATTER OF an appeal by [the Appellant]
AICAC File No.: AC-98-80

PANEL:	**Mr. J. F. Reeh Taylor, Q.C. Chairman** **Mrs. Lila Goodspeed** **Mr. Colon Settle, Q.C.**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') was represented Ms Joan McKelvey.** **The Appellant was represented by [Appellant's representative].**
HEARING DATE:	**January 26, 2000**
ISSUE(S):	**A. Whether Appellant entitled to reinstatement Income Replacement Indemnity (IRI)** **B. Whether Appellant entitled to reinstatement of Psychotherapy treatments**
RELEVANT SECTIONS:	**83(1)(a), 84(1)&(3), 106(1)&(2), 110(1)(c) and 136(1) of the Manitoba Public Insurance Act ('the Act')**

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

[Text deleted], the appellant, was the victim of a motor vehicle accident ('MVA') on July 26, 1996. [The Appellant] was en route to work, proceeding into an intersection on a green light, when a truck entered the intersection and his car was hit broadside on the driver's side. [The Appellant] lost consciousness for some 90 minutes; he was taken to

[hospital] where he was observed and assessed for two days. He suffered a concussion and sustained fractures to his left 8th and 9th ribs, and fractures to the left transverse processes of L2, 3, and 4. He also sustained soft tissue injuries to his neck, shoulder girdle and thoracolumbar spine.

He saw his family physician, [text deleted], on August 6 who reported that he had significant limitation in function and was unable to work at any job. He was prescribed Ibuprofen and Tylenol #3 and referred to physiotherapy.

Prior to his accident, [the Appellant] had been disabled following bypass surgery in 1986 to address peripheral vascular disease, from which he was left with residual leg pains. After surgery, he had been in receipt of Canada Pension Plan disability benefits from 1987 until March 1996.

Between 1989 and 1991, [the Appellant] worked sporadically for some nine different food retailers and wholesalers, earning an aggregate of about $24,000. From 1992 to 1994, his earnings were $22,177. He was, therefore, capable of part-time work from 1989 through 1994. His employment history from 1994 through 1996 is unclear. He was apparently able to resume work in January 1999 on a part-time basis for [text deleted] working as a cook and bartender for 20 to 30 hours a week. Prior to the accident, he testified, he had not had disabling back problems. He had had no difficulties working, despite his leg and perceived cardiac problems for which he was prescribed Nitroglycerin. His employer was aware of his condition and allowed him to take rests

when he needed them. After his accident, [text deleted] would not reinstate him in his former employment because he was unable able to carry out the full duties such as lifting. He testified that [text deleted] no longer employed [text deleted] cooks after 1997. His CPP disability payments seem to have been reinstated in June 1999.

[The Appellant] stated that MPI referred him to the [rehab clinic #1] for an assessment which [Appellant's doctor] approved; however, [Appellant's doctor] would not allow him to participate in any programs because [Appellant's doctor] was fearful that [the Appellant] might suffer a heart attack. Later, [Appellant's doctor] referred him to [Appellant's cardiologist] and other cardiologists where he underwent a number of stress tests, with the conclusion that the chest pains were not cardiac but musculoskeletal in origin.

[The Appellant's] evidence was that, currently, he has 'gnawing pain' in his lower back, and if he is on his feet too long he has pains in his leg. For relief he takes five or six Tylenol #3 daily and wears a support belt. [Appellant's doctor] had told him to reduce the number of Tylenol to one or two per day; however, he feels he needs five to six for the pain. [The Appellant] said he is currently only seeing [Appellant's doctor] who, despite expert opinion that he has no cardiac condition, prescribes him Nitroglycerin He spends his day going for short walks, doing some volunteer work at the church, but no stretching or other exercise 'because it hurts.' He stated that he still had circulatory problems with his leg and has pain that turns to numbness in the back of his calves, mostly in his left leg.

[The Appellant] underwent the following assessments and procedures:

- On August 13, 1996, [the Appellant] was examined by [text deleted], orthopedic surgeon at [text deleted], who advised him that he was not fit for work and recommended a course of gentle physical therapy to work on his mobility at the [text deleted] Clinic. Therapy commenced on August 14th, 1996, for an estimated duration of eight to 12 weeks. [Appellant's doctor] advised [the Appellant] in September to stop physiotherapy because he complained of some chest pains for which [Appellant's doctor] prescribed Ibuprofen and Tylenol #3.
- On October 3, 1996, MPI requested [vocational rehab consulting company] to undertake a Job Demands Analysis of [the Appellant's] job at [text deleted] to determine the duties and tasks required to fulfill his former part-time position as a bartender. [Vocational rehab consulting company] noted that the bartender position included medium to heavy duties and that duties were performed independently. [Vocational rehab consulting company] recommended that [the Appellant's] functional abilities would need to be matched to the job demands to ensure a safe and effective early return to work. As well, [vocational rehab consulting company] suggested that [the Appellant] might benefit from Occupational Therapy education regarding proper body mechanics, pacing and energy conservation if returning to this job.
- [The Appellant] was again examined on September 3rd and October 15th, 1996, by [Appellant's orthopedic surgeon #1]. X-rays taken on October 15th, ten weeks post-injury, showed progress in the healing of his rib and vertebral fractures.

[The Appellant] was advised by [Appellant's orthopedic surgeon #1] that his injuries were now stabilizing and that he should continue to work on function and attend a physical therapist. [Appellant's orthopedic surgeon #1] expressed the view that, at the time of his last examination on October 15th, [the Appellant] was still unable to resume his work as a cook, but that, with appropriate physical therapy and reconditioning over the next six to eight weeks, he could recover to a functional level where he could undertake some modified activity and begin a graduated return to his previous employment. He further stated that conflicting medical advice would not benefit him and if he was happy with his family physician he should continue to follow up with him. [Appellant's orthopedic surgeon #1's] clinical notes and x-ray results were sent to [Appellant's doctor]. [The Appellant] followed the advice of [Appellant's doctor], to the effect that he was to remain off work and without any activity because of a concern of an angina attack and circulation problems.

- On January 22, 1997, the adjuster wrote to [Appellant's doctor] stating that MPIC was required to determine an employment for [the Appellant] and his capability of holding that employment on a full-time basis. [Appellant's doctor] was asked to estimate the number of hours that [the Appellant] would have been able to work as a cook considering his pre-morbid history, had his accident not occurred. [Appellant's doctor] responded that [the Appellant] would have been able to work a full 40 hours per week, since his angina and circulation problems had not limited 'his ability to do various heavy work.' We are constrained to

note that this opinion is not supported by the Appellant's pre-accident history of employment.

- MPI sent [the Appellant] to [text deleted] Physiotherapy Clinic, where he was seen by [Appellant's physiotherapist #1] on January 23rd 1997, for an assessment of his current physical status and for recommendations regarding ongoing rehabilitation.

  [Appellant's physiotherapist #1] reviewed reports from [Appellant's doctor] of September 6th and December 13th , from [Appellant's orthopedic surgeon #1] of November 19th, 1996, and from the [text deleted] Physiotherapy Clinic of August 14th, 1996. [Appellant's physiotherapist #1] recommended a multidisciplinary approach to successful rehabilitation, including psychological counselling for pain management and pool exercises, which would progress to dry land flexibility, and strengthening exercises if [the Appellant's] physician approved. He believed [the Appellant] could do some duties as a cook (with frequent breaks) and a few bartending duties. He believed the main barrier to [the Appellant's] occupation was more related to his leg and angina problems than to his back.

- [The Appellant] was referred by MPIC to the [rehab clinic #1] for a work hardening program assessment. On February 20, 1997, occupational therapist, [text deleted], and physiotherapist, [text deleted], reviewed reports by [Appellant's physiotherapist #1] and [Appellant's orthopedic surgeon #1],

[Appellant's doctor's] notes, and the Job Demands Analysis that had been completed by [vocational rehab consulting company] in October 1996.

- On February 20, 1997, [Appellant's physiotherapist #2] and [Appellant's occupational therapist] concluded that significant psychological intervention would be required to assist the client with the barriers of chronic pain behaviour and lack of motivation to participate in a program. They cited the concern expressed by [text deleted], the program psychologist, who stated that one of the significant barriers which existed to successful programming was [the Appellant's] belief that more active, rigorous types of intervention would cause him to drop dead. Their recommendations for [the Appellant] were as follows: assessment in a multidisciplinary chronic pain program with more emphasis on psychological intervention than on a work hardening program; attendance in a program in close proximity to [the Appellant's] home to improve compliance; a review of program deadlines and expectations with [the Appellant] and MPIC prior to commencement; a closely monitored physical program due to cardiovascular concerns; and a review by [Appellant's doctor] of the client's medication regime and consideration of a possible trial of anti-depressant medication following [Appellant's psychologist #1's] recommendation.
- Occupational therapist [text deleted] talked to [Appellant's doctor] on February 14th . [Appellant's doctor], although he supported the assessment for [the Appellant], would not authorize the client's participation for programming because, he said, [the Appellant] would not be able to do physically demanding work again due to angina and poor cardiovascular status. This, we should note,

seems contrary to [Appellant's doctor's] earlier advice to MPIC on January 31st, 1997, to the effect that [the Appellant's] angina and circulation problems, that [Appellant's doctor] had observed for a long time prior to [the Appellant's] accident of July 26th, 1996, had never limited his working ability.

- On April 3rd, 1997, [MPIC's doctor], of MPIC's in-house medical consultancy team, examined [the Appellant's] file and recommended that he undergo psychological testing by [Appellant's psychologist #1] to determine if there had been any cognitive dysfunction that had developed from the MVA, and whether there was an apparent need for psychological counselling. [MPIC's doctor] also undertook to write to [Appellant's doctor] for his opinion whether [the Appellant's] physical limitations were more a result of his underlying cardiovascular disease or a result of the physical symptoms developed as a result of the MVA. [MPIC's doctor] advised MPIC that, once this information was received, appropriate steps should be taken in order to assist [the Appellant] in returning to his pre-collision status.

- [The Appellant] was referred to [Appellant's psychologist #2] on June 3rd, 1997, for a neuro-psychological assessment to determine any possible underlying cognitive impairments as a result of the accident and for psychological counselling to deal with any issues arising as direct results of the accident. [Appellant's psychologist #2's] initial assessment reported that [the Appellant] was deconditioned and had significant barriers to rehabilitation, including low motivation, avoidance of activities, low-level social recreational activities, sleep difficulties, and a fear of exacerbating his cardiovascular condition. He

recommended that [the Appellant] not enter into a work hardening program at that date, due to his low level of pain tolerance and past medical concerns; he recommended psychological intervention to assess [the Appellant's] understanding of the nature of the rehabilitation process. A third recommendation was for a multidisciplinary rehabilitation program with psychological intervention initially to address psychosocial issues, pain management, and sleep difficulties. He believed that [the Appellant] could, after these interventions, be a candidate for a functional restoration program. Since counselling had been authorized by MPIC, arrangements were made for it to start immediately, once a week, with a re-evaluation of [the Appellant's] psychological condition after three months, which would be September, 1997.

- On June 24th, 1997, [the Appellant's] adjuster wrote to him, to say that the Corporation had determined an employment for him as of the 181st day following his accident, pursuant to Section 84 of the Act. The employment selected for him was that of a cook, and the Gross Yearly Employment Income assigned to him, after adjustment under the Regulations, was $25,669.99. His Income Replacement Indemnity was set at $660.42 bi-weekly, based upon a perceived ability, pre-accident, to work 27.75 hours per week.
- [The Appellant] was referred to [Appellant's neuropsychologist] for a neuropsychological assessment which took place on June 6th, 1997. In his report of July 5th, [Appellant's neuropsychologist] concluded that [the Appellant] was functioning within normal limits for all functions related to the neuropsychological testing. [Appellant's neuropsychologist] found that,

emotionally, there were chronic pain issues due to a very real fear on [the Appellant's] part of a possible heart attack if he were physically to over-exert himself. [Appellant's neuropsychologist] found no necessity for further neuropsychological follow-up, but recommended that [the Appellant] should continue with the pain management program with [Appellant's psychologist #2].

- [The Appellant] was referred by MPIC for a follow-up examination with [text deleted], physiotherapist, on July 2nd, 1997, to determine his condition at that date. [Appellant's physiotherapist #1] noted [the Appellant's] exaggerated pain response to all activities and concluded that there was no significant organic source for the back pain of which the Appellant still complained, but hoped that [Appellant's psychologist #2's] therapy would help in management of [the Appellant's] pain. [Appellant's physiotherapist #1] was of the opinion that [the Appellant's] inability to return to the position of a part-time cook was the result of 'psychological/social factors and other health issues.' However, after obtaining a job description from the Appellant, he believed that [the Appellant] might be able to perform a graduated return to work, starting two hours per day and alternating between sitting and standing for the food preparation duties. [Appellant's physiotherapist #1] stated that it might not be safe for [the Appellant] to serve meals or receive and store supplies.

- On September 15th, 1997, [MPIC's doctor] had a conversation with [Appellant's doctor] about an appropriate physical rehabilitation program for [the Appellant]. [MPIC's doctor] suggested that a physiotherapist would outline a program and have it reviewed by [Appellant's doctor] for his comments and approval.

[MPIC's doctor] felt that the physiotherapist would be able to educate [the Appellant] regarding a stabilization program to improve his level of function. [Appellant's doctor] had agreed that this would be appropriate, but stressed again that [the Appellant] could not engage in any heavy weight exercises because of his ischemic heart disease.

- [Appellant's psychologist #2] reported on September 26th that [the Appellant] reported positive feedback regarding his ongoing psychotherapy and that he experienced significant improvement in the level of his pain and the onset and maintenance of his sleep. He had gained more control over his pain sensations and reportedly was gradually increasing his level of social/recreational activity. His future vocational concerns continued to be hindered by the history of cardiovascular problems and the ongoing medical investigation of his current condition. In his recommendations, [Appellant's psychologist #2] offered the opinion that [the Appellant] was not currently capable of entering into a work hardening program due to his circulatory problems and that he did not believe [the Appellant] would be able to attend a multidisciplinary rehabilitation program in the near future. He recommended continuing with pain/stress management. He felt that [the Appellant] was vulnerable to change due to his high level of perceived stress and low-level pain tolerance, in addition to his medical history. A gradual increase of his social and recreational activities and the level of his physical exercise seemed to be crucial to his physical and vocational future.
- In an interdepartmental memorandum to the MPI case manager, dated October 10th, 1997, [MPIC's doctor] gave his opinion that [the Appellant's] inability to

return to his previous part-time work was solely the result of his cardiovascular problems. He noted that [the Appellant] had shown improvement in his psychological problems and that there was no medical documentation to indicate that [the Appellant] was physically unable, as a result of his motor vehicle accident, to perform the duties of a part-time cook. [MPIC's doctor] reported that he had recommended, with [Appellant's doctor's] support, that a rehabilitation program with restrictions should be undertaken by [the Appellant]. He went on to recommend that IRI be discontinued because [the Appellant's] inability to return to work was due to his unstable pre-existing cardiovascular condition. He did feel, however, that [the Appellant] should receive education with regard to home exercises that would not place unreasonable demands upon his already unstable cardiovascular condition. Beyond this treatment program, [MPIC's doctor] did not feel any further coverage was necessary for psychological and physical therapy since [the Appellant's] underlying cardiovascular condition would prevent more active rehabilitation taking place.

- On October 16th, 1997, based upon [MPIC's doctor's] advice, the adjuster informed [the Appellant] that IRI benefits would be discontinued as of October 17th, with coverage of psychotherapy ending on October 31st, 1997. He stated further that [rehab clinic #2] would do an assessment to determine the level of a physiotherapy program for [the Appellant] and that there would be coverage for a short course of physiotherapy designed for educating [the Appellant] on home-based exercises. [The Appellant] filed an application for review of the injury claim decision on October 20th, 1997.

- [Appellant's doctor] referred [the Appellant] to [text deleted], orthopaedic surgeon, who, having reviewed [the Appellant's] medical reports and job analysis, reported on January 19th, 1998, about his examination of [the Appellant] on November 19th, 1997. He summarized [the Appellant's] condition, stating that a fracture of the four transverse processes of the lumbar spine had resulted in the patient sustaining a significant injury. X-rays were taken of [the Appellant's] lumbar spine which demonstrated degenerative changes more pronounced than the patient had on the x-rays of July 26th, 1996. He concluded that the patient sustained a sprain of his cervical spine with aggravation of the pre-existing degenerative changes. At the date of this report, his opinion was that the patient still had some disability and restrictions related to the MVA. It was his opinion that [the Appellant] was physically capable of light duties with restrictions of lifting 20 pounds and bending, stooping or twisting.
- On January 28th, 1998, [text deleted], Internal Medicine specialist, reported that after sophisticated stress testing and Holter Monitoring, he concluded that there was no problem with [the Appellant's] heart but rather the chest pains were musculoskeletal in nature.

A decision from the Acting Internal Review Officer dated May 5th, 1998, upheld the decision of the adjuster, stating that [the Appellant] was permanently disabled from a full-time cook position as a result of his peripheral vascular disease which was a pre-existing condition, and not as a result of the motor vehicle accident. It is from this decision of the Internal Review Officer that [the Appellant] appeals to this Commission.

ISSUE

The question to be determined is whether [the Appellant] had attained pre-accident status on the dates of termination of his Income Replacement Indemnity benefits on October 17th, 1997, and the termination of psychotherapy treatment for pain management on October 31st, 1997.

At the request of [the Appellant's] counsel, [the Appellant] was examined on January 13th, 1999, by [text deleted], orthopaedic surgeon, who rendered his report on February 10th, 1999. His finding was that [the Appellant] had sustained an acute lumbar back injury as a result of the July 26th, 1996, MVA and that there was some pre-existing, presumably asymptomatic, degenerative disc disease. He reported that there was significant reduction in lumbar flexibility and an element of chronic pain behaviour or chronic pain syndrome. In relation to his pre-MVA work as a cook, [Appellant's orthopaedic surgeon #3] considered [the Appellant] to be unfit to handle the physical demands of walking and standing for prolonged periods of time, constant bending, stooping, lifting and carrying or use of stepstools or ladders that is required for food preparation in his job. He concluded that:

> Only by being pushed to the maximum with a therapy program and the use of appropriate pain control measures would an end result be achieved. This would then allow one to state whether there was a significant measurable physical impairment resulting from his 1996 accident, or whether pre-existing presumably asymptomatic lumbar degenerative disc disease was contributing to his perceived impairment, or was his main impairment the result of his chronic pain syndrome.

On September 28th, 1999, [Appellant's orthopaedic surgeon #3] reviewed [the Appellant's] complete file, including [Appellant's doctor's] medical records dating back to 1993. He reported that there was only one reference to the lumbar spine in 1993, and at that time the x-rays showed extensive degenerative disc disease and no significant ongoing problems until the MVA in July 1996. [Appellant's orthopaedic surgeon #3] disagrees with the apparent perception of [MPIC's doctor] that [the Appellant] had a pre-existing symptomatic condition referable to the lumbar spine. Despite having a back at risk because of extensive lumbar degenerative disc disease, there had been no significant lumbar complaint recorded prior to [the Appellant's] MVA. [Appellant's orthopaedic surgeon #3] pointed out that [the Appellant] had been able to work part-time as a cook and as a bartender from January 1996 until his accident in July of that year. The duties of a cook, in particular, would be classified as moderate to heavy.

[Appellant's orthopaedic surgeon #3's] opinion was that the fractures sustained by [the Appellant] would normally have taken three to six months to heal. The pre-existing degenerative disc disease condition found in [the Appellant] would have prevented many individuals from performing light to moderate to heavy duties; it was surprising that [the Appellant] actually worked as a cook and bartender and was able to perform those duties. [Appellant's orthopaedic surgeon #3] could not tell whether the MVA had transmitted enough energy to the vulnerable lumbar spine to now make it symptomatic. As he puts it: "Significant violence was absorbed. There was extensive pre-existing degenerative disease and [the Appellant] had a back at risk. In other words, a lesser degree of injury could have provoked greater symptomatology."

[Appellant's orthopaedic surgeon #3] noted that [the Appellant] had been able to function as a cook and bartender without documented cardiovascular, circulatory or lumbar back problems. [Appellant's orthopaedic surgeon #3] was not able to state that [the Appellant] had permanent physical impairments that are a result of the motor vehicle accident nor measure what the effect of the accident was on the lumbar spine and the pre-existing degenerative disc disease. If the accident aggravated the pre-existing lumbar degenerative disc disease to the point at which it had now become symptomatic, the degree of pre-existing disease would likely prevent [the Appellant] from pursuing any occupation that required heavy manual physical work.

[Appellant's orthopaedic surgeon #3] concluded that [the Appellant's] overall presentation would prevent him from pursuing any type of manual physical labour; however, this was based more on the mechanical lumbar back pain and chronic pain behaviour. Further, he had no doubt that the pre-existing lumbar disc disease had been aggravated by the motor vehicle accident. [Appellant's orthopaedic surgeon #3] added that, unless the chronic pain behaviour and chronic pain syndrome are altered or changed, a specific answer to the degree of physical impairment coming from the lumbar spine as a result of the motor vehicle accident is not possible.

It is clear that [the Appellant] had had arterial by-pass surgery prior to the accident, due to numbness in his right leg caused by an arterial blockage. Even after that surgery, he seems to have experienced discomfort in both legs after prolonged standing. Despite this,

he was able to work part-time from January 1996 to the time of the MVA on July 26th, 1996, as a cook and bartender for 20 to 30 hours per week. [Appellant's orthopaedic surgeon #2], [Appellant's orthopaedic surgeon #3], [Appellant's neuropsychologist], [Appellant's psychologist #2] and [Appellant's doctor] have collectively provided sufficient evidence to persuade us that [the Appellant's] condition—not healthy before his accident—was exacerbated by his accident to the point of precluding his return to work. All the medical evidence points to the fact that physical restoration and a return to work would not occur for [the Appellant] without psychotherapy for chronic pain management.

MPI recognized the need to deal with [the Appellant's] psychosocial problems before the physical therapy was likely to have lasting benefits. Recommendations were made by [Appellant's psychologist #2], [Appellant's neuropsychologist], as well as [Appellant's physiotherapist #1] and even [MPIC's doctor], that [the Appellant] should undertake a program of psychotherapy for pain management that would later assist him in a physical rehabilitation program. Despite resultant improvements and recommendations, therapy was discontinued in October of 1997 and the recommended stabilization program not pursued on the basis (later established to have been invalid) that [the Appellant's] inability to start a graduated return to work was due to his pre-existing cardiovascular problems.

COMMISSION'S FINDINGS OF FACT

We summarize our basic findings as follows:

- [The Appellant], immediately before his motor vehicle accident, had a lower back 'at risk,' by reason of lumbar degenerative disc disease; he also had a fragile psyche, evidenced by a pre-accident history of anxiety, depression and anger, with psychiatric treatments over an extended period;
- Both those conditions were exacerbated by [the Appellant's] MVA;
- [The Appellant] was also affected for a number of years before his MVA by peripheral vascular disease, causing him intermittent claudication in his legs. This, together with his lumbar disc problems, limited him to part-time employment—at least in any setting requiring prolonged standing or any frequent heavy lifting, bending, or torso twisting. His peripheral vascular disease was not affected by his MVA;
- On a strong balance of probabilities, underscored by the evidence of [Appellant's cardiologist] and despite the apparent, bona fide belief of [Appellant's doctor] and of the Appellant himself, [the Appellant] did not have any cardiac abnormality. If he was precluded from post-MVA, part-time employment by cardiovascular problems, it was the perception of those problems rather than their reality that was the hurdle. That perception was, patently, shared by [Appellant's doctor];
- The program of psychological therapy from [Appellant's psychologist #2], upon which [the Appellant] had embarked in July 1997, had brought about significant, although by no means complete, improvement in his ability to manage pain. More counselling was required before he could be pronounced fit for entry into a multidisciplinary rehabilitation program. That counselling would be directed towards pain management and the obliteration of abnormal or chronic pain behaviour;

- The Appellant's psychological and physical therapies were terminated prematurely, based upon the apparent belief of all persons involved that it was a pre-existing heart condition that precluded [the Appellant's] return to the workforce. In fact, the factors that prevented his renewed, part-time employment were the psychological barriers referred to above, combined with an overall deconditioning, particularly (although not limited to) the lumbar region.

DISPOSITION

i) MPIC shall therefore reinstate [the Appellant's] program of counselling with [Appellant's psychologist #2] in order to address pain management, chronic pain syndrome and such other psychological and psychosocial issues as, in [Appellant's psychologist #2's] view, are medically necessary to enable [the Appellant] to commence a Functional Restoration Program;

ii) When, upon [Appellant's psychologist #2's] advice, [the Appellant] is ready to commence a multidisciplinary Functional Restoration Program, MPIC shall initiate that program with a view to returning the Appellant to his pre-accident condition—that is to say, a physical ability that would allow him to work part-time as a cook and part-time as a bartender (approximately 13.5 hours in each occupation), if those fields of employment were available;

iii) If, in the considered opinion of [the Appellant's] multidisciplinary team, it is not possible to achieve the foregoing level of rehabilitation, then MPIC shall arrange for such Functional Capacity Evaluation and retraining as may be appropriate in order to reintegrate [the Appellant] into the workforce

iv) MPIC shall also reinstate [the Appellant's] Income Replacement Indemnity ('IRI') from October 18th, 1997, until the foregoing objectives have been reached, but shall deduct from that IRI any income actually earned by [the Appellant] between October 17th, 1997, and the date of final termination;

v) MPIC shall pay interest to [the Appellant] upon the IRI referred to in sub-paragraph (iv), at the statutory rate.

vi) The ongoing benefits described in sub-paragraphs (i), (ii), (iii) and (iv) are contingent upon [the Appellant's] total cooperation and participation, failing which those benefits may be terminated by MPIC.

Date at Winnipeg this 16th day of March, 2000.

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J. F. Reeh Taylor, Q. C.

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Lila J. Goodspeed

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Colon Settle, Q.C.