Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-99-144

PANEL:	**Mr. J. F. Reeh Taylor, Q.C., Chairman** **Ms. Yvonne Tavares** **Mr. F. Les Cox**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') was represented by Ms. Joan McKelvey;** **the Appellant, [text deleted], appeared on her own behalf**
HEARING DATE:	**May 10th, 2000**
ISSUE:	**Whether termination of chiropractic benefits justified.**
RELEVANT SECTIONS:	**Sections 136(1)(a) of the MPIC Act (‘the Act’) and Section 5 of the Manitoba Regulation 40/94**

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

Reasons For Decision

The Appellant, [text deleted], was injured on Saturday, December 12th, 1998, when, at about 2:50 p.m., her [text deleted] automobile was rear-ended by a [text deleted] half-ton truck. Her care-giver, throughout, has been [text deleted], doctor of chiropractic, who examined and assessed her initially two days after her accident. He diagnosed “spinal and extremity subluxation/fixation complex” and initially classified her injuries as a Grade 3a Whiplash Associated Disorder. The symptoms of which [the Appellant] then complained were of “headache, light-headedness, tension, dizziness, stiff sore neck with difficulty moving, pain

between her shoulders, lower back pain, anxiety, nervous, limited ability to sit or shoulder-check to the left, and insomnia related to discomfort." [Appellant's chiropractor's] report of December 14th, 1998, also makes reference to the sequellae of prior motor vehicle accidents, the fact that the Appellant was, at the time of her accident, taking non-steroid anti-inflammatory drugs and that he had apparently been seeing her prior to the current accident, at a frequency of about once monthly. He reported that she could work modified duties but was capable of less than full function due to her symptoms and/or functional deficits.

By January 15th, 1999, [Appellant's chiropractor] was able to report an improvement in the Appellant's classification from a Grade 3a to a Grade 2 Whiplash Associated Disorder. While encouraging [the Appellant] to maintain an active lifestyle with home exercise activity, he estimated that she would need continuing chiropractic manipulations three times weekly until April, twice weekly thereafter until the end of July, once weekly until November and twice monthly into December. The insurer approved the initial part of [Appellant's chiropractor's] treatment plan, that is to say, three treatments per week to mid-April 1999, when continued treatment would be reconsidered.

[Appellant's chiropractor's] further report of April 1st, 1999, reflected minor improvements in the Appellant's own perceptions of her degrees of pain and ranges of motion, with the same treatment plan as was noted in January.

MPIC then referred [the Appellant] for an independent chiropractic examination by [independent chiropractor] and, in the meantime, reserved its decision respecting the remainder of [Appellant's chiropractor's] treatment plan. She met with [independent chiropractor] on April 28th, 1999. [The Appellant] reportedly told [independent chiropractor] that she had sustained an aggravation

of an ongoing problem with her lower back that had troubled her since 1989. She reported only slight improvement since commencing post-accident treatments from [Appellant's chiropractor]—an improvement that she estimated at 15%. However, she thought that her chiropractic treatments were helping but that her improvement was slow. She had injured her lower back in a slip-and-fall incident in 1989 and had never fully recovered. She had been involved in a motor vehicle accident in 1997 when her neck and upper back had been injured and her lower back condition exacerbated. She reported that, during approximately six months immediately prior to her accident of December 12th, 1998, she thought that she had been attending for chiropractic treatment once or twice per week for what she termed 'maintenance care'. (This recollection runs contrary to that of [Appellant's chiropractor], who wrote of monthly visits.) [Independent chiropractor's] examination included some self-assessment questionnaires, specifically: a revised Oswestry disability index questionnaire respecting her lower back pain, wherein she scored 38% compared to a score of 26% that had been recorded on January 15th, 1999, and a Vernon-Mior questionnaire respecting her neck pain, wherein she scored 42% compared to 18% on January 15th, 1999. [Independent chiropractor] noted that, while [the Appellant's] perceived disability in her lower back area had increased, it was still within the moderate range; her neck score, however, had gone from minimal disability range to the severe disability range, in the three and one-half months prior to his assessment.

[Independent chiropractor] recommended an increase in [the Appellant's] active, therapeutic, spinal exercises (twice daily) including certain specific maneuvers that he outlined. As her job was sedentary [text deleted], [independent chiropractor] felt that she should return to her aerobics, starting slowly and increasing the levels of her workouts accordingly. As to chiropractic treatment, he believed that the frequency of her adjustments would be decreased within two months, with an anticipated discharge by the end of August 1999. He concluded that

[the Appellant] was not disabled and had not sustained any type of permanent, physical impairment. Her functional prognosis was good although, said [independent chiropractor], she would likely have a continuance of some symptoms, similar to those she had experienced over the past number of years and which had necessitated ongoing care.

[Independent chiropractor's] report to the insurer was then referred to MPIC's chiropractic consultant, [text deleted], whose recorded comment reads:

> May 4/99
> [Independent chiropractor's] recommendations do not seem unreasonable. Care beyond that recommended by [independent chiropractor] can be supported if [Appellant's chiropractor] reports decreased physical signs and improved questionnaire answers toward end of August/99.

On May 7th, 1999, the adjuster's notes to MPIC's file read as follows:

> Called [Appellant's chiropractor].
> Advised [text deleted] that we'll need patient's questionnaires every two months and if [Appellant's chiropractor] feels further care warranted beyond August 31/99 when discharge is anticipated we'll have a look at the medical documentation and see whether further funding will be considered. If there is a demonstrated improvement then we <u>may</u> consider extending care at that time. She is to relay info to [Appellant's chiropractor].

A further note made by the adjuster on that same date reads:

> Called victim to apprise her of situation. Explained our plan on this and she was very happy we called her to let her know where this was going. I advised I'd send her a letter okaying care to Aug 31/99 etc.

Unfortunately, the actual letter sent by the adjuster to the Appellant, ostensibly confirming his oral advice to her, simply said that the insurer would continue to pay for chiropractic care to August 31st, 1999. "This means that you will be responsible financially for any expenses incurred after August 31st, 1999." A copy of that letter was sent to [Appellant's chiropractor] in whose office someone has written, on the face of that letter (the handwriting is certainly not that of the Appellant):

June 2/99
Care beyond Aug 31/99
Preferable to have V.M/Oswest.

This latter reference is to two separate but similar forms of pain self-assessment, the one (Vernon-Mior) related to neck pain and disability, while the other (Revised Oswestry) relates to low back pain and disability. It is apparent from that notation that either [Appellant's chiropractor] or one of his staff spoke with someone with MPIC on June 2nd and was told that the payment for chiropractic treatments after August 31st would in some measure, at least, be dependent upon the results of those two tests.

Nothing further appears to have been heard from [Appellant's chiropractor] until a letter, bearing date February 11th, 2000, was received from him by this Commission on February 17th of this year. In the meantime, MPIC's Internal Review Officer had denied [the Appellant's] claim for the continuance of chiropractic treatments at the insurer's expense after August 31st. That decision, rendered on October 22nd, 1999, is based upon the fact that no communication had been received from [Appellant's chiropractor] or his office since May 7th, 1999, and, in particular, nothing to suggest that [the Appellant] required the continuance of chiropractic treatment related to her December 12th, 1998, motor vehicle accident. [Appellant's chiropractor] suggests that the very fact that he continued to render bills to MPIC should have been evidence enough of the appellant's need for continuing care resulting from her accident. We do not accept that proposition: he rendered no supporting reports and his bills were returned to him, unpaid.

[The Appellant] filed a Notice of Appeal with this Commission on December 6th, 1999. In support of it, we received a letter from [Appellant's chiropractor] dated February 11th, 2000. That letter advances two positions: firstly, that [the Appellant] was injured in her motor vehicle

accident in December of 1998; secondly, that she continues to need chiropractic adjustments for those injuries.

[Appellant's chiropractor] first point is not denied—indeed, the causal relationship between her accident and her need for treatment was obviously accepted by MPIC, which paid for something in excess of 50 chiropractic adjustments over the eight and one-half months immediately following [the Appellant's] accident.

However, with respect to the second facet of [Appellant's chiropractor's] position, we quote with approval part of the comment of [MPIC's chiropractor] in an interdepartmental memorandum dated April 3rd, 2000:

> The…argument…misses the point. [Appellant's chiropractor] presents the argument that chiropractic care should be continued because the literature has demonstrated effectiveness of this type of care. In my opinion, the argument based on the literature is that chiropractic care should be attempted, since this type of care is thought to be effective in many cases. However, in the absence of improvement with an adequate trial of such care, continuation of care is not supported by the literature nor by common sense. Sufficient improvement has not been demonstrated. The claimant reported only 15% improvement in the 4-1/2 months prior to attending [independent chiropractor] for a third party chiropractic evaluation. Despite this, a further four months of care was provided. No evidence has been presented that supports improvement in this interval. Therefore, further care of the same kind does not appear to be indicated.

It is, perhaps, germane, to note that there is some disparity between the records maintained at MPIC, the evidence of [the Appellant], and a more recent communication received by this Commission from [Appellant's chiropractor].

- As noted above, MPIC's file contains no notation of any communication from [Appellant's chiropractor's] office following the telephone conversation between the adjuster and the lady called [text deleted] on May 7th. However, it does seem quite clear from the handwritten notation at the foot of [Appellant's chiropractor's] copy of the May 13th letter to [the

Appellant] that the message originally transmitted by phone on May 7th was reiterated on June 2nd—presumably, also by telephone.

- [The Appellant's] testimony was that [Appellant's chiropractor's] secretary, [text deleted], had telephoned the adjuster twice without success and had sent two unanswered messages by facsimile, seeking further directions as to whether MPIC would continue to fund chiropractic care to December 12th or not.
- Following the hearing of [the Appellant's] appeal, we wrote to [Appellant's chiropractor] to ask him whether his file revealed any communications between his office and that of MPIC following his receipt of the May 7th telephone message and the adjuster's confirmatory letter. We also asked for a copy of [Appellant's chiropractor's] clinical notes covering the period from May 7th to August 31st, 1999. His response does not indicate that any faxed letters were exchanged between the two offices, contrary to the Appellant's belief. He does say "It appears that our office message got lost in the confusion at MPI during that time" but does not indicate to which 'office message' he is referring. He indicates that [text deleted] from his office had phoned the legal assistant at MPIC's office "at a later date…also on September 3 at 3 p.m." but without response. [Appellant's chiropractor] refers to some responses of [the Appellant] to an Oswestry questionnaire in which she appears to indicate slow but steady improvement; however, that questionnaire bears date May 28th, 1999, and still offers us no evidence of continued improvement between that date and August 31st.

From the fact that, even by May 29th, 2000, neither [Appellant's chiropractor] nor the Appellant herself have been able to furnish any evidence that, by the end of August 1999, [the Appellant] had continued to improve to a point that would have justified additional chiropractic care, it seems clear that there was no such improvement. To quote from Clinical Guidelines for

Chiropractic Practice in Canada, being a supplement to the Journal of the Canadian Chiropractic Association, Volume 38, No. 1, March 1994:

> 8.14(ii) …Failure to show additional improvement over any period of six weeks of treatment should result in patient discharge or appropriate referral, or the patient will be deemed as having achieved maximum therapeutic benefit (MTB). If MTB has been reached, maintenance or supportive care may be considered.

[The Appellant] testified that she has continued attending upon [Appellant's chiropractor] on a weekly basis, which is the same frequency with which she was attending at the time her benefits were terminated by MPIC. Treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain that benefit and progressively deteriorate when there are periodic trials of withdrawal of treatment, is known as 'supportive care'. To quote, again, from the Clinical Guidelines for Chiropractic Practice in Canada,

> Supportive care follows appropriate application of active and passive care including rehabilitation and lifestyle modifications. It is appropriate when alternative care options, including home-based self care, have been considered and attempted. Supportive care may be inappropriate when it interferes with other appropriate primary care, or when the risk of supportive care outweighs its benefits, i.e., physician dependence, somatization, illness behaviour, or secondary gain.

If, as appears to be the case from the absence of any evidence to establish continued improvement beyond August 31st, 1999, [the Appellant] has, in fact, reached maximum therapeutic benefit, no periodic trials of withdrawal of treatment have yet been undertaken.

A careful review of all of the evidence and, in particular but without limitation, the apparent absence of any noticeable improvement in the Appellant's condition following August 31st, 1999, lead us to conclude that her appeal must fail.

There are, however, two additional comments that we wish to make, with respect to the manner in which MPIC's adjustment team handled this claim:

(i) Having decided and having, indeed, advised [Appellant's chiropractor's] office, that payment for further treatments would be considered if, at the end of August, continued improvement were shown, it does not seem appropriate to us that the adjuster would then write to [the Appellant] on May 13th to say, in part, "this means that you will be responsible financially for any expenses incurred after August 31st, 1999", with no mention at all of the possibility that, given continued improvement, further treatment would be considered. In this particular case, the practitioner was obviously made aware of the need for supporting evidence if further treatments were to be authorized, but the fact remains that the adjuster's letter of May 13th did not accurately reflect what he had said to [Appellant's chiropractor's] staff.

(ii) When a claimant is advised that her benefits are going to cease several months later, she is placed in the difficult position of having to start the appeal process before she knows whether, in fact, she will need continued benefits. Thus, in [the Appellant's] case, she is told on May 7th that her chiropractic benefits will terminate on August 31st and she has 60 days within which to apply for a review of that decision. We are of the view that, in similar circumstances, the adjuster should arrange for the file to be brought forward at or about the anticipated termination date and, absent some new factors, a final, confirmatory letter should then go out, to the effect that the benefits in question have now been terminated, giving the appellant 60 days from that date within which to seek a review. In that way, the appellant will be better able to determine whether a review is, in fact, necessary and, if so, to marshal proper evidence to place before the Internal Review Officer.

In the present instance, while it is patently too late to remedy that situation, the fact remains that, even at the hearing of [the Appellant's] appeal on May 10th and later with our receipt of

[Appellant's chiropractor's] letter of May 29th, 2000, evidence sufficient to support [the Appellant's] claim is still lacking and we are obliged to dismiss her appeal.

Dated at Winnipeg this 16th day of June, 2000.

J. F. REEH TAYLOR, Q.C.

YVONNE TAVARES

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