Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-00-106

PANEL:	**Ms. Yvonne Tavares, Chairperson** **Mr. Wilson MacLennan** **Mr. F. Les Cox**
APPEARANCES:	**The Appellant, [text deleted], appeared on her own behalf, assisted by her husband;** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Mark O'Neill.**
HEARING DATE:	**February 6, 2002**
ISSUE:	**Entitlement to Income Replacement Indemnity ('IRI') benefits.**
RELEVANT SECTIONS:	**Sections 81(1), 110(1)(a) and 110(2) of The Manitoba Public Insurance Corporation Act (the 'MPIC 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

The Appellant, [text deleted], was involved in a motor vehicle accident on November 3, 1994. At the time of her motor vehicle accident, [the Appellant] was employed on a full-time basis as a nurse's assistant at [Text deleted] in [text deleted].

As a result of the motor vehicle accident, the Appellant sustained soft tissue injuries to her neck and back. During the accident, the Appellant recalled her head "going forward and back." She stated she did not hit her head or lose consciousness. A headache, neck pain and "a generalized

ache" gradually increased throughout the day. [The Appellant] saw her chiropractor, [text deleted], the following day. She received chiropractic treatment daily for the next few months, which was decreased to two to three times per week in January 1995. [Appellant's chiropractor] diagnosed her condition as a whiplash injury resulting in cervical acceleration/deceleration syndrome and re-injury and exacerbation of mid- and lower back condition.

In order to determine her abilities and limitations with regard to her job, and for the purpose of recommending appropriate rehabilitation intervention, the Appellant underwent a Functional Capacity Evaluation ('FCE') in September 1995. Based on the results of the FCE, the occupational therapist recommended that [the Appellant] be referred for a comprehensive physical reconditioning, work hardening and graduated return-to-work program. This type of program was available through the [rehab clinic]. The Appellant commenced the reconditioning program on September 20, 1995, and began work-hardening activities on October 31, 1995.

In November 1995, the Appellant was described as progressing well with her aerobic and muscular education programs. However, the Appellant had fear and anxiety about returning to work, and was subsequently referred to [Appellant's psychologist #1] for psychological assessment and pain counselling. In a report dated February 27, 1996, [Appellant's psychologist #1] noted that the Appellant was mildly depressed, having difficulty coping with her current situation, having been the victim of several tragic events in her life. The Appellant minimized the impact that the current situation was having on her life. She was encouraged to undergo counselling to deal with her pain focus and treatment sessions were commenced. [Appellant's psychologist #1's] last report to file dated July 4, 1996, states that the Appellant was five months pregnant and due at the end of September 1996. The Appellant was described as being very happy with this development and did not see it as a barrier to her ability to return to work. The

Appellant expressed the opinion that she no longer required psychological services, and it was mutually determined to terminate their sessions.

Due to the motor vehicle accident of November 4, 1994, the Appellant had been on an indefinite medical leave of absence from her position of Unit Assistant at the [Text deleted]. As of October 31, 1995, the Appellant's pre-MVA position was no longer available to her. She was advised that when she was cleared to return to work, she would be placed on a preferential waiting list for full-time positions as a unit assistant as they became available throughout the [Text deleted]. Seniority would be a factor in awarding positions.

A Graduated Return to Work program was attempted in January 1996. However, on the advice of her family physician, [Appellant's doctor #1], the Graduated Return to Work program was discontinued after one week, due to reports of increased pain from the Appellant. On May 13, 1996, the Appellant recommenced the Graduated Return to Work program at three hours per day, three days per week, in a supernumerary capacity. [The Appellant] attended the program regularly, but was unable to progress beyond 3 hours per day, 3 days per week due to complaints of lower back pain and leg weakness.

The Appellant was then referred for an Independent Medical Examination by [text deleted], a physiatrist, to further assess and provide recommendations for treatment of the Appellant's lumbar pain and leg weakness. In her report dated July 24, 1996, [independent physiatrist] noted the following:

> My impression of this lady is that she has evident chronic pain behavior syndrome with her symptoms far outweighing any objective evidence of underlying problems. The only objective finding that I saw was that she had myofascial pain of her neck muscle in the form of the trapezius and sternomastoid muscle.

> I explained to [the Appellant] that I did not find anything clinically which would limit her to increase her hours of return to work. I suggested to her that she work for three hours for five days of the week and then increase it to four hours for five days and then slowly increase up to eight hours.
>
> ….
> This lady's complaint of back pain is more because of a chronic pain behavior syndrome rather than any objective evidence that she has any kind of severe problems with her back. She has mild tightness of her left paraspinal muscle, but other than that there is no evidence that she has got a disc protrusion or a facet problem or anything which would cause her chronic problems.
>
> One has to realize that getting a client back to work in full-time duties is entirely dependent upon the motivation of the client rather than an accurate diagnosis.
>
> As far as your question regarding whether any further investigations are needed, I do not think that any further investigation is needed. Physiotherapy should follow her until her return to work is completed except for the time when she will be away on maternity leave, I do not see any point in physio or OT following her at the time she is off.
>
> As far as resolution of injuries is concerned, the prognosis is extremely good in most of my clients that I see. They do continue to improve and in the long run are free of symptoms except for occasional exacerbation when they are emotionally or physically under stress.

After the birth of her baby [text deleted], active rehabilitation services were once again begun by [Appellant's rehab consultant], a rehabilitation consultant with [Rehab consulting company]. In order to determine her current status and a recommended treatment program, [the Appellant] underwent a physical assessment. The assessment was once again carried out by the [rehab clinic]. In her report, dated December 16, 1996, [text deleted], physiotherapist, made the following recommendations:

> 1) It is my opinion that [the Appellant] would be unable to perform the job demands as a full-time [Text deleted] at the [Text deleted] at this time. At my last assessment, I indicated that [the Appellant's] muscles were extremely weak and deconditioned. My opinion has not changed, she remains weak and generally deconditioned.
>
> 2) The primary physical barrier preventing [the Appellant's] return to work is muscle weakness. She has poor stability of the proximal spinal muscles and poor strength of the extremity muscles affecting both upper and lower limbs. The non-physical barrier, which in my mind is more significant is

> pain. [The Appellant] is positive on 4/5 Waddell signs for inorganic pain: all over tenderness, pain on axial compression, inconsistent straight leg raise and signs of symptom magnification.
>
> 3) Physiotherapy may be indicated at this time. I feel that a multidisciplinary approach to treatment is critical. Psychological intervention is required to deal with the non-physical barriers. It would be helpful to begin assessment and treatment in this arena before recommencing on a physical reconditioning program. [The Appellant] must understand that her pain at this point does not indicate any physical dysfunction and should not dictate her level of activity. She has pain whether she is active or not. [The Appellant] is unable to demonstrate the exercises that she participated in at the exercise sessions. Either she can not recall the exercises of she is physically unable to perform them. She needs assistance to be reinstructed in a program that involves stretching and strengthening of all muscle groups as well as increasing general exercise tolerance and endurance.
> …
>
> 4) A final comment, in terms of the multidisciplinary approach, it is my opinion that without psychological services as part of the team, [the Appellant] would not benefit from any further physical intervention.

Following up on the recommendations of [Appellant's physiotherapist #1], [the Appellant] was referred for psychological assessment by her rehabilitation consultant, [text deleted], in order to assist and provide recommendations for further rehabilitation activities. [Appellant's psychologist #2] conducted the psychological assessment of [the Appellant]. In his report dated February 10, 1997, he noted the following:

> In summary, there are no significant psychological issues at this time with the exception of a mildly disruptive sleep which is reportedly related to the sleep pattern of her baby. Her mood is reasonably stable and there is no indication of passive wishes to die, active suicidal thoughts or intent.
>
> **RECOMMENDATIONS**
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> Given [the Appellant's] status, her presenting symptoms, her previous involvement with physiotherapy, her current level of physical functioning, her mild sleep disorder, and her vocational situation and interest, the following recommendations are made:
>
> 1. Return to her physiotherapy program at [rehab clinic] in the very near future. (She is in agreement with this).

2. Discuss her vocational future planning with her rehab consultant, [text deleted].

3. I believe that there is no need at this point for psychological assistance. However, this option should be considered in the future if she required supportive counselling to assist with her physiotherapy program with [rehab clinic] or a return to gainful employment.

4. [The Appellant] does not see a need to attend counselling regarding weight control, although believes that it negatively contributes to her pain sensations. She stated that "she could start a weight control program on her own".

On February 17, 1997, the Appellant commenced a reconditioning/work-hardening program at [rehab clinic]. Improvement was noted in [the Appellant's] physical status and the Appellant stated she was progressing well in the program. The Appellant reported evidence of increased leg and back muscle strength and decreased pain. [Appellant's doctor #1] cleared the Appellant for a return to work for April 1, 1997, with the only restriction being that *"no heavy (greater than 15 pounds) lifting on repetitive basis."* The Appellant commenced a graduated return-to-work program on April 21, 1997, on a [text deleted] unit at the [Text deleted].

Based on her physical improvement and progress through the graduated return-to-work program, MPIC's case manager wrote to the Appellant on June 2, 1997, to advise her that:

> I understand that your job placement schedule has been maintained and the target end date, at which time you would be deemed capable of returning to your full-time nurse's aide occupation, is June 16, 1997. At that time, you will enter a new phase of entitlement for Income Replacement Indemnity.
>
> We wish to advise that Income Replacement Indemnity will continue for up to one year, until such time as reasonable comparative employment has been found. The decision to allow a continuation of Income Replacement Indemnity benefits is based on Section 110(2) of The Manitoba Public Insurance Corporation Act, which reads:
>
> > **Temporary continuation of I.R.I. after victim regains capacity**
> > **110(2)** Notwithstanding clauses (1)(a) to (c), a full-time earner or part-time earner who lost his or her employment because

> of the accident is entitled to continue to receive the income replacement indemnity from the day the victim regains the ability to hold the employment, for the following period of time:
>
> > (d) one year, if entitlement to an income replacement indemnity lasted for more than two years.
>
> As I trust you are aware, we are in the process of completing a job search with the hopes of identifying a nurse's aide position for which you would be suitable. In the meantime, your Income Replacement Indemnity benefits will continue for up to one year.
>
> We wish to advise that you will be responsible for maintaining your level of conditioning to allow you to enter into the workforce, should that opportunity arise in the coming year. To facilitate your continued fitness, we have authorized a three-month gym membership [text deleted]. I look forward to receiving the receipts for the cost of the gym membership for reimbursement.

Once [the Appellant] had completed her graduated return-to-work program on the [Text deleted] unit, she completed a three-week work trial on an [Text deleted] unit at the [Text deleted], in order to provide her additional exposure to different units throughout [text deleted]. She worked eight-hour day shifts and was "buddied" with another unit assistant on the unit, as was usual working practice on that unit. [The Appellant] reported that she missed five and a half days of work due to increased muscle soreness in her lower back, which radiated up to her shoulders and neck areas. She reported difficulty with lifting and bending at times, due to the increased soreness. However, as per the "buddy" unit assistant, [the Appellant] was able to complete all job duties during her work trial. She completed two-person lifts and transfers of patients, as per normal working practice on that unit.

[The Appellant] saw [text deleted], physiotherapist at the [rehab clinic], on July 15, 1997. [Appellant's physiotherapist #2] reported that [the Appellant] described increased muscle soreness. [Appellant's physiotherapist #2] noted no new injury or change in [the Appellant's] condition, and attributed the increased soreness to increased muscle use and activity level. She

advised [the Appellant] to attend a pool for independent exercises and stretching routines with which she was already familiar.

[The Appellant] also attended upon [Appellant's doctor #1] for assessment on July 28, 1997, for complaints of muscle soreness in her back, shoulders and neck areas. As per [the Appellant's] report, [Appellant's doctor #1] advised that there was no new injury or change in her status, and "it was sore muscles." [Appellant's doctor #1] did not revise or add any restrictions to [the Appellant's] ability to work as a unit assistant on [text deleted] units.

[The Appellant] sought an internal review of the case manager's decision of June 2, 1997. The Internal Review Officer requested several medical reports from the [the Appellant's] various care-givers as part of her review.

In a report dated October 29, 1997, [Appellant's physiotherapist #1], the physiotherapist who had been assisting [the Appellant] with her rehabilitation, noted the following:

> [The Appellant] presented for treatment on August 21, 1997 with complaints of upper lumbar area pain which had increased since she had returned to work. In the ten days prior to August 21, 1997, [the Appellant] felt that her lower back pain had increased in intensity and was now radiating into the left anterior thigh area to the knee level. She expressed concern as the pain would not resolve with her exercises and home stretching program.
>
> On examination, her lumbar range of motion was significantly limited in flexion and at approximately ¾ normal range for the remaining lumber movements. Actively, there was a restriction in (R) SF at L3-4, L4-5 segments. Passive intervertebral joint testing was normal at all lumbar levels.
>
> The hip flexor and quadriceps muscles were tighter on the left side and the hip. Internal rotators were also tight bilaterally.
>
> [The Appellant] was treated with ultrasound to the left posterior hip (piriformis) area and manual therapy including proprioceptive neuromuscular techniques. Her home stretching program was reviewed. She reported reduced symptoms post treatment.

> On her subsequent visits, her quadriceps and hip flexors had regained some flexibility and she reported less pain. Her active lumbar range of motion improved and she was discharged with reinforcement and encouragement to maintain her home program.
>
> It is my opinion, that [the Appellant] is experiencing muscular reactions to performing her job as a Nurses' Assistant. One would expect this to occur based on the length of time she was away from the activity. As such, when she is unable to reduce the muscle tightness or irritability with her home program independently, she may require short periods (1-4 treatments) of physiotherapy intervention from time to time to facilitate her return to work. In the long-term, I would not anticipate any permanent disability or inability to perform the duties of a Nurses' Assistant. However, in view of her progress to date, it may be prudent to restrict the amount (lbs.) of lifting and favour a [text deleted] position.

[Appellant's doctor #2], in her medical report dated November 3, 1997, noted the following:

> As you know, [the Appellant] was injured in the MVA on November 4, 1994. She was treated for her neck and back injury by a chiropractor until September of 1995. She contacted me for the first time on December 13, 1995, complaining of increasing pain in her neck and low back since she started the work hardening program.
>
> On examination that day, she had restricted range of movement at her neck and low back area with a slightly increased muscle tension along the C and LS spine. Neurologic examination was normal. She was advised to continue with the work hardening program.
>
> The next visit was on February 2, 1996. [The Appellant] told me that she had finished her program and has started a gradual return to work. She was experiencing more pain in the injured areas. Her physical examination did not change.
>
> Her next visit related to her injury was on June 24, 1997. [The Appellant] was complaining of increasing pain in the low and mid back, more so on the left side. She requested a referral to a specialist. Her examination showed almost a full range of motion in the cervical spine. The lumbar spine showed mild limitation with some tenderness over the low thoracic and upper lumbar area and a slight increased tone in the paraspinal muscles. Neurological examination was normal. [The Appellant] was assessed by [Appellant's rehab medicine specialist], a specialist at the rehabilitation medicine on two occasions. His diagnosis was mechanical low back pain with facet joint dysfunction at her T12-L1 and L4-L5 levels. X-ray of the spine did not reveal any abnormalities. It was suggested to [the Appellant] to continue with exercises at home and a trial of chiropractic manipulation was advised too.

> Her last visit in my office was on October 6, 1997. [The Appellant] told me that she was not able to tolerate frequent lifting and bending at her job.
>
> In my opinion, she should be assessed by an occupational therapist to find out if she has any limitations with respect to her occupation as a nurse's aid.

[The Appellant] had been referred to [Appellant's rehab medicine specialist] by [Appellant's doctor #2]. In a report to dated August 28, 1997, [Appellant's rehab medicine specialist] commented as follows:

> On examination she has moderate truncal obesity. There is no obvious bony deformities or muscle asymmetry. Cervical spine showed full and non painful range of motion in all planes except for slight decrease with rotation towards the right side. The lumbar spine showed full flexion and extension, mild limitation of rotation bilaterally, and a moderate limitation of lateral flexion, producing a pulling sensation on both sides. Stressing the lumbar facet joints was unremarkable. Her gait pattern is normal and there is no pelvic obliquity. On palpation there is some tenderness over the low thoracic and upper lumbar area. Slight increased tone is noted in the paraspinal muscles. Soft tissue examination of the gluteal region was unremarkable.
>
> Neurological examination showed break away weakness in both lower limbs. Sensory testing was normal with respect to pin and light touch. Reflexes are normal and symmetrical in both lower limbs; toes were upgoing bilaterally. Straight leg raise was negative in the sitting and supine position. Faber's test showed tightness of the adductors, Thomas and Ober's tests were also positive for tight hip flexors and adductors.
>
> This patient's low back pain may be mechanical in origin. However, some of her pseudovisceral symptoms and hip symptoms may be resulting from thoraculumbar dysfunction. I have asked her to continue with stretching exercises of the trunk extensors and gluteal muscles. I have also ordered an x-ray of her lumbar spine. I will follow up with her in my clinic.

In his follow up report to [Appellant's doctor #2] dated September 25, 1998, [Appellant's rehab medicine specialist] made the following observations:

> [The Appellant] was reassessed in clinic on September 17, 1997. X-ray of her lumbosacral spine showed no bone, joint or disc abnormalities.
> Examination today revealed tenderness over her axial spine from the low thoracic to the sacral area. She was especially tender over the spinous processes and facets bilaterally at the level of T12-L1 and L4-5. Palpation of her anterior, posterior and lateral iliac crest pints was also very tender.

> She was informed of my diagnosis of mechanical low back pain with facet joint dysfunction at the above mentioned levels. Diagnostic/therapeutic injections to those areas were offered to her. She declined this treatment because she has heard bad stories about cortisone injections. Therefore she was instructed to continue with her current therapeutic exercises at home. A trial of chiropractic manipulation may be a useful adjunct to her exercises for some symptomatic control.

[Appellant's doctor #1], in a report dated March 27, 1998, had the following comments:

> On examination, she is tender with spasm of her thoracic and lumbar paraspinal muscles. Forward flexion is limited to 75º. She had tenderness over the spinous process from T11-L4. Neurologic examination was normal. Lifting her 30 lb. child, even once, causes back pain.
>
> In my opinion, she should not lift anything greater than 20 lbs., and even that weight should not be on a regular basis.
>
> I feel she is capable of working full-time, provided the above restrictions are met. Perhaps she could a [*sic*] position such as a ward/unit clerk.

The foregoing medical reports were forwarded to [text deleted], Medical Director of MPIC's Claims Services Department, for his comment. He was also asked to comment upon whether the Appellant was able to return to full-time work as a nurse's aide. In his Inter-departmental Memorandum dated May 8, 1998, [MPIC's doctor] commented that:

> At this point, in my opinion, there is insufficient evidence to conclude that the motor vehicle collision in question is the predominant cause of the patient's current voiced complaints of pain. Prior to the motor vehicle collision in question, the patient had seven weeks of disability from her position as a nurse's aide because of a compensation-related dorsal spine injury. The objective findings listed prior to the motor vehicle collision in question, appear to be more severe than those currently listed. It is noteworthy that the findings listed by the treating chiropractor prior to the motor vehicle collision, have relatively poor interater reliability, and are not valid objective outcome measures.
>
> The primary consistency in this patient's clinical picture are her voiced complaints of pain with activity. Her self-report is that she has discomfort with increasing physical activity. There appear to be inconsistencies in the voiced inability of this patient to act as a nurse's aide with limitations in lifting of 20 pounds, and the fact that she is a full-time mother with a child of 30 pounds.

> It is noteworthy, that pregnancy is frequently associated with thoracic pain complaints.
>
> ….
>
> **Disability**
> At this time, the primary factor associated with any limitation in workplace performance appears to be the patient's self-report of pain. Pain is an emotion, and strongly influenced by psychosocial factors. There has been documentation on file that this woman has suffered tragedies in her past, as documented by [Appellant's psychologist #1]. She also had prolonged absenteeism from the workplace prior to the current motor vehicle collision in question. These factors raise the question of significant psychosocial impediments to recovery. In the interim, however, the patient has had a child, and has been functioning in the home as a mother. This clearly documents a modicum of work capacity.
>
> The most recent medical information on file indicates what appears to be consensus that this patient is capable of full-time work. There also appears to be consensus that it may be prudent to restrict the amount of lifting. In my view, based on the medical information on file, there is insufficient objective evidence to support the necessity of these restrictions.
>
> …
>
> **RECOMMENDATIONS**
>
> **Therapeutic**
> With regards to this woman's ongoing therapy, it is my opinion that there is no valid treatment options which will significantly change her clinical picture. She has had extensive treatment to-date without substantial change from her pre-accident condition.

An additional Inter-departmental Memorandum dated March 19, 1999, was provided by [MPIC's doctor], based upon his review of certain information which was missing from the Appellant's file when he did his previous review. In this report, [MPIC's doctor] notes the following:

> Given the evidence of the clinical notes from [Appellant's chiropractor's] office, there is insufficient evidence to state that ongoing spinal manipulative therapy is a necessity for this patient. There is insufficient evidence to substantiate this patient has a significant physical impairment. There is insufficient evidence to establish a cause/effect relationship between the patient's current pain and the motor vehicle collision in question.

In a further report, dated March 10, 2000, [MPIC's doctor] was asked to review [Appellant's chiropractor's] in-clinic notes. [MPIC's doctor] noted that:

> Given the documentation on file, and in my opinion, it is difficult to apportion the patient's physical findings to any particular episode of trauma. It is difficult to apportion them to the motor vehicle collision in question, given the pre-accident problems, and description in October 1994. In my opinion, given the documentation on [Appellant's chiropractor's] file, it would be very difficult to determine functional capability in a retrospective fashion. It would be very difficult to apportion physical findings from one condition to the next. Therefore, in my opinion, there is insufficient evidence on file to apportion [the Appellant's] current complaints to the motor vehicle collision in question. There appears to be more information on file, apportioning it to the Workers Compensation Board injury, and indeed to previous factors dating back to February 1994.

In her Internal Review decision of August 16, 2000, the Internal Review Officer upheld the case manager's decision of June 2, 1997, and dismissed the Application for Review. In her decision, the Internal Review Officer commented that:

> After examining various medical reports, including information provided by [Appellant's physiotherapist #1], [Appellant's doctor #1], [Appellant's doctor #2] and MPIC Medical Director [text deleted], I agree with [text deleted's] decision that you are capable of returning to your job as a full time nurses aid as of June 16, 1997 and that IRI benefits continue up to one year from that date.
>
> After reviewing [MPIC's doctor's] reports of May 8, 1998, March 19, 1999, January 26, 2000, March 10, 2000 and July 17, 2000, I find that there is insufficient evidence to conclude that the motor vehicle accident is the predominant cause of the pain which you complain of. [MPIC's doctor] observes that it is difficult to apportion your pain to any particular trauma, let alone the motor vehicle accident of November 1994. He observes that the assessment is complicated by information that you suffered from back pain as early as 1990, that you received Workers Compensation Board disability benefits previous to the accident and that, in the intervening period, you were involved in a pregnancy, to which low back pain is often attributed. Given these difficulties, [MPIC's doctor] notes that you do not suffer from any permanent impairment and that the primary limitation to your return to work is your self reported pain. It is his opinion that it is in your best interests to return to work and that there is no scientific reason to restrict your involvement in the workplace. For these reasons, I support your Case Manager's assessment that the symptoms of which you complain cannot be apportioned to your motor vehicle accident on the evidence provided. Therefore, the Case Manager's decision of June 2, 1997 stands.

The Appellant has now appealed the decision of the Internal Review Officer dated August 16, 2000, to this Commission. The issue which requires determination in the Appellant's appeal is whether the termination of Income Replacement Indemnity benefits by the case manager on June 2, 1997, pursuant to Section 110(1)(a) and Section 110(2) of the MPIC Act was correct.

The relevant sections of the MPIC Act to the present appeal are as follows:

Section 81(1):

> **Entitlement to I.R.I.**
> **81(1)** A full-time earner is entitled to an income replacement indemnity if any of the following occurs as a result of the accident:
>
> (a) he or she is unable to continue the full-time employment;
>
> (b) the full-time earner is unable to continue any other employment that he or she held, in addition to the full-time regular employment, at the time of the accident;
>
> (c) the full-time earner is deprived of a benefit under the *Unemployment Insurance Act* (Canada) or the *National Training Act* (Canada) to which he or she was entitled at the time of the accident.

Section 110(1)(a):

> **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.

Section 110(2):

> **Temporary continuation of I.R.I. after victim regains capacity**
> **110(2)** Notwithstanding clauses (1)(a) to (c), a full-time earner or a part-time earner who lost his or her employment because of the accident is entitled to continue to receive the income replacement indemnity from the day the victim regains the ability to hold the employment, for the following period of time;
>
> (a) 30 days, if entitlement to an income replacement indemnity lasted for not less than 90 days and not more than 180 days;

> (b) 90 days, if entitlement to an income replacement indemnity lasted for more than 180 days but not more than one year;
>
> (c) 180 days, if entitlement to an income replacement indemnity lasted for more than one year but not more than two years;
>
> (d) one year, if entitlement to an income replacement indemnity lasted for more than two years.

The Appellant submits that she was not capable of returning to her job on June 16, 1997, when MPIC determined that she could. She advises that, when she was on the graduated return-to-work program at [Text deleted], she was not able to complete all of the work demands that were part of the unit assistant position. She feels that she still has not recovered from the effects of the motor vehicle accident of November 3, 1994, and certainly was not recovered in June 1997, when MPIC terminated her IRI benefits.

The Appellant also refers to the medical report of [Appellant's doctor #1], dated January 2, 2001, wherein [Appellant's doctor #1] notes that:

> An x-ray of her lumbar spine, performed December 14th, 1995, revealed no abnormalities. A follow-up x-ray of her spine, performed March 10th, 2000, shows "there is straightening of the normal lumbar lordosis. The heights of the lumbar vertebrae are not remarkable. There is minimal squaring of several lumbar vertebral bodies. Minimal degenerative narrowing of the L4-5 interspace is suspected. The remaining lumbar interspaces are unremarkable as are the pedicles and SI joints."

She argues that the current X-rays, as noted by [Appellant's doctor #1], clearly demonstrate that there have been changes to her spine subsequent to the motor vehicle accident. She submits that there is a causal connection between these changes, the motor vehicle accident and her ongoing complaints of pain. Therefore, the Appellant submits that the termination of IRI benefits by MPIC was premature and that her benefits should be reinstated.

Counsel for MPIC submits that the Appellant was capable of returning to work in June 1997. He notes that the objective evidence as relayed by the physiotherapists, by [independent physiatrist], and by [text deleted], the rehabilitation consultant demonstrates that the Appellant was capable of returning to work in June 1997. He argues that the fact that the Appellant may have some pain, should not prevent her from performing her occupational duties. Additionally, he submits that the reports of [Appellant's doctor #1] should be discounted as he provides no objective evidence in his reports of a medical condition which would prevent the Appellant from working. Lastly, he notes that the symptoms that are being reported by the Appellant are found in the general population. Further, these symptoms cannot be causally connected to the motor vehicle accident of November 3, 1994. There have been a number of additional factors, including the Appellant's three intervening pregnancies and her previous Workers Compensation injury, which would have also contributed to the symptoms that the Appellant currently complains of.

Subsection 110(1)(a) of the MPIC Act provides that an entitlement to an Income Replacement Indemnity ends when a victim is able to hold the employment that she held at the time of the accident. In June 1997, [the Appellant] had progressed through a reconditioning/work hardening program at [rehab clinic] and successfully completed a graduated return-to-work program. The objective evidence at that time, including the independent medical examination conducted by [independent physiatrist], was that she was capable of returning to her employment as a nurse's assistant. Upon consideration of the totality of the evidence, we find that as of June 16, 1997, the Appellant was able to hold the employment that she held at the time of the accident.

Consequently, the Appellant's entitlement to Income Replacement Indemnity benefits was properly terminated by MPIC pursuant to Subsection 110(1)(a) of the MPIC Act. Additionally, since the Appellant lost her previous position because of the accident, she was entitled to

continue to receive Income Replacement Indemnity benefits for an additional year, pursuant to Subsection 110(2)(d).

Accordingly, for these reasons, the Commission dismisses the Appellant's appeal and confirms the decision of MPIC's Internal Review Officer, bearing date August 16, 2000.

Dated at Winnipeg this 5th day of June, 2002.

YVONNE TAVARES

WILSON MacLENNAN

F. LES COX