Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-13-102

PANEL:	**Ms Laura Diamond, Chairperson** **Mr. Tom Freeman** **Ms Janet Frohlich**
APPEARANCES:	**The Appellant, [text deleted], was represented by Mr. Dan Joanisse;** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Trevor Brown.**
HEARING DATE:	**September 28 and 29, 2015 and May 6, 2016.**
ISSUE(S):	**Whether the Appellant is entitled to further chiropractic treatments.**
RELEVANT SECTIONS:	**Section 136(a) and 138 of The Manitoba Public Insurance Corporation Act ('MPIC Act') and Section 5 of 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 was injured in a motor vehicle accident on December 31, 2010. He sustained a blow to the head with loss of consciousness, bilateral neck pain, left-sided arm and shoulder pain, left abdominal pain, left back pain, left hip and knee pain, left shoulder pain and left-sided headaches. There were no fractures and his injuries were soft-tissue in nature. He was unable to return to his duties as a self-employed [text deleted] and was in receipt of Income Replacement Indemnity ("IRI") benefits.

The Appellant developed other issues as a result of the accident and further medical investigation was undertaken to address cognitive concerns regarding memory and chronic pain issues. He was diagnosed with a Major Depressive Disorder as well as Post-Traumatic Stress Disorder and received treatments for these conditions.

The Appellant also received treatment from his chiropractor, [Appellant's chiropractor], as well as his family doctor, [Appellant's doctor]. He was diagnosed with a post-concussion syndrome and back pain and received chiropractic care. His family doctor recommended that he should also continue with physiotherapy treatments, and anti-inflammatory and muscle relaxant medication.

The Appellant received MPIC funding for Track I and Track II chiropractic care. In a report dated January 14, 2012, [Appellant's chiropractor] requested funding for further treatment. This was reviewed by the Health Care Services chiropractic consultant for MPIC, who concluded that there was insufficient improvement to warrant further treatment funding. Further treatment coverage was approved while an independent assessment was arranged and the Appellant attended for an independent chiropractic assessment with [independent chiropractor] on April 23 and May 9, 2012. In a report dated August 2, 2012, [independent chiropractor] concluded that the Appellant had not made any substantial improvement in his symptoms through long term exposure to chiropractic care with [Appellant's chiropractor]. The Health Care Services consultant concurred with this opinion and approved treatment coverage up to a maximum of 104 treatments in total, after which no further chiropractic treatments would be covered.

The Appellant's case manager communicated this decision to him in a letter dated September 12, 2012. The Appellant sought Internal Review of this decision, and on June 19, 2013, an Internal Review Officer for MPIC concluded that the medical reports supported the opinion that further chiropractic care was not medically required. The case manager's decision was upheld.

It is from this decision of the Internal Review officer that the Appellant has now appealed.

Issue:

The parties agreed that the issue before the Commission was whether the Appellant should be entitled to supportive chiropractic care as a result of the motor vehicle accident. Upon consideration of the documentary evidence filed, as well as testimony heard at the appeal hearing and the submissions of counsel, the panel concluded that the Appellant had failed to meet the onus upon him to establish, on a balance of probabilities, that the criteria for supportive care had been met. The Appellant's appeal is therefore dismissed.

Evidence and Submission for the Appellant:

The Commission was provided with a number of medical reports in regard to the Appellant's condition, including reports from his family practitioner, psychiatrist and physiotherapists. In addition to the medical reports contained in the Appellant's indexed file, the Commission heard oral testimony at the appeal hearing from the Appellant, and from his chiropractor, [Appellant's chiropractor].

The Appellant described his good health prior to the motor vehicle accident and his involvement in work, family and recreational activities. He testified that he did not suffer from any significant health problems or concerns before the motor vehicle accident. Although he received

chiropractic treatment prior to the motor vehicle accident, this was a lifestyle choice and not a result of any specific injuries. He would attend once or twice a month to receive adjustments. These made him more relaxed and able to cope with daily life. He described this as maintenance, since he did [text deleted] work which was very physically demanding.

The Appellant described the difficulties that he had following the motor vehicle accident, both with physical pain as well as with depression and stress. He was not able to work or drive.

He attended several times a week to [Appellant's chiropractor] to deal with his severe pain following the motor vehicle accident. He also went for physiotherapy. He experienced very little improvement with physiotherapy and when he tried aqua-therapy he had panic attacks and had to terminate that program.

The Appellant also described the medications that he was taking and his home exercise program, which had been prescribed for him by the physiotherapist.

According to the Appellant, chiropractic care provides him with temporary relief, as does medication. It takes a little bit of pressure off his back and he has slightly less pain, so that he can manage better. It also helps him deal with his anxiety and stress. The Appellant testified that he still goes for chiropractic treatment once every two weeks or so and that he feels that if he could continue with the treatment once or twice per week this would benefit him. Although he believed that chiropractic care does not take away 100% of his pain and that it is not permanent, he finds temporary relief, with his pain coming down from 7 out of 10 to even a 3 or 4. This makes a big difference to him. He feels a little more relaxed for a few days and can manage his pain better.

On cross-examination, the Appellant was asked about trial periods of withdrawal of chiropractic care and what happened during and after those periods. The Appellant could not recall the details of these trial withdrawals of care or the result. He did agree that, as [Appellant's chiropractor] had noted in reports, he had reached maximum therapeutic benefit in the sense that his progress had plateaued. He still felt, however, that he required chiropractic care on a supportive basis.

[Appellant's chiropractor] also testified at the hearing into the Appellant's appeal. He was qualified as an expert in chiropractic care. He detailed his diagnosis of the Appellant's injuries following the motor vehicle accident and noted that, as the case progressed nine months post-motor vehicle accident, the Appellant was going down the road of a chronic pain condition. He recognized the Appellant's need for the psychological care which he was receiving.

[Appellant's chiropractor] was referred to and elaborated upon reports which he had provided addressing the criteria for supportive chiropractic care, dated May 7, 2014 and August 1, 2014. He was also referred to copies of his chart notes, which were in the Appellant's indexed file.

In these reports [Appellant's chiropractor] opined that the Appellant had reached maximum therapeutic benefit but was still dealing with issues of immobility, pain relief and quality of everyday life. The symptoms for which he was being treated were related to the motor vehicle accident. The Appellant had undergone active and passive care including rehabilitation and home based care attempts. He also underwent withdrawals of chiropractic treatment for periods of four weeks or longer between September 24 and October 23, 2013 and between April 5 and May 3, 2014. In both cases, there was a demonstrated decrease in his range of motion and a subsequent increase in pain. A corresponding decrease in his quality of life was noted.

[Appellant's chiropractor] testified that in his view "medically required" includes providing quality of life to the patient. When asked how often such care would be required, he said that he could not say and that the patient dictates the frequency of care. He noted that one in five of his patients come in "when the wind brings them in". He lets the patient decide. They then experience more mobility instantly. This lasts one to four days, but he admitted that he has no way of knowing this because he no longer looks at pain scales.

[Appellant's chiropractor] indicated that he was familiar with the criteria for supportive care but that in practicality that is not what happens. He disagreed that measurable pain and mobility scores were important in this assessment. When working with the Appellant, he indicated that in his chart notes he simply circles areas of the spine that he works on. He had no documentation to show what the range of motion levels were. On cross-examination he agreed that he should have done more measurable tests before and after treatment and that in hindsight he should have obtained status inventories and goniometer readings, but in his view the patient seeking care was in and of itself an objective measure of their need for care. He testified that he had a four year relationship with the Appellant as a patient and did not need to test and record results to know that there was pain.

In his report of August 1, 2014, [Appellant's chiropractor] stated that upon withdrawal of care there was a decrease of range of motion greater than 25%. He then noted:

> "As his care has been supportive in nature and his toleration of testing procedures is limited when in a flare up, no specific measurements using a goniometer were performed. The notations were based upon my estimations which I stand by firmly. Most notably when he attends in the grips of a flare up, his general movements are slow and guarded with pronounced fear avoidance behaviors demonstrated. [the Appellant's] care has been palliative in nature provided to him on an as needed basis (p.r.n.). His attendance has been on his own timeline – established by what he what he perceives as being required to get him through a particular day. Thus, our goal with each visit has

> been to restore range of motion and ease his pain and discomfort in order to aid in his quality of life."

Counsel for MPIC asked [Appellant's chiropractor] whether there was any way to show, given his chart notes, whether a patient had made improvement or not. [Appellant's chiropractor] indicated that he had not done testing and documentation to demonstrate whether there was an increase in pain or a decrease of motion and functionality during a withdrawal of care.

It was [Appellant's chiropractor's] opinion that the Appellant's condition deteriorated without chiropractic treatment and that ongoing chiropractic care that lessens pain and inflammation and increases range of motion and function would progress the Appellant towards his rehabilitation goals. He recommended that the Appellant receive supportive chiropractic treatment at a frequency of once every seven to ten days or 3 to 4 times per month while continuing to pursue both active and passive forms of in office and home based self care. [Appellant's chiropractor] opined that chiropractic care assisted with his repeated flare-ups.

Counsel for the Appellant submitted that the evidence established that the Appellant had met the criteria for the necessity for supportive chiropractic care. He reviewed the definition of supportive care from the Clinical Guidelines for Chiropractic Practice in Canada which defines supportive care as follows:

> "**Supportive Care:** Treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain this benefit and progressively deteriorate when there are periodic trials of withdrawal of treatment. Supportive care follows appropriate application of active and passive care including rehabilitation and life style 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, somatisation, illness behaviour, or secondary gain."

Counsel submitted that for the Appellant, such chiropractic care could be funded either under Section 136 or Section 138 of the MPIC Act. The Appellant was at maximum therapeutic benefit and had pursued other relevant forms of care and rehabilitation. Other active and passive care options had been considered or attempted but the Appellant obtained relief for his chronic neck and jaw pain from chiropractic care. This was essential to his rehabilitation.

Counsel noted the severity of the motor vehicle accident and the Appellant's long struggle with the lasting impacts of pain and psychological impact from the accident.

The reports and testimony of his chiropractor showed that without chiropractic care the Appellant experienced more pain, less mobility and less function. When trial withdrawals of care were attempted, the Appellant's condition deteriorated and then improved again when chiropractic care was reinstated.

Although [independent chiropractor] did not support continued chiropractic care for the Appellant, counsel noted that he did not have the same relationship with the Appellant which [Appellant's chiropractor] had. [Appellant's chiropractor] had a long-standing care relationship with the Appellant and this is important for someone who suffers from chronic pain. This relationship allowed [Appellant's chiropractor] to assess the Appellant's pain complaints and provide effective treatment.

Counsel for the Appellant submitted that the Appellant suffered significant soft tissue injuries which had severe lasting impact on the Appellant's daily functioning. He didn't respond well to the majority of treatments provided by physiotherapists and other specialists and only medication and chiropractic care were really beneficial for him. The relief of his pain allowed the Appellant

to have better function and a substantial improvement in his quality of life. Therefore, although the effects may have been short lived, the supportive chiropractic care allowed him to have better quality of life overall. The Appellant was seeking supportive chiropractic treatment once every seven to ten days or three to four treatments per month, as essential for lessening his disability, and facilitating his return to a normal life and re-integration into society. It was submitted that the Appellant should be reimbursed for the supportive care which he had received to date, at his own expense at that frequency, and that MPIC should fund ongoing supportive care at the same frequency.

Evidence and Submission for MPIC:

Counsel for MPIC relied upon a variety of reports on the Appellant's indexed file, and in particular, upon reports from MPIC's chiropractic health care consultant and [independent chiropractor], who provided reports following a third party chiropractic assessment.

Following a review of the Appellant's file and examination of the Appellant, [independent chiropractor] concluded that the Appellant had not made any substantial improvement in his symptoms after long term exposure to a variety of interventions, including chiropractic care with [Appellant's chiropractor]. He noted that chiropractic treatment provided the Appellant with a short-term comforting effect, but had not yielded any traction towards a recapture of function. In [independent chiropractor's] view, the Appellant was no longer deriving therapeutic benefit from chiropractic care. It would not lead to a favourable outcome. He recommended that a discharge from chiropractic treatment should be imminent, as the medical necessity of continued chiropractic care was not established by an inert response to the lengthy course of treatment to date or by the nature of the Appellant's condition. He recommended that the continuum of care should focus on psychological management and greater exposure to activity.

MPIC's chiropractic care consultant reviewed [independent chiropractor's] and [Appellant's chiropractor's] reports as well as the Appellant's psychologist's report. He indicated, in a report dated September 12, 2012, that after reviewing the file information it was his opinion that the Appellant had reached his maximum therapeutic benefit under his current chiropractic care regime. Further chiropractic care would best be described as elective care. On August 19, 2014, he noted that in spite of [Appellant's chiropractor's] estimation that the Appellant's range of motion worsened by over 25% with withdrawal of care, [independent chiropractor's] examination in 2012, while the Appellant was under active care, also reported range of motion findings with a decrease of 25%, while under care.

Counsel for MPIC submitted that it was clear from [Appellant's chiropractor's] evidence that what he considered to be supportive care is not the same as what others in his profession consider to be supportive care. True supportive care requires that several elements be met. The patient has to have reached maximum medical improvement. Further rehabilitation efforts have to be attempted. There must be trial withdrawals of care of four weeks or more which result in demonstrated deterioration and improvement in function with the return of care. It was submitted that even [Appellant's chiropractor] agreed that all of those elements must be present.

However, in this case, because [Appellant's chiropractor] had failed to use any pain scores or properly document results, there was no objective evidence that the Appellant had experienced a measurable decrease in function or increase in symptoms after trial withdrawals of care. No status inventory scales which could measure pain and function (including the Oswestry and Neck Index) were utilized. This, it was submitted, is where [Appellant's chiropractor] failed his patient. Nor was there anything in his clinical notes to establish that upon a return from trial

withdrawals the Appellant's function had decreased and pain increased. The Commission was left with only [Appellant's chiropractor's] verbal assertions, from memory, that the Appellant's condition had worsened. There was no information contained in his clinical notes which shed light on this question.

Although he asserted that trial withdrawals of care resulted in a decrease of range of motion greater than 25%, [Appellant's chiropractor] had nothing to measure this against, since no baseline measurements were recorded.

Therefore, the panel was left with only the subjective evidence of the Appellant regarding his claims of decline without chiropractic care and improvement with a return to care, and [Appellant's chiropractor's] estimates or impressions.

This is not sufficient to discharge the Appellant's onus of proof. The Commission should require objective medical evidence. Therefore, based upon the test for supportive care, the Appellant had not met the essential test of showing that there was a decline following a withdrawal of care and improvement with the return to care.

Therefore, counsel submitted that the appeal should be dismissed and the decision of the case manager upheld.

Discussion:

The MPIC Act provides:

> 136(1) Subject to the regulations, the victim is entitled, to the extent that he or she is not entitled to reimbursement under *The Health Services Insurance Act* or any other

Act, to the reimbursement of expenses incurred by the victim because of the accident for any of the following:

(a) medical and paramedical care, including transportation and lodging for the purpose of receiving the care;

Corporation to assist in rehabilitation

138 Subject to the regulations, the corporation shall take any measure it considers necessary or advisable to contribute to the rehabilitation of a victim, to lessen a disability resulting from bodily injury, and to facilitate the victim's return to a normal life or reintegration into society or the labour market.

Manitoba Regulation 40/94 provides:

Medical or paramedical care

5 Subject to sections 6 to 9, the corporation shall pay an expense incurred by a victim, to the extent that the victim is not entitled to be reimbursed for the expense under *The Health Services Insurance Act* or any other Act, for the purpose of receiving medical or paramedical care in the following circumstances:

(a) when care is medically required and is dispensed in the province by a physician, nurse practitioner, clinical assistant, physician assistant, paramedic, dentist, optometrist, chiropractor, physiotherapist, registered psychologist or athletic therapist, or is prescribed by a physician, nurse practitioner, clinical assistant, or physician assistant;
(b) when care is medically required and dispensed outside the province by a person authorized by the law of the place in which the care is dispensed, if the cost of the care would be reimbursed under *The Health Services Insurance Act* if the care were dispensed in Manitoba.

The onus is on the Appellant to show, on a balance of probabilities that he should be entitled to further chiropractic care, on a supportive basis.

An accepted test for determining supportive care sufficient to establish “a medical requirement” of chiropractic treatment includes the following elements:

1. The initial treatment must provide a benefit and the claimant must be at a maximal medical benefit;
2. the condition deteriorates in the absence of a therapeutically relevant time frame;

3. the condition improves with the resumption of treatment;
4. alternative approaches have been attempted without success;
5. an appropriate home-based program is in place;
6. risks (especially reliance upon a passive treatment) are out-weighed by the benefits.

Counsel for MPIC submitted that there was no medical evidence to support the criteria set out in tests for supportive care, beyond the subjective evidence of the Appellant. The panel does not agree that no medical evidence was provided in support of the Appellant's subjective evidence. The Appellant's chiropractor, [Appellant's chiropractor], provided medical reports dated May 7, 2014 and August 1, 2014 which addressed the criteria for supportive care. These reports advanced [Appellant's chiropractor's] opinion that all of the tests for supportive care had been met. He opined that the Appellant had reached maximum therapeutic benefit and received an appropriate application of active and passive care. The reports confirmed that the Appellant's condition and symptoms were related to the motor vehicle accident and opined that supportive chiropractic treatment would lessen the Appellant's disability, pain and inflammation, and increase his range of motion and function towards his rehabilitation goals, recommending in-office treatment once every seven to ten days or three to four times per month. Both letters indicated that the Appellant had undergone trial withdrawals from chiropractic care and experienced demonstrated decreases in ranges of motion with subsequent increases in pain and decreases in quality of life as a result. [Appellant's chiropractor] noted a decrease of range of motion greater than 25% as a result. He also indicated in his letters that upon return to care after the trial withdrawals the Appellant experienced periods of pain relief and improved mobility.

As set out above, [Appellant's chiropractor's] testimony at the appeal hearing reflected the information provided in these medical reports.

However, while these reports and testimony were provided as medical evidence to support the Appellant's claim for supportive care, the panel finds that they did not provide sufficient evidence to establish on a balance of probabilities that all of the recognized and accepted tests for supportive care have been met in this case.

In particular, [Appellant's chiropractor] admitted on cross-examination that he had failed to properly document with sufficient detail the Appellant's condition at various points in time. Such documentation might have allowed him to undertake a proper analysis or comparison of the patient's status. As counsel for MPIC submitted, and [Appellant's chiropractor] acknowledged upon cross-examination, his chart notes failed to provide the detailed record of patient status on the dates prior to and after the trial withdrawals of care which would be needed to demonstrate increases in pain or decreases in function after the breaks, and improvement with the return of care. Such data would be needed to analyze and answer these questions.

Instead, with breaks in care identified between September 24 and October 23, 2013; and April 5 and May 3, 2014, the only documentation found in [Appellant's chiropractor's] chart notes was the note of September 24, 2013 reading "*getting worse*", of October 23, 2013 noting "*bad couple of days bedridden decrease ROM greater than 25%*" and May 3, 2013 "*decrease ROM greater than 25%...*" (*the last word was illegible*). No notes were recorded on other relevant dates.

In addition to the absence of detailed charting, [Appellant's chiropractor] did not provide any pain scores, range of motion testing results, status inventories, Oswestry scales or neck disability indexes.

Therefore, the panel agrees with [MPIC's chiropractor's] comments in his report of August 19, 2014 which stated:

> "Although the report in question advances on going care as 'supportive' in nature there is insufficient evidence to qualify the care as medically required. Specifically aside from estimated limitations in range of motion of "greater than 25%" following a therapeutic withdrawal from care there is no objective evidence that describes a worsening of the claimants condition follow a withdrawal from care."

The parties agreed that one of the accepted criteria for supportive care require that the Appellant establish on a balance of probabilities that his condition declined after trial withdrawals of care, and improved again with resumption of care. Although the Appellant testified and provided subjective evidence regarding this decline and improvement with resumption of treatment, and [Appellant's chiropractor's] reports supported this view, the medical evidence and documentation before the panel failed to provide clear support for this position. [Appellant's chirorpactor's] testimony and, in particular, his cross-examination, showed that he had failed to test, chart and document findings which would support such conclusions. As a result, the panel was left to conclude that one of the tests for supportive care regarding deterioration with trial withdrawal of care and improvement with the resumption of treatment had not been met. The panel is not convinced that the Appellant has established that he derives sufficient benefit from supportive care or that such care was medically required or necessary and advisable after September 12, 2012.

Accordingly, the Appellant's appeal from the Internal Review decision of June 19, 2013 is dismissed and the Internal Review decision upheld.

Dated at Winnipeg this 16th day of June, 2016.

LAURA DIAMOND

TOM FREEMAN

JANET FROHLICH