Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-15-055

PANEL:	**Ms Laura Diamond, Chairperson** **Dr. Sharon Macdonald** **Ms Linda Newton**
APPEARANCES:	**The Appellant, [text deleted], appeared by teleconference on her own behalf;** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Morley Hoffman.**
HEARING DATE:	**June 21 and 22, 2016**
ISSUE(S):	**Entitlement to a permanent impairment benefit for concussion, facial numbness or post-concussion syndrome.**
RELEVANT SECTIONS:	**Section 127 of The Manitoba Public Insurance Corporation Act ('MPIC Act'), Section 1.1, 4.6, 4.7 and 4.9 of Division 2 Subdivision 1, and Section 5 and 6 of Division 2, Subdivision 3 of Manitoba Regulation 41/94.**

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

Background:

The Appellant was involved in a motor vehicle accident on March 20, 2013 when she was a passenger in a car struck by another vehicle. As a result of that accident, the Appellant complained of headaches, neck pain, upper back pain, shoulder pain, arm pain, mid-back pain, facial and arm numbness, dizziness, nausea and fatigue. She was in receipt of MPIC funded

chiropractic treatment, but on August 26, 2013, her case manager issued a decision advising her that there was no entitlement to further funding for chiropractic treatment beyond Track II Phase 1 to a maximum of 40 treatments. The Appellant sought Internal Review of the decision and subsequently appealed that decision to the Commission. The Internal Review decision was upheld upon appeal and on June 12, 2014, the Commission found that the Appellant was not entitled to reimbursement for further chiropractic treatment.

The Appellant also sought a permanent impairment benefit from MPIC, pursuant to Section 127 of the MPIC Act. The case manager issued decisions dated May 27, 2014 and May 30, 2014. The Appellant's case manager reviewed her claim for a permanent impairment award and indicated that in spite of the Appellant's complaints of concussion, facial numbness and pain and suffering, medical reports indicated there were no signs of cerebral contusion, no ambulance had attended the scene and there were no medical reports to support a permanent impairment entitlement for such injuries. The case manager also noted that there are no provisions under the MPIC Act to allow for payment of general damages for pain and suffering. The Appellant sought Internal Review of these decisions.

On August 12, 2014, an Internal Review Officer for MPIC instructed the benefits administrator to reconsider the May 30, 2014 case manager's decision (based upon new information) and to issue a new decision letter.

A new benefits administrator's decision of November 24, 2014 once again confirmed that there were no provisions under the MPIC Act to allow for payment of general damages for pain and suffering. Further, after reviewing the medical reports on the Appellant's file, the decision indicated that:

> "At this point, your file information does not indicate a probable permanent impairment entitlement. The facial numbness does not have a patho-anatomic correlate accounting for that symptom that is at maximum medical improvement and permanent. The numbness has not been objectively documented by the neurologist. The chiropractor documented multiple areas of cervicogenic numbness, but this is improbable based on the remainder of the information in the claim file. You have not manifested loss of consciousness or amnesia which are required for permanent impairment entitlement in concussion."

The Appellant sought Internal Review of this decision and on February 25, 2015, an Internal Review Officer for MPIC found that the medical information did not establish that the Appellant had sustained an injury that would qualify her for a permanent impairment award for concussion, facial numbness, or post-concussion syndrome. The Appellant appealed to this Commission and a hearing was held on June 21 and 22, 2016.

Preliminary Issues:

At the appeal hearing, the Appellant testified that she suffered from right arm numbness as a result of the motor vehicle accident and referred the panel to numerous reports on the indexed file which refer to this condition. She submitted that she should be entitled to a permanent impairment award for this condition.

The Appellant also testified that she suffered from visual disturbances as a result of the motor vehicle accident and that she should be entitled to a permanent impairment award in this regard.

The panel reviewed the Internal Review decision of February 25, 2015 and found that this decision, as well as the benefits administrator's decision which preceded it, did not deal with a claim by the Appellant for a permanent impairment benefit in regard to right arm numbness or visual disturbances.

The Appellant was advised that as these issues were not the subject matter of the Internal Review decision under appeal, the panel did not currently have jurisdiction to consider these questions and that she should pursue further possible entitlement to permanent impairment benefits which she believes she may have in this regard, with her case manager.

Further, the Appellant submitted that this panel should revisit the Commission's previous decision of June 12, 2014 which dismissed her appeal for reimbursement and ongoing expenses for chiropractic care. The panel noted that the question of chiropractic benefits had already been decided by the Commission and was not the subject of the current appeal.

Issue:

The issue before the panel is whether the Appellant is entitled to a permanent impairment award for concussion, facial numbness or post-concussion syndrome. After reviewing the evidence on the Appellant's indexed file, her testimony and submissions and the submissions of counsel for MPIC, the panel finds that the Appellant has failed to establish, on a balance of probabilities that she is entitled to permanent impairment awards in this regard.

The Hearing:

At her request, the Appellant testified, was cross-examined and provided oral submissions by way of teleconference. She provided her evidence and submissions during a full day on June 21, 2016. On June 22, 2016, counsel for MPIC provided his submissions and the Appellant was afforded an opportunity to reply to MPIC's submission.

The Appellant chose to represent herself, as she noted that she could not afford a lawyer, and confirmed that although she had been offered the services of representation from the Claimant

Adviser Office, after some contact, she had declined to continue to receive representation from them and decided to represent herself.

The Appellant asked whether she could record the proceedings, but was advised that the Commission does not record its proceedings and does not authorize audio or video recordings of its proceedings by participants.

The appeal hearing involved consideration of various sections of Regulation 41/94 to the MPIC Act, concerning permanent impairment benefits. The Commission provided a copy of the particular sections discussed to counsel for MPIC, with an email copy to the Appellant. She was able to refer to this copy of the relevant provisions during the telephone hearing.

Benefits Claimed:

The Appellant referred the panel to a "Summary of Expenses" dated November 23, 2015 which she indicated represented her expenses from the motor vehicle accident for which she was seeking compensation at the appeal.

This list of expenses, which has been reproduced exactly as it was received by AICAC, set out the following:

> *Expenses from the March 20, 2013 car accident of [the Driver].*
> *To: Automobile Injury Compensation Appeal Comission*
> *From: [the Appellant]*
>
> *1. [The Appellant] sustained a Concussion Injury, with ongoing head and neck pain, and Facial and right arm numbness. I am still dizzy and off balance, have memory problems and vision problems, depression, from the March 20, 2013 car accident of the driver, as I was a passenger, and lost consciousness. I needed tylenol 2 and 3, painkillers prescribed by my gp, [text deleted], From March 20, 2013 to present. I was also told by my gp to take robaxacet and advil which I have some receipts for, estimated about $215.92 per year, x 50 years, ongoing = $10,796.00*

I am prescribed Diffu&max creme for ongoing neck and back pain from car accident of March 2013, to Dec. 2015 = $501.66. $37.50 x 12 mths = $450.00 per year x 50 years ongoing = $22500.00

2. Also, I required and needed funds for ongoing chiropractic treatment recommended by 2 chiropractors, [Appellant's chiropractor #1] (previous)and [Appellant's chiropractor #2] who is away sick and ([Appellant's chiropractor #3] is looking after his files who I saw in Nov. 2015, his technique is torque release which helps with concussion injuries). I was also recommended by my gp, for ongoing chiropractic treatment, June 3, 2015 letter in July 15, 2015 letter. My neurologist, [text deleted], recommended ongoing treatment and he told me I must live with symptoms of head and neck pain and facial numbness, letter on file. I was diagnosed at [hospital] Emergency with concussion and numbness and possible fracture. My Neurologist diagnoses me with concussion, ongoing head and neck pain and facial numbness that I must live with in July 15, 2015 letter. My gp said I, [the Appellant], must live with the pain, and it is permanent, see [Appellant's doctor #1's] clinical notes.

3. I, [the Appellant], claim damages from MR of $250,000.00 for Permanent Impairment so I can pay for ongoing chiropractic treament needed to sustain MMI and reduce some pain levels and for transportation costs, taxis as I have pain when I drive from the 2013 car accident and I cannot cook as often as I have ongoing head and neck pain and right arm numbness and I need to pay for hired help to cook, vacuum, do laundry. Money is owed to friends and my daughter for helping drive, cook, clean, etc. from March 2013, ongoing. It is MPI's responsibility and not my daughter who is in university and does not always have time and not my friends responsbililty. I am also asking $750,000.00 damages and compensation, from MPI for not following [the Appellant's] medical doctors reports on your file, in the July 15, 2015 letter sent to you, for ongoing chiropractic treatment and ongoing care needed for [the Appellant's] concussion injuries sustained in [the Driver's] March 20, 2013 car accident.
The driver, [text deleted] car accident facts are not correct, so facts to AICAC's June 12, 2014 decision fetter for ongoing chiropractic treatment was denied, and MPIs internal review officer's facts were also incorrect and I lost MPI benefits.
I ask that you subpoena [the Driver] to verify his-car-accident report. His car was written off and he received cash.

I also asked for several case conference meetings with AICAC before Oct. 2015 court with MPI as I was told, when I asked, the director of AICAC, I could claim damages against MPI in court which I did. The judge in court with MPI said I need to go to AICAC for my damages back from MPI.

4. [Appellant's chiropractor #2's] rate is $40.00 per treatment x twice per week = $80.00 x 4 weeks = $320.00 per month, December 2015 $320.00 x 12 = $3,840.00 per year x 50 years ongoing = $192,000.00 and I request funds back for chiropractic treatments recommended from [Appellant's chiropractor #2] from Feb. 2015 to July 2015 for about 25 visits.

I am requesting my backpay and I would like reimbursement from Sept. 26, 2013 denial of chiropractic visits from June 12, 2014 decision of AICAC, from [Appellant's chiropractor #1], to January 2015 = $600.00

5. Meals outside the home as I could not cook as often as I have ongoing head and neck pain and facial and right arm numbness, Costs from March 2013 - March 2014 = $1050.00 x 12 mths = $12,600.00 per year x 3 years = $37,800.00 up to Dec. 2015, tentative Dec. 8, 2015 meeting, ongoing x 50 years = $630,000.00 needed

6. Photocopying expenses, did not keep all receipts = $100.00

7. Transportation costs - gas and mileage costs as friends and my daughter helped drive me to the bank, groceries and chiropractor office, etc, since March 20, 2013 car accident, $1200.00 per year until Dec. 2015, 2 years and 9 months = $3,300.00, x 50 years = $165,000.00

8. Care expenses (funds to pay friends and daughter to vacuum, carry groceries, cook, laundry,,, as I had friends and daughter help) $600.00 per month, from March 2013- Dec. 2015 = $19,800.00

9. Recreation as recommended by [Appellant's chiropractor #2], whirlpool therapy as my friend helped pay for me to the YWCA for whirlpool therapy. It was 67.00 per month, $1005.00 MPI owes me back as it was not his responsibility for treatment, but the responsibility of MPI's.
Whirlpool therapy recommended by [Appellant's chiropractor #2] and [Appellant's chiropractor #1] in their letters = $804.00 per year x 50 years ongoing = $40,200.00

10. Movies and aids (neck pillows and back supports, as I cannot sit long periods due to March 20, 2013 car accident, need funds of ($200.00 per mth x 12 = 2, 400.00.per year. $6,200.00) 120,000.00

(I have ongoing chest soreness and shoulder pain). I cannot lie on my chest doing chiropractic treatment due to [text deleted] physical force of 2014 – [the Appellant] advised to get protection order, see gp notes.

Total damages claimed = $1,078,918.50

I request a Permanent Impairment award of $250000.00 and damages from MPI for not following my medical reports on file of $750,000.00 a.s.a.p. I need funds to pay for ongoing, chiropractic treatment, meals outside home, transportation, (taxis), hired help. maid to help vacuum, do laundry, and cook as it is MPI's responsibility to cover me as a passenger for concussion and numbness, body injuries sustained in the driver's March 20, 2013 car accident and I need all my backpay back from March 20, 2013.

Per [Appellant's chiropractor #4], a new chiropractor, because [Appellant's chiropractor #2] is away on sick leave, and who I saw on Oct. 16, and 20, and 26, 2015 for the March 2013 car accident. [Appellant's chiropractor #4] reports concussion and whiplash injuries and that my condition has gotten worse as I have no funds to pay for ongoing treatments recommended by all my numerous health professionals on your file.

It is MPI's responsibility to cover my ongoing chiropractic treatments and survival expense. I saw [Appellant's chiropractor #4] on November 24, 2015 and he performed a nystagnous test for vision problems, which was positive, due to brain injury (concussion) from the March 20, 2013 car accident.

[Appellant's chiropractor #2], chiropractor, also reports vision and memory problems for me in his reports. Also the Manitoba Brain Injury Association who I talked to, reports, people who suffer brain injuries have memory problems, vision problems and depression and these side effects are life long. I suffer from these side effects, memory, vision problems and depression, after the March 20, 2013 car accident of [the Driver], see Drs. reports on your file.

Internal Review Decision:

The Internal Review decision under appeal (dated February 25, 2015) made the following conclusions in upholding the benefit administrator's decision and dismissing the Appellant's Application for Review:

"**Concussion**

Schedule A of Manitoba Regulation 41/94 outlines the criteria required to qualify for a minor cerebral concussion or contusion which reads as follows:

1.1 Cerebral concussion or contusion (a) minor (post traumatic amnesia) (PTA) < 30 minutes of loss of consciousness (LOC) < 5 minutes)...0.5%

At the hearing, you confirmed that the ambulance was not called to the scene and your first post-accident medical visit was with [Appellant's chiropractor #1] the following day. You did attend [hospital] on March 26 and were seen in Emergency. A brief letter from [hospital] confirmed the visit and listed the diagnosis as "*concussion*".

However, without objective medical evidence confirming a loss of consciousness or post-traumatic amnesia, that are typically confirmed by Emergency Medical Services, there is no objective medical evidence that you had sustained a concussion. You do not qualify for a Permanent Impairment award for this reported condition.

Facial Numbness

In order to qualify for an award regarding a facial nerve, there needs to be objective evidence of a Permanent Impairment. This can include, but is not limited to the following; facial weakness, dysfunctionally dry mouth, swallowing difficulty, etc. [Appellant's neurologist] has not confirmed an objective impairment listed with the Regulations. I concur with the consultant that you do not qualify for a Permanent Impairment award regarding facial numbness.

Post-Concussion Syndrome

> Although not specifically mentioned in the decision letter, I asked the consultant for an opinion regarding [Appellant's neurologist's] comment that you had sustained post-concussion syndrome. In the review of February 18, 2015 (copy enclosed), the consultant indicated that not only did [Appellant's neurologist's] September 10, 2014 report not alter the previous opinions rendered, a probable diagnosis of post-concussion syndrome has not been rendered. I concur with the consultant's opinion."

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

Evidence and Submission for the Appellant:

The Appellant testified at the hearing into her appeal.

She introduced her evidence by indicating that she was seeking funds from MPIC to compensate her for a concussion she received in the motor vehicle accident when her head hit the side window glass. As a result she suffered from head and neck pain, vertigo and dizziness as well as facial and right arm numbness. She could not cook, drive or sleep without painkillers and needed help with everything, including hiring a maid to help her and taking meals outside the home. Although she received some chiropractic treatment, this was eventually denied by MPIC and the Commission.

Accordingly, she sought a permanent impairment benefit of $250,000, a catastrophic injury benefit of $233,000 and wishes MPIC to provide her with $750,000 in compensation because there were errors in the accident report provided by the driver of the vehicle in which she was a passenger ("the Driver").

The Appellant described the motor vehicle accident and its location on [text deleted], emphasizing that the accident had not occurred at a slow speed in a parking lot, but rather at a

high speed on a roadway, which resulted in greater injury to her. She emphasized that the location of the car accident was very important for this reason.

The Appellant testified that she had suffered a "whiplash" in a previous motor vehicle accident in 2010 and had also been injured in a motor vehicle accident in September 2012. These were not the subject of claims to MPIC for Personal Injury Protection Plan ("PIPP") benefits.

She saw a chiropractor ([Appellant's chiropractor #1]) as a result of these issues and had been to a chiropractic appointment on the morning of March 20, 2013, just before the motor vehicle accident occurred. She recalled that the Driver had been driving across [text deleted] at the median and was proceeding to turn left. She indicated that this was all she remembered; she didn't see anything and she didn't see the motor vehicle accident. She became aware as her head and face hit the side window glass. She was wearing a seatbelt but the car did not have an airbag. She testified that she must have lost consciousness then because when she became aware the car was on the other side of the road. She experienced head and neck pain. She said she was in shock and had pain in her face and arm. The Driver yelled at her to stay in the car as he was exchanging particulars so she did not see the driver of the other car. Because the Driver had to go to work, she told him she did not want to go to Emergency and instead he took her to see her general practitioner, [text deleted], who lives near her apartment. She testified that her doctor advised her to go to Emergency if she needed to and to follow-up with her chiropractor.

She went to see the chiropractor the next day, who diagnosed her and provided treatment.

The Appellant then said she felt sick, dizzy and nauseous and spent three months on bed rest. About one week later, because she couldn't do anything and was still feeling sick and dizzy, the Driver took her to Emergency at the [hospital].

The Appellant testified that she couldn't cook, clean or drive and that she had problems with dizziness, vertigo and vision. She had pains in her head and neck and had trouble sitting, sleeping, driving or doing laundry. She had to get friends and her daughter to help her with household chores.

She testified that she has ongoing head and neck pain as well as a numb right arm and face and pain in her ribs. She takes medication such as Tylenol 2's and 3's and Advil, but she has a sensitive stomach, so she tries to rely upon natural herbs.

In response to questioning from the panel and counsel for MPIC, the Appellant indicated that she is able to do her banking by telephone. She gets help buying groceries. She has phone contact with her friends by speaker phone and although her arm numbness prevents her from using a computer, she does use an IPad.

She agreed that she had not worked for approximately four years before the motor vehicle accident. She agreed that an ambulance did not attend at the site of the motor vehicle accident. She indicated that she received 40 chiropractic treatments. She suffered intermittently and to varying degree from dizziness, nausea and fatigue, and although her chiropractor may have reported that these symptoms were overall resolved after three months on January 13, 2014, the Appellant indicated that she has these symptoms at all times. Some days they are better and

some days are worse. She explained that if she is under a lot of anxiety and stress, her numbness, head pain and dizziness get worse.

On cross-examination the Appellant agreed that she had only seen [text deleted] (neurologist) once, but she noted that in his reports and in their visit he had indicated that she was not getting better and she would have to live with the pain. She agreed that [Appellant's neurologist's] report did not describe any inability to speak or use language or to chew or swallow food. She had never needed to be institutionalized because of the motor vehicle accident and she lives at home without full time supervision or care, aside from her doctors' visits. She does not have any diagnosed cognitive dysfunction or psychiatric problems and has not needed to see a psychologist or psychiatrist. She is able to read, write, add and subtract. She also indicated that she has not been prescribed any medication specifically for anxiety or a psychiatric condition.

The Appellant also indicated that although she may have reached maximum medical improvement from chiropractic care, she still requires care twice a week to sustain that.

She also explained that [Appellant's doctor #2], who submitted a medical report on her file, was a friend of hers from church who came to her house to see how she was doing, but who had not conducted a physical exam or treated her.

The Appellant referred to the expense list which she had submitted, dated November 23, 2015, and set out above. She submitted that this sheet summarized the difficulties and injuries she has suffered and is suffering from and the compensation which she requires from MPIC as a result.

She submitted that she sustained a concussion injury with ongoing head and neck pain as well as numbness, dizziness, memory problems and depression. She maintained that she had lost consciousness during the motor vehicle accident. Her doctors and chiropractors agreed with and supported her need for chiropractic care and had led her to believe that she would have to live with her symptoms of head and neck pain and numbness.

The Appellant submitted that she had been diagnosed with a concussion and that her neurologist, [text deleted], had diagnosed post-concussion syndrome.

She reviewed the list of compensation to which she was entitled, highlighting claims for chiropractic treatment for the rest of her life, meals outside the home, photocopying expenses, transportation costs for life, hired help, recreation, and whirlpool therapy. The total amount added up to over $1,000,000, she submitted.

The Appellant reviewed reports and chart notes from her general practitioner, her two chiropractors and the neurologist, [text deleted]. She emphasized that she had lost consciousness, that she suffered from severe head and neck pain, numbness (facial and arm), anxiety, fear and depression. She indicated that the car accident was far more severe than the accident report and the statement of the Driver might lead one to believe, as the facts provided by the Driver in his statements were not correct.

The Appellant submitted that she had been diagnosed with a concussion and post-concussion syndrome and that since the motor vehicle accident which caused these was not her fault, she should receive appropriate compensation from MPIC, to meet the needs outlined in her statement of expenses.

Submission for MPIC:

Counsel for MPIC began his submission with an overview of the permanent impairment sections of the MPIC Act, indicating that permanent impairments are awarded to victims who suffer permanent physical or mental impairment because of an accident. They are determined by reviewing the objective medical evidence. They are not based on reported symptoms, but are evaluated according to the medical information on the file and although subjective reported complaints of the victim are considered, there must be some verifiable confirmation of an impairment. Nor is every symptom or complaint compensable. For example, complaints of pain and suffering under the tort system of personal injury law are not listed in the permanent impairment schedule and are not compensable. This would apply to complaints like neck pain, arm pain, back pain or headaches.

Counsel also emphasized that the Appellant has the onus of showing, on a balance of probabilities, that she is entitled to a permanent impairment award. He noted that some of the Appellant's claims actually relate more to treatment or obtaining a proper medical diagnosis and that the Appellant may have issues which she wishes to be explored by doctors and specialists, but for which there is no current objective evidence of a permanent impairment.

Counsel for MPIC then went on to review three possible impairments identified and reviewed by the Internal Review Officer in the decision of February 25, 2015.

1. Concussion

Counsel noted that no ambulance was called to the scene after the motor vehicle accident and that there is no indication in the Driver's statement that the Appellant was knocked out or rendered unconscious. Although she said she hit her head on the window, no cuts were seen and

she got out of the car on her own. The Driver makes no reference to any other injuries although he saw her often after the motor vehicle accident for almost a year. She later saw her general practitioner and chiropractor and complained of headaches.

There was no evidence of any amnesia, as the Appellant never complained that she couldn't remember what happened.

About a week after the motor vehicle accident, the Appellant attended at the [hospital]. There is no report to them of any blackouts, evidence of amnesia or evidence of any cerebral contusions in her CT scan.

The Appellant's chiropractor's narrative report does not mention blackouts or any such problems reported to her by the Appellant.

The Appellant's general practitioner does not mention blackouts in his notes.

Although [Appellant's neurologist] noted that the Appellant had blacked out a few times after the accident, counsel submitted that he clearly was reporting what the Appellant had told him, and there is no evidence of her blacking out. Moreover, there was no indication as to when any of the blackouts might have occurred or whether they had anything to do with the motor vehicle accident of March 20, 2013.

[Appellant's chiropractor #2] also reported that the Appellant experienced blackouts following the motor vehicle accident. However, he did not see her until two years after the motor vehicle accident and clearly was only reporting what the Appellant had told him.

Therefore there is no confirmation that the Appellant had any blackouts, let alone when they might have happened or whether they had anything to do with the motor vehicle accident. More objective evidence would be required before anyone could say that the Appellant was knocked out in the motor vehicle accident and entitled to a permanent impairment award regarding consciousness.

MPIC's Health Care Services reviewed the file and also opined that the Appellant does not qualify for a permanent impairment award in this regard as there is no evidence in the file that she sustained any loss of consciousness or amnesia.

Under Division 2, Subdivision 1, Section 1.1 of Regulation 41/94, there must be a finding of post-traumatic amnesia of 30 minutes or less or a loss of consciousness of 5 minutes or less, for an Appellant to be entitled to even the minimum award for minor concussion. Even a diagnosis of a mild "concussion" does not meet the minimum qualifying criteria under the schedule to be eligible for the award without such loss of consciousness or post-traumatic amnesia.

Accordingly, counsel submitted that the Appellant had failed to meet the onus upon her of showing that she was entitled to an award for concussion.

2. Facial Numbness

Counsel noted that [text deleted], the neurologist, does not list anything in his report that would qualify the Appellant for a permanent impairment award for facial numbness. He lists headaches as her main complaint and does not even mention facial numbness in his initial report. It is only in [Appellant's neurologist's] subsequent report, in September of 2014, that he even mentions facial numbness as a complaint. However, counsel noted that there was no

objective documentation for this complaint. There is no indication that [Appellant's neurologist] performed any tests to confirm this. There is no evidence that he had EMG, nerve conduction, or blood test performed. There was no evidence he even did a physical examination, as he does not say where on the face the numbness is supposed to be located. He makes no mention of particular complaints such as dry mouth, swallowing issues, facial weakness, etc. Nor does [Appellant's neurologist] say how this complaint could be related to the March 20, 2013 motor vehicle accident or whether this facial numbness is a permanent condition.

This issue was reviewed by MPIC's Health Care Services consultant. The consultant noted that there is no accounting for the facial numbness from the motor vehicle accident or evidence that it is permanent. No diagnosis had been provided to explain how facial numbness could have occurred in the motor vehicle accident or whether it is a condition which will continue forever.

In reviewing the potentially relevant sections of the Regulations, counsel for MPIC analyzed Section 6, Facial Nerve under Division 2, Subdivision 3 regarding facial nerve dysfunction. However, he noted that there was no evidence that anything listed had been affected, such as eye closure, loss of sense of taste, dry mouth, middle ear dysfunction resulting in fear of loud noises, etc. Nothing in [Appellant's neurologist's] reports indicated problems in this regard. A further analysis of Section 5, Trigeminal Nerve under Division 2, Subdivision 3 of the Regulation, showed that there was no evidence showing anything had been affected such as chewing dysfunction, swallowing difficulty, speaking difficulty, malalignment, or dystonic or other involuntary movement of the jaw. Nothing in [Appellant's neurologist's] report supported the existence of such dysfunctions in the Appellant.

Accordingly, counsel submitted that there is no basis to show that there has been a nerve dysfunction or any other criteria that qualifies for a permanent impairment award and that the Appellant had not met the onus of showing, upon a balance of probabilities, that she was entitled to an award under the schedule of the Regulations for facial numbness.

3. Post-Concussion Syndrome

Counsel addressed [Appellant's neurologist's] letter of September 10, 2014 which stated that the Appellant has post-concussion syndrome, predominantly with headaches. In counsel's view, most of this report involved the neurologist simply restating what the Appellant had reported to him.

MPIC's Health Care Services consultant reviewed the issue of post-concussion syndrome and noted that this was not a probable diagnosis and that post-concussion does not generally result in a permanent impairment award.

In this regard, counsel reviewed the sections of the Regulations dealing with post-concussion syndrome. The schedule does compensate, he submitted, for certain permanent mental impairments, but there needs to be a serious dysfunction to qualify for this and the Appellant did not come close to qualifying. Section 4.6 of the Regulation deals with communication disorders such as dysphasia, aphasia, alexia, agraphia and acalculia. There is no evidence in the Appellant's case that any of the listed disorders have any application to her case. The Appellant understands everything, and communicates in person, via her phone and her IPad. She does her banking by telephone.

Counsel also examined Section 4.7 dealing with alterations of consciousness such as post-traumatic cataplexy, coma, epilepsy, narcolepsy and syncope (fainting). He submitted that there was no evidence in this case that any of those listed disorders have any application to this case. There is no evidence that the Appellant requires any institutionalization or supervision or any medication or that she cannot perform any daily living activities.

Finally, counsel reviewed Section 4.9 and Division 11 regarding cognitive functions. He noted there are various classes of dysfunction (1-5) listed there, but there is no evidence in this case of any psychiatric condition causing any impairment requiring psychiatric intervention or medication. There must be evidence of cognitive or psychiatric dysfunction under these sections for the Appellant to qualify for a permanent impairment, and she has not even seen a psychiatrist or been diagnosed with any such syndrome or phenomenon.

Further, the Health Care Services consultant noted that the Appellant had not reached maximum medical improvement regarding some of her issues and had not seen a neuro-psychologist or tried other treatment that might reduce any such symptoms.

As such, the Appellant has failed to meet the onus upon her of showing any entitlement for post-concussion syndrome.

Counsel did note that the Appellant is always free to gather further evidence in support of her claim for a permanent impairment and that it will be looked at by MPIC. However, to date, there is no evidence to support any permanent impairment for concussion, facial numbness or post-concussion syndrome. Simply having symptoms does not equate to a permanent

impairment entitlement. As such, the Internal Review Officer's decision should be confirmed and the appeal dismissed.

Discussion:

The onus is on the Appellant to show, on a balance of probabilities, that the Internal Review Officer erred in finding that she was not entitled to a permanent impairment award for concussion, post-concussion syndrome, or facial numbness.

Section 127 of the MPIC Act provides:

> **Lump sum indemnity for permanent impairment**
>
> 127(1) Subject to this Division and the regulations, a victim who suffers permanent physical or mental impairment because of an accident is entitled to a lump sum indemnity of not less than $500. and not more than $100,000. for the permanent impairment.

a) Concussion

Section 1.1 of Division 2, Subdivision 1 of Regulation 41/94 provides:

> **Division 2: Central and Peripheral Nervous System**
>
> **Subdivision 1: Skull, Brain and Carotid Vessels**
>
> **1. Alteration of brain tissue**
>
> 1.1 Cerebral concussion or contusion
>
> (a) minor (post-traumatic amnesia (PTA) < 30 min or loss of consciousness (LOC) < 5 min).. 0.5%
> (b) moderate (PTA > 30 min < 24 hrs or LOC > 5 min < 1 hr.)...................... 2%
> (c) severe (> 24 hrs of (PTA) or > 1 hr (LOC)).. 5%
> (d) post concussion syndrome: (see sections 4.6, 4.7 and 4.9 of this subdivision)

The panel has reviewed the evidence presented by the Appellant and by MPIC. We find that there was no objective evidence of loss of consciousness or amnesia.

The Appellant testified that she lost consciousness in the accident but did not know it at the time and didn't know it until October of 2015.

A written statement by the Driver noted that the Appellant "said she hit her head on the passenger door window. I didn't see any cuts. She got out of my car on her own. ..."

There is no ambulance report or record of an ambulance attending at the scene. The Appellant indicated that no ambulance was called and that she did not attend at an Emergency Room, because the Driver had to go to work. She did seek medical care from her family physician immediately following the accident, but her doctor did not make a note that the Appellant had lost consciousness.

The Appellant attended for chiropractic treatment the next day, but her chiropractor did not note a loss of consciousness in the accident.

The Appellant attended at the [hospital] Emergency on March 27, 2013. Chart notes and an Emergency Report Form from that date noted mild concussion, but a CT scan noted no signs of cerebral contusion or abnormality. A letter dated December 23, 2014 from the Records Department at the [hospital] noted a diagnosis of concussion. None of these chart notes or medical reports from the [hospital] noted a loss of consciousness.

Accordingly, none of the caregivers who saw the Appellant within a week of the motor vehicle accident documented any loss of consciousness. As a result of a lack of objective evidence of loss of consciousness or post-traumatic amnesia, the Commission finds that the Appellant has

failed to meet the onus upon her, on a balance of probabilities, to establish that there was a loss of consciousness or post-traumatic amnesia which would qualify her for a permanent entitlement for cerebral concussion or contusion pursuant to Section 1.1(a) of the Regulation.

b) Post-Concussion Syndrome

Section 1.1(d) of Division 2 of Subdivision 1 of Regulation 41/94 provides:

Division 2 Central and Peripheral Nervous System
Subdivision 1: Skull, Brain and Carotid Vessels

2. Alteration of brain tissue

1.1 Cerebral concussion or contusion
(d) post concussion syndrome: (see sections 4.6, 4.7 and 4.9 of this subdivision)

4.6 Communication disorders (Dysphasia, aphasia, alexia, agraphia, acalculia and other communication disturbances)

(a) disturbances leading to a complete inability to understand and use language..... 70%

(b) disturbances not affecting the ability to understand linguistic symbols, but severely interfering with the ability to use sufficient or appropriate language.......... 50%

(c) disturbances not affecting the ability to understand linguistic symbols, but moderately interfering with the ability to use sufficient or appropriate language..... 25%

(d) disturbances entailing minor communication difficulties.................................. 7.5%

4.7 Alterations of consciousness (Posttraumatic cataplexy, coma, epilepsy, narcolepsy, syncope and other neurological disorders and disturbances of consciousness)

(a) cognitive disorder that prevents the performance of all activities of daily living sufficient to require supervision in an institutional setting on a permanent basis, including any adverse effects of medication.. 100%

(b) cognitive disorder that severely disrupts the performance of activities of daily living sufficient to require supervision in an institutional setting on a periodic basis (more than 50% of the time), including any adverse effects of medication........... 70%

(c) cognitive disorder that severely disrupts the performance of activities of daily living sufficient to require supervision in an institutional setting on a periodic basis (less than 50% of the time), including any adverse effects of medication............. 35%

(d) cognitive disorder that moderately disrupts the performance of daily living not requiring institutionalization, but requiring occasional supervision........................ 15%

(e) cognitive disorder that minimally disrupts the performance of the activities of daily living, without the need for supervision, including the side effects of medication.. 7.5%

4.9 Cognitive dysfunction
To be rated according to Division 11.

DIVISION 11: COGNITIVE FUNCTION

Mental Functioning System

Class	**Symptom or condition**	**Impairment rating**
Class 1	A psychiatric condition, syndrome or phenomenon that causes an impairment all activities of daily living, social functioning or sense of well-being sufficient to require supervision in an institutional setting on a permanent basis, including adverse effects of medication.	100%
Class 2	A psychiatric condition, syndrome or phenomenon that causes an impairment in activities of daily living, social functioning or sense of well-being to require supervision in an institutional setting on a periodic basis (more than 50% of the time). Any adverse effects of medical treatment contributing to impairment should be considered.	70%
Class 3	A psychiatric condition, syndrome or phenomenon that causes an impairment in activities of daily living, social functioning or sense of well-being, sufficient to require supervision in an institutional setting less than 50% of the time. Any adverse effects of medical treatment contributing to impairment should be considered.	35%
Class 4	A psychiatric condition, syndrome or phenomenon that causes an impairment in activities of daily living, social functioning or sense of well being sufficient to require psychiatric follow-up on a monthly basis.	15%
Class 5	A psychiatric condition, syndrome or phenomenon that causes an impairment in activities of daily living, social functioning or sense of well-being sufficient to require regular medication, psychiatric intervention or both on an occasional basis (less than once per month).	5%

The Appellant took the position that she had suffered a permanent post-concussion syndrome injury. She pointed to evidence from the indexed file reports that noted post-concussion symptoms or referred to post-concussion syndrome. In this regard, the panel reviewed reports from the following caregivers:

1. Chart notes from the Appellant's general practitioner, [text deleted], do not contain a diagnosis of post-concussion syndrome.
2. Chart notes and reports from the [hospital] noted a diagnosis of concussion or mild concussion. However, there was no evidence of any follow-up by the hospital or any diagnosis of post-concussion syndrome.
3. One of the Appellant's chiropractors, [Appellant's chiropractor #1], provided a diagnosis of post-concussion syndrome in a report dated April 3, 2013. However, in a narrative report dated January 13, 2014, [Appellant's chiropractor #1] described the Appellant's symptoms and progress noting "... The dizziness, nausea and fatigue were overall resolved after three months."
4. [Text deleted], a neurologist, reported "post-concussion symptoms as well as headache" in his report of April 10, 2014. On September 10, 2014 he stated:

   > "It is my medical opinion that [the Appellant] is suffering from symptoms consistent with post-head trauma related symptoms. These symptoms are often collectively referred to as post-concussion syndrome or post-traumatic syndrome. Common symptoms include dizziness and headache. Chronic daily headache is one of the most frequent and debilitating features of this problem."

5. The Appellant's chiropractor, [Appellant's chiropractor #2], provided a report dated March 10, 2015 which stated:

   > "... has reached MMI, suffers from post-concussion syndrome, a concussion confirmed by the ER report of [hospital], and a diagnosis of post-concussion syndrome formalized in report by a board certified neurologist, [text deleted]"

In a report dated July 10, 2015 he described her symptoms and stated:

> "... The constellation of residual symptoms described here and in the neurologist's report led [text deleted] (neurologist) to conclude [the Appellant] suffers from post-concussion syndrome."

Counsel for MPIC reviewed [Appellant's neurologist's] reports in his submission. He noted that they involved the doctor restating what the Appellant had reported to him. He further pointed to a report from MPIC's Health Care Services team dated February 18, 2015 which stated:

> "... A probable diagnosis of post-concussion syndrome has not been rendered. That condition does not usually lead to permanent impairment."

The Health Care Services consultant had earlier opined, on October 27, 2014 that the patient was not seeing a neuro-psychologist and had not had more invasive cervical spine treatment which might reduce her symptoms or indicate that she was at maximum medical improvement.

Counsel for MPIC also reviewed the impairments and dysfunction listed under Sections 4.6, 4.7 and 4.9 of Manitoba Regulation 41/94 regarding post-concussion syndrome. He noted that there was no evidence that the Appellant suffered from any of the communication disorders listed under Section 4.6. Indeed, the Appellant's evidence established that she understands everything, communicates effectively, communicates with her phone and IPad and does her banking over the telephone.

Further, there was no evidence that the Appellant suffered from any of the disorders listed as alterations of consciousness under Section 4.7 or that the Appellant suffers from a cognitive disorder that minimally disrupts the performance of the activities of daily living.

Finally, counsel submitted that there was no evidence of cognitive or psychiatric dysfunction causing any impairment requiring psychiatric intervention or medication which would entitle the Appellant to a permanent impairment award pursuant to Section 4.9 and Division 11. Depression was noted by her general practitioner on September 8, 2014 but there was no evidence of a referral to a psychologist or psychiatrist, or of prescribed medication for depression or anxiety. There was no evidence that the Appellant had seen a psychiatrist or been diagnosed with any psychiatric condition syndrome or phenomenon.

The panel agrees that there is insufficient objective evidence to establish an entitlement to a permanent impairment for any of the disorders listed in the Regulations regarding post-concussion syndrome. Having reviewed the file and listened to the Appellant's evidence we also agree that she is able to assemble information and communicate it. Her own evidence, upon cross-examination, established that she was able to speak and use language, to swallow food without difficulty and is able to read, write, add and subtract. She has never required institutionalization or supervision aside from her doctor's care, has not been provided with a psychiatric diagnosis or needed to see a psychologist or psychiatrist. She has not been prescribed anti-anxiety or psychiatric medication.

Therefore, the Commission finds that the Appellant has failed in the onus upon her to establish on a balance of probabilities an entitlement to a permanent impairment award for post-concussion syndrome under the Regulations.

Facial Numbness:

Counsel for MPIC reviewed two sections of the Regulation which he believed might possibly be considered to relate to facial numbness.

DIVISION 2: CENTRAL AND PERIPHERAL NERVOUS SYSTEM

Subdivision 3: Cranial Nerves

5. Trigeminal

Add impairment ratings to arrive at a total. If bilateral, add impairment ratings for each side to arrive at a total impairment rating.

(a) Motor (unilateral or bilateral):
- (i) detectable weakness but no functional impairment.............................. 1%
- (ii) weakness with resulting difficulty chewing... 2%
- (iii) weakness with resulting difficulty swallowing.................................... 5%
- (iv) weakness with resulting difficulty speaking.. 3%
- (v) weakness with malalignment resulting in pain.................................... 5%
- (vi) dystonic or other involuntary movement of jaw:
  - (A) mild or no treatment needed... 2%
  - (B) moderate controllable with treatment....................................... 5%
  - (C) severe uncontrollable, with pain.. 10%

(b) sensory – rate according to the following table:

	Class 1 No impairment	Class 2 hypoesthesia	Class 3 complete loss
V1 (includes EYE)	0%	2%	5%
V2	0%	1%	3%
V3	0%	1%	3%

(c) with associated pain (Painful dysesthesia or typical neuralgia):
- (i) controlled by medication.. 2%
- (ii) partially controlled by medication, or not functionally limiting............ 3%
- (iii) uncontrolled by medication and functionally limiting........................... 10%

6. Facial Nerve

(a) motor:
- (i) stapedius weakness:
  - (A) stapedius reflex lost with sonophobia..................................... 2%
- (ii) facial weakness:
  (add 2% if weakness results in difficulty eating)
  (add 2% if weakness results in difficulty speaking)
  - (A) Class 1: no weakness... 0%
  - (B) Class 2: weakness but full eye closure...................................... 2%
  - (C) Class 3: weakness with incomplete eye closure........................ 4%
  - (D) Class 4: near complete paralysis.. 6%
  - (E) Class 5: complete paralysis.. 8%

(iii) facial synkinesia... 1%
(iv) hemifacial spasms... 3%

Where facial weakness is associated with alteration in form and symmetry, (See Division 13 – The Skin).

(b) sensory:
(i) loss of sensation in ear canal.. 0%

(c) lacrimation:
(i) dry eye(s), no drops needed.. 0.5%
(ii) dry eye(s), needing drops.. 2%
(iii) excessive tearing (crocodile tears)... 1%

(d) salivation:
(i) dysfunction leading to dry mouth.. 1%

(e) taste:
(i) incomplete loss (very difficult to clinically confirm)............................ 0.5%
(ii) total loss (i.e. bilateral lesion).. 2%

The Appellant testified that she had suffered from facial pain and then numbness ever since the motor vehicle accident. The [hospital] Emergency Report form of March 27, 2013 noted that the Appellant complained of facial numbness. Facial symmetry and power was normal.

The chiropractor, [Appellant's chiropractor #1], noted in her report of January 13, 2014 that the Appellant suffered from "numbness across the face and forearms."

[Appellant's doctor #1's] notes of March 31, 2014 reported that the patient still has numbness on her face.

Although the neurologist, [text deleted], did not report facial numbness on April 10, 2014, his report of September 10, 2014 reported that the Appellant described facial numbness persisting since the accident and not improving to date.

The chiropractor, [Appellant's chiropractor #2], reported facial numbness in his letter of March 10, 2015.

[Appellant's doctor #2], who the Appellant testified was a friend and had not examined her with regard to her motor vehicle accidents, also noted facial numbness in a letter dated September 28, 2015.

Counsel for MPIC submitted that in spite of these notations, there was no objective documentation for the Appellant's complaint of facial numbness. Although [Appellant's neurologist] mentioned it in his second report, there was no indication that he had performed any test to confirm this. There was no evidence that the Appellant had undergone an EMG, nerve conduction or blood test or that [Appellant's neurologist] had even performed a physical examination to note where on the face the numbness was located or indicated whether it was a permanent condition. He makes no mention of dry mouth, swallowing issues or facial weakness and makes no mention of how the condition could be related to the motor vehicle accident.

A report from MPIC's Health Care Services team dated October 27, 2014 opined that:

> "... The facial numbness does not have a patho-anatomic correlate accounting for that symptom that is at maximum medical improvement and permanent. The numbness has not been objectively documented by the neurologist. The chiropractor documented multiple areas of cervicogenic numbness, but this is improbable based on the remainder of the information in the claim file. She has not manifested loss of consciousness or amnesia which are required for permanent impairment entitlement in concussion.
>
> The patient appears to be equating symptoms with permanent impairment entitlement. These are not synonymous."

In reviewing Section 5 of Regulation 41/94 regarding trigeminal nerve damage, counsel for MPIC pointed out that there was no evidence indicating that anything had been affected such as chewing dysfunction, difficulty swallowing or speaking, malalignment or dystonic or other involuntary movement of the jaw.

In regard to Section 6, facial nerve dysfunction, there is no evidence that anything had been affected in regard to eye closure, loss of sense of taste, dry mouth or middle ear dysfunction.

The panel found, and has set out above, several instances of documentation in the reports on the Appellant's medical file which note facial numbness. There is, however, a lack of objective expert description, assessment, measurement or testing results which would establish an entitlement to a permanent impairment award. There is a lack of detailed evidence that would objectively establish these references to numbness, their connection to the categories of permanent awards set out in the Regulations reviewed, or their causal connection to the motor vehicle accident.

Therefore the Commission finds that the Appellant has failed to establish on a balance of probabilities that she is entitled to a permanent impairment award for facial numbness at this time.

However, as counsel for MPIC pointed out, should the Appellant receive further treatment, assessment or diagnosis regarding her complaints of facial numbness and its connection to the motor vehicle accident and the permanence of the condition, it remains open to the Appellant to

present this information to her case manager pursuant to Section 171(1) of the MPIC Act dealing with fresh information.

Section 171(1) of the MPIC Act provides:

> **Corporation may reconsider new information**
> 171(1) The corporation may at any time make a fresh decision in respect of a claim for compensation where it is satisfied that new information is available in respect of the claim.

For example, the panel noted that although MPIC's Health Care Services consultant pointed out in his report of October 27, 2014 that "(T)he patient is not at maximum medical improvement. She has not seen a neuropsychologist...", evidence of such assessment or treatment was not before the panel. Should the Appellant receive further assessment, diagnosis and/or treatment recommendations from a neuropsychologist, neurologist or other specialist, she may present this information to her case manager pursuant to Section 171(1) of the MPIC Act.

Thus, as noted by counsel for MPIC, if the Appellant comes into possession of fresh evidence which provides objective support for her claim of permanent impairment regarding these or other conditions caused by the motor vehicle accident, she is free to present this information to her case manager for assessment and evaluation in accordance with the evidence and the provisions of the MPIC Act and Regulations.

Accordingly, the Appellant's appeal from the Internal Review decision of February 25, 2015 is dismissed and the decision of the Internal Review officer is therefore upheld by the Commission.

Dated at Winnipeg this 12th day of July, 2016.

LAURA DIAMOND

DR. SHARON MACDONALD

LINDA NEWTON