Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-12-039

PANEL:	**Ms Laura Diamond, Chairperson** **Ms Karin Linnebach** **Ms Janet Frohlich**
APPEARANCES:	**The Appellant, [text deleted], was represented by Mr. Ken Kalturnyk of the Claimant Adviser Office;** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Anthony Guerra.**
HEARING DATE:	**February 8 and 9, 2018**
ISSUE(S):	**Entitlement to Personal Injury Protection Plan benefits regarding right hand numbness.**
RELEVANT SECTIONS:	**Sections 70(1) and 71(1) of The Manitoba Public Insurance Corporation Act ('MPIC Act')**

AICAC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE APPELLANT'S PRIVACY AND TO KEEP PERSONAL INFOMRATION 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 (MVA) on November 6, 2009. At the time of the accident, he was employed as a [text deleted] and screener operator. Based on initial medical information, it was believed the Appellant sustained soft tissue injuries involving his right hip, both shoulders and neck. He also reported chest pain, and later, problems with his right hand.

The Appellant missed two shifts following the MVA, and then returned to work.

On June 18, 2011, he contacted his case manager and advised that he had experienced slurred speech and right hand numbness. Although he was investigated for a potential stroke, he indicated that he had been advised his right hand numbness stemmed from neck pain as a result of the MVA and that he had been on disability since December 2010.

Following a review by MPIC's Health Care Services medical consultant, the case manager provided a decision dated September 15, 2011 indicating that there was no cause and effect relationship between the MVA and the reported right hand numbness. Therefore, no coverage of benefits was provided to the Appellant.

The Appellant sought an Internal Review of this decision. On November 22, 2011, an Internal Review Officer for MPIC reviewed the facts surrounding the Appellant's accident and the medical information on his file at that time. Reports from the Health Care Services medical consultant were reviewed alongside information from [hospital #1], the Appellant's general practitioner and chiropractor, as well as [Appellant's doctor #1], a physician with experience in Sports Medicine. The Internal Review Officer agreed with the Health Care Services consultant that the evidence did not establish a cause and effect relationship between the Appellant's right hand numbness and the accident. He found support in the almost one year post-accident before the initial report of these symptoms. This would, he noted, suggest something other than accident related trauma to account for the numbness. The case manager's decision was upheld. It is from this decision of the Internal Review Officer that the Appellant has now appealed.

The issue before the Commission is whether the Appellant's right hand numbness was caused by the MVA. Following a review of the evidence and submissions, the Commission has concluded that the MVA caused or materially contributed to the symptoms of numbness in the Appellant's right hand.

Evidence and Submission for the Appellant:

The Appellant testified at the hearing into his appeal and also relied on additional medical evidence from his chiropractor, his general practitioner, [Appellant's doctor #2], and from [Appellant's doctor #1].

Evidence of the Appellant:

The Appellant described the circumstances of the MVA, when his truck swerved on an icy road and he was hit head-on by a [text deleted]. He described being propelled forward with the seatbelt strap under his chin and then backwards, so that his head broke the back window in his truck. He suffered injuries in his hip, shoulder, and lower back. He was attended by paramedics and transferred to hospital, where he was prescribed medication. He missed two days of work and then returned to his job as a [text deleted] and screener operator.

The Appellant described the nature of his job duties prior to the MVA. He described chiropractic treatment for his hip, neck, shoulders and for headaches. He consulted with [Appellant's doctor #1] and received approval from him to continue with chiropractic treatment, as long as the chiropractor did not crack his neck. He continued chiropractic treatment until approximately April 2010.

Around that time, the Appellant began to experience numbness in his right hand. First, his pinky went numb, and the next day two of his fingers were numb. After 1½ weeks, his whole hand and then his whole arm started to feel numb. The Appellant indicated that at first he just kept on working, although he did mention the numbness to his boss. His boss indicated that they were going to be getting a [text deleted] so he should just continue doing his duties until the [text deleted] was acquired. Then he could drive that, which would be less difficult for him, given his hand and arm symptoms. The Appellant testified that he did not report his symptoms to his doctor at that time because he did not want it to affect his job. He was having difficulty doing his normal tasks but his boss "had his back". The organization was in transition, and his boss was about to retire with someone else taking over, so the Appellant wanted to keep working as much as he could.

He then began driving a brand new [text deleted].

The Appellant also described a few episodes where he had difficulty speaking at work.

Finally, these episodes and his right hand numbness led him to seek treatment at the [hospital #2]. He was then referred to the [clinic]. The Appellant indicated that he was told that he had not suffered a stroke and should undergo MRI investigation for a possible pinched nerve in his neck or "something like that".

His employer then recommended that he go on group insurance, as he was not able to work as much or as long into the season as he had when he was a [text deleted] operator. There was less work available over the course of the season for a [text deleted] driver, and the employer did not always have a [text deleted] on hand for him to drive.

Therefore, the Appellant was, for various periods, in receipt of [text deleted] disability benefits in regard to the condition of his right hand.

The Appellant indicated that he did not have pain in his arm or hand, but only numbness. He could pick things up, but when he did so he might not necessarily have feeling or sensation, which might cause him to spill or drop things. Except for the two incidents which he described, where he had difficulty speaking, he had no further difficulties in regard to his speech.

The Appellant explained that he has continued working, although he cannot do his old job because it is difficult to clean the screens and bang the chute. Therefore, he continued with truck driving. This has resulted in implications for him on the seniority list, including the necessity to transfer locations with his employer, thereby experiencing earlier layoffs and later call-backs.

The Appellant, on cross-examination, confirmed that he is a heavy smoker and takes medication for high blood pressure. He also acknowledged that in approximately 2006 or 2007 he had rotator cuff surgery on his right shoulder. He described the [text deleted] job as a physically demanding one. He denied ever having been hospitalized or suffering from Raynaud's disease. He agreed that his hand numbness gets worse in the winter, but not that his symptoms were magnified, just that it seems worse in the cold "just like anything else".

The Appellant was cross-examined on his recollection of the MVA and whether he hit his head on the back window of his truck. While the Appellant acknowledged that he was not covered in glass, there was no blood on his head and he didn't look to see if the window had broken, he was adamant that his head flew back and hit the window.

The Appellant also confirmed on cross-examination that after going to [hospital #2] for his symptoms, he was referred to the [clinic], but indicated that they had advised him that he had not suffered from a stroke.

When asked whether he was aware that he had been diagnosed with cervical radiculopathy, the Appellant indicated that he did not understand that, but he understood he was suffering from a pinched nerve in his neck, at about the C5 level.

Medical Reports:

The Appellant also relied upon reports from his chiropractor, [text deleted]. In a report dated June 23, 2011, the chiropractor described treating him for neck pain and headaches, which started when he woke up the day after his MVA. He described his headache as a sharp pain that started from the back of his head, went around to the back of his eyes, and occurred daily for the first two weeks after the accident. His right hip was in severe pain, and both shoulders were tight and sore. He stated that it was hard to move his arms back and over his head without pain and discomfort. The chiropractor recorded positive findings of right shoulder depressive cervical spine compression, Apley's scratch test and Yeoman's bilaterally. The chiropractor diagnosed subluxation in the cervical spine, lumbar spine and both SI joints.

> The headaches were diagnosed as cervicogenic, concomitant with a severe sprain/strain of the cervical soft tissues and both shoulders.

The Appellant also relied upon a report by [text deleted] dated June 24, 2011:

> Had assess w/ stroke clinic yesterday. Symptoms not stroke related. Feel issue w/ C spine (OA) which is putting pressure on nerves in neck. EE has been referred to a surgeon (date and name unknown) but has been given heads up surgical option not likely.

A report from the [hospital #3] was dated July 8, 2011. It reported on an MRI of the brain and cervical spine:

> **Test Results:** MRI Cervical spine showed right C3-C4 osteophyte formation causing mild foraminal impingement. At C4-C5, there is a mild posterior disc bulge contacting but not compressing the thecal sac. There is also left C4-C5 osteophyte formation again causing mild foraminal narrowing. At C5-C6, there is moderate to severe osteophyte formation with impingement on the right. At C6-C7, again is mild right osteophyte impingement on the foramen.
>
> MRI brain shows an area in the left frontal lobe suspicious for remote trauma. November 6, 2009, he did have an MVA, and did put his head through the back window of his truck.
>
> **Risk Factors:** hypertension.
>
> **Impression:** No cause of the dysarthria found.
>
> **Recommended Treatment:** Follow up with [Appellant's doctor #1]. Considering there are no motor symptoms, we will not be referring to a spine service at this point.
>
> We do not need to follow [the Appellant] on an ongoing basis. …

The Appellant continued treatment with [Appellant's doctor #1] who provided reports (dated January 13, 2011, August 11, 2011, February 7, 2012, February 24, 2013, August 1, 2013 and December 3, 2016), as well as providing testimony at the hearing (reviewed below).

The Appellant's general practitioner, [Appellant's doctor #2], provided an opinion dated March 6, 2013. He noted that the Appellant first complained of hand numbness on November 16, 2010 and that he had no documentation of right hand numbness prior to the MVA. Nor did he have record of any other mechanism of injury other than the MVA. As a result, he concurred with [Appellant's doctor #1's] opinion that right hand numbness was likely to be permanent given the duration of the symptoms and stated:

> I would consider it possible that [the Appellant's] r. hand numbness is related to the November 6, 2009 MVA although it is more difficult to establish a direct causal relationship given the timeline. However, it would be my opinion that the previous

> injury is likely to be a contributing or predisposing factor to [the Appellant's] symptoms.

He also confirmed the Appellant's physical restrictions relative to the duties of a truck driver.

Evidence of [Appellant's doctor #1]:

[Appellant's doctor #1] provided several medical reports and testified at the hearing into the Appellant's appeal. He provided details regarding his experience as a sports medicine adviser and with reviewing files. The parties agreed that he should be qualified as an expert in the field of medicine.

In a report dated August 11, 2011, [Appellant's doctor #1] diagnosed a right C6 vs C7 radiculopathy, describing continuing symptoms including numbness/tingling to the first, second and third digits of the hand with some lateral forearm tingling. Fine finger manipulation and strength were also affected. An MRI showed an environment of degenerative change. He identified degenerative change in the spine at that level as having the potential to delay recovery.

In a report dated February 7, 2012, [Appellant's doctor #1] confirmed his diagnosis and cited the MVA as a possible cause. In a report dated February 24, 2013 he noted continued symptoms and restrictions and stated:

> On the balance of probabilities, without any other noted mechanism of injury it is probable rather than not that the noted collision in question was the cause or would (sic) contributed to the development of the condition. This is after further review and analysis of a possible alternate explanation.

In his testimony before the panel, [Appellant's doctor #1] reviewed a report he had provided on August 1, 2013. In that report, he indicated that it was his view that the MVA was the cause of the Appellant's symptoms, as there was no evidence of any other reported mechanism of injury

other than the MVA in question. He stated that it was probable rather than not that the MVA was the cause of or would have contributed to the development of a right cervical radiculopathy which manifested as right hand numbness. In addressing the timing of its presentation, [Appellant's doctor #1] stated:

> Cervical radiculopathy may present to clinic and health care practitioners as shoulder pain, upper back pain, jaw pain, upper arm pain, elbow pain, forearm pain or hand pain with or without perceived numbness. The writer's first consultation in regards to the MVA was on Dec. 9, 2009. [the Appellant] did not present initially with right hand numbness or tingling but did present in November of 2010 with reported months history of hand/numbness and tingling. Patients may present with different manifestations of cervical radiculopathy through the course of the injury as noted above. This may explain the lapse in presentation.

[Appellant's doctor #1] was asked to compare this diagnosis with symptoms which may present from a Whiplash Affected Disorder (WAD). He indicated that cervical radiculopathy symptoms typically last longer than those caused by a WAD and can last anywhere from 6 to 18 months.

He noted that a Spurlings test for radiculopathy, if positive, would in 96% of the cases show a C6-C7 nerve root compromise. However, the test has low sensitivity, so an absence does not necessarily rule out the diagnosis since false negatives are more likely than false positives.

In reviewing physical findings noted in various caregiver reports on the Appellant's file, [Appellant's doctor #1] was of the view that a cervical radiculopathy diagnosis could not be ruled out. In his view, degenerative changes shown on imaging could be present in most people in the Appellant's demographic but have nothing to do with an anatomical reason for pain. He did not base his clinical diagnosis on imaging. Rather, it was an aggregate based on clinical signs and symptoms, his examination of the patient and evaluation of symptoms. He was not aware of the Appellant reporting any symptoms consistent with a cervical radiculopathy prior to the MVA or any report of an injury to the neck aside from the MVA. Although he agreed that

the mild degree of osteoporosis and foraminal impingement shown by MRI on the right side could produce a numb hand and arm, he noted that these can also be the symptoms of a cervical radiculopathy.

[Appellant's doctor #1's] review of the file indicated that there was no evidence that the Appellant had ever suffered an actual stroke. A Transient Ischemic Attack (TIA) would not produce permanent neurological deficit. Nor would the frontal lobe lesions correlate to arm symptoms, as lesions in that area do not have anything to do with motor function or sensation. Further, [Appellant's doctor #1] confirmed that he found no evidence of Raynaud's disease upon examination of the Appellant.

In a report dated December 3, 2016, [Appellant's doctor #1] confirmed his opinion. He stated:

> After review of the newly submitted information. The previous opinion is unchanged.
>
> There is no evidence of any other reported mechanism of injury other than the MVA in question. This is upon review of the medical information available at this time.
>
> It is more probable rather than not that the noted collision was the cause of or would have contributed to the development of right cervical radiculopathy manifested as right hand hypoesthesia or numbness.

On cross-examination [Appellant's doctor #1] did not disagree with a diagnosis of the Appellant having suffered a TIA, resulting in some problems with speech. However, he noted that the hallmark symptoms of TIA are temporary and seem to resolve, while the Appellant's arm numbness, which was not resolving, would be inconsistent with a TIA.

He confirmed that he did not rely upon x-ray imaging to diagnose a cervical radiculopathy and that his diagnosis was based on subjective complaints and objective findings. More particularly,

he noted subjective complaints of right-sided pain and numbness, two and three digit numbness and pain, with objective strength deficits correctly with tenderness at C5, C6 and C7. A combination of all these clinical features led him to a diagnosis of cervical radiculopathy.

[Appellant's doctor #1] confirmed that because the Appellant did not exhibit arm or hand symptoms prior to the MVA and within months, described numbness and tingling in that area to caregivers, he remained of the view that this MVA was the mechanism of injury causing the Appellant's symptoms. While there may have been an aggravation of previously asymptomatic degenerative changes in the spine, it remained his view that the cervical radiculopathy caused the Appellant's symptoms.

Evidence for MPIC:

Medical Reports:

Counsel for MPIC relied upon reports from [MPIC's doctor] (of MPIC's Health Care Services team) as well as an independent medical report prepared by [independent doctor].

[MPIC's doctor's] first report, dated September 14, 2011 set out his opinion that a cause/effect relationship could not be established between the MVA and the reported right hand numbness of the Appellant. He noted that the Appellant first presented with soft tissue symptoms involving his neck, chest, right hip and right shoulder and that there was an absence of documentation indicating that he presented with any clinical findings in keeping with the cervical radiculopathy until October 2010. He noted degenerative changes that pre-dated the MVA as well as a possibility that the Appellant had suffered a TIA. An MRI of the brain also identified changes in the frontal lobe in keeping with a remote traumatic event or vascular insult, with an absence of documentation indicating that the Appellant sustained a traumatic head injury as a result of the

MVA. He cited the Appellant's high cholesterol and high blood pressure as known contributing factors to the development of a TIA. [MPIC's doctor] was of the view that the right hand numbness had nothing to do with the MVA.

In a later review dated September 9, 2013, [MPIC's doctor] reiterated this opinion. He disputed [Appellant's doctor #1's] reports, which attributed causation of the Appellant's symptoms to the MVA while noting that he was not aware of any other mechanism of injury. [MPIC's doctor] was of the view that this does not establish, by itself, a causal connection to the incident in question, as the majority of patients that present with a clinical picture in keeping with cervical radiculopathy have no history of a preceding traumatic event. Further, he noted that a history of pain or altered sensation that radiates from the neck/shoulder to the arm/hand is paramount to a diagnosis of cervical radiculopathy, which is diagnosed based on history, physical findings and/or electrophysiological findings. To his knowledge, a positive Spurlings test or clinical findings of spinal nerve dysfunction were not evidenced in the medical documentation submitted to the claim file prior to November 2010.

In a further review dated March 28, 2013, [MPIC's doctor] indicated:

> [Appellant's doctor #1] does not provide medical evidence that outlines a plausible explanation for the time that lapsed between the date of the incident in question and the onset of hand symptoms. [Appellant's doctor #1] makes reference to the absence of any other noted mechanism of injury that might account for the reported hand symptoms. Based on my experience in treating patients that present with symptoms and clinical findings of cervical radiculopathy the majority of cases are void of a specific mechanism or event that would account for symptoms and findings.

In a report dated August 29, 2014, [MPIC's doctor] once again noted the lack of a positive Spurlings test and/or reports to a health care professional revealing findings in keeping with a cervical radiculopathy prior to November 2010.

In this report [MPIC's doctor] also reviewed the risk factors, symptoms and description of a TIA, noting that the Appellant had various risk factors rendering him at great risk to develop a TIA or experience a stroke. He felt it was not unreasonable to opine that the Appellant did experience a stroke at some stage.

He reviewed the MRI performed on the Appellant's brain and cervical spine, which identified degenerative changes throughout the spine (more so on the left side but to a mild degree on the right side at C6-C7). The report specifically indicated evidence of spinal nerve compression, a narrowing of the foramen, which could render the spinal nerve more vulnerable to compression. Changes in the frontal lobe of the brain were opined to be secondary to remote trauma or vascular insult, and [MPIC's doctor] reiterated that the evidence did not support the position that the Appellant sustained a head injury secondary to the MVA.

He concluded:

> *Can you explain whether the lapse in reported numbness can be seen as a different manifestation of cervical radiculopathy, as suggested by [Appellant's doctor #1] in his August 1, 2013 report*:
>
> The medical evidence indicates [the Appellant] has underlying degenerative changes affecting the cervical spine that pre-date the incident in question, in all probability. As noted previously the changes could render a spinal nerve more vulnerable to compression. If [the Appellant] sustained an injury to the neck secondary to the incident (the medical evidence indicates he did and his presentation was in keeping with WAD II) that adversely affected the pre-existing degeneration to the extent a spinal nerve was injured then neurological symptoms would develop shortly after in most cases. … Based on my experience in managing patients with cervical radiculopathy, I have never come across a situation where a spinal nerve was injured, as a result of a specific event, but did not produce symptoms or clinical findings until many months after. …

This was followed by a report from [independent doctor], a physiatrist charged with providing an independent medical review of the Appellant's file.

On July 23, 2015, [independent doctor] provided a report which opined that, on a balance of probabilities, the MVA did not cause or materially contribute to the Appellant's radiculopathy. He indicated that there was no available file evidence of structural injury occurring to the cervical spine as a result of the MVA. A significant injury to the cervical spine or to the cervical nerve roots, resulting in a cervical radiculopathy, would have been expected to be immediately symptomatic and to have had persisting continuous symptoms over the following period. However, the initial reporting of any symptoms that could be ascribed to a cervical radiculopathy did not occur until September of 2010, eleven months after the MVA. Further, he noted that the scientific literature reports the most common causes of cervical radiculopathy to be related to degenerative changes and not to trauma.

In his view, the medical file which he reviewed did not suggest any alternative explanation as to the source of the Appellant's cervical radiculopathy, on a balance of probabilities, and with good certainty. Although the most common cause of cervical radiculopathy is related to degenerative changes, which had been documented as pre-existing, there were no degenerative structural findings present on the right side of the cervical spine that would explain the Appellant's right-sided radiculopathic symptoms.

Although the medical evidence suggested that the Appellant suffered several "mini strokes" (TIA), there was no objective way to confirm that TIAs did in fact occur and insufficient evidence that they caused or materially contributed to his cervical radiculopathy symptoms.

[independent doctor] stated:

> In summary, there is no available medical file information to support that the neurological symptoms (right upper extremity numbness) that had onset in September of 2010 had any medical relatedness to the motor vehicle accident of November 6th, 2009. As well the early post-injury documentation suggests minimal, if any, trauma received related to the motor vehicle accident in question; with no loss of consciousness, no head/cranial neurologic symptoms, no continuous neck symptoms on the initial medical assessment, a documented with in normal neck range of motion, and only minor subjective chest area soft tissue findings. No identification has been made on the file of any November 06th, 2009 MVA related significant physical or structural injury, and no related patho-anatomic diagnosis.

[MPIC's doctor] addressed the matter again on January 25, 2017. He again reiterated that in the majority of cases, patients presenting with a clinical presentation in keeping with a cervical radiculopathy cannot recall a specific event that would account for the development of the condition. He noted that he could only assume that the Appellant performed numerous activities and positions while carrying out the activities of daily living between November 6, 2009 and November 2010 when he reported right hand numbness and tingling to [Appellant's doctor #1]:

> … In other words the cervical spine as well as the rest of his body was exposed to various challenges, which could test his physical health. It is more probable than not the demands of daily living contributed to the onset of the most common form cervical radiculopathy (i.e. idiopathic) and not an event that occurred one year previously that did not altered (sic) the cervical spine to the extent the (sic) [the Appellant] would be more prone to developing cervical radiculopathy.

Evidence of [MPIC's doctor]:

[MPIC's doctor] also testified at the hearing into the Appellant's appeal. By agreement of the parties he was qualified as an expert and specialist in sports medicine.

[MPIC's doctor] began by explaining his understanding of the condition of cervical radiculopathy. He described typical symptom complaints associated with the condition, explaining that it may or may not be accompanied by pain complaints and would include weakness and changes in sensation. Numbness could be a symptom, which, if significant, could

affect the execution of fine motor skills. Most commonly, cervical radiculopathy is caused by compression on the nerve, more persistent than an irritation or inflammation, which might also be present. An irritation or inflammation would resolve sooner, however. But with a cervical radiculopathy, the numbness or altered sensation may be much longer lasting.

[MPIC's doctor] indicated that in most patients he sees with a cervical radiculopathy, up to 95% have no history of insult or injury. Most cases involve a gradual onset of symptoms, although some people experience an acute onset. Numbness is usually the first complaint, and there may be neck pain and weakness identified at a later time.

[MPIC's doctor] discussed the importance of a Spurlings manoeuver test to identify and assess symptoms of cervical radiculopathy. He agreed with [Appellant's doctor #1's] evidence that while a positive Spurlings test is very helpful in diagnosis, a negative Spurlings test might not necessarily rule out a cervical radiculopathy. Rather, it would just make him less suspicious.

More specifically, [MPIC's doctor] discussed the forensic review he had conducted of the Appellant's medical records. His assessment of reports from the Appellant's trip to the emergency room at [hospital #1], his chiropractic treatment and [Appellant's doctor #1's] examination of December 9, 2009, did not disclose immediate reports of neck injury. Things started to stiffen up and get sore a couple of days after the MVA. There was no historically significant note of numbness or tingling which would indicate significant neurological problems in those reports. [MPIC's doctor] noted imaging evidence of degenerative changes. He explained why, in his view, clinical findings of cervical radiculopathy based on nerve dysfunction would show up fairly quickly after an acute injury, such that the timing of the onset

of the Appellant's symptoms, several months after the MVA was sufficiently separate from the MVA to cause him to question a connection between the two.

Further, the diffuseness of the Appellant's symptoms (which affected his whole hand), as well as reported difficulties with speaking at different periods, caused [MPIC's doctor] to have a higher level of concern for the Appellant regarding the possibility of something more significant than a simple nerve irritation. He referred to risk factors regarding a possible TIA and indicated that, in spite of the indication by the neurology clinic that the Appellant had not suffered a stroke, he remained concerned that there may have been frontal lobe changes due to a traumatic injury or vascular insult (stroke or TIA) which might account for the Appellant's numbness.

[MPIC's doctor] dismissed a suggestion that the MVA aggravated pre-existing degenerative changes in the Appellant's cervical spine, noting that there was no evidence that the Appellant had suffered from any pre-existing problems or symptoms. The caregivers' documentation on the file indicated only that they were concerned that the Appellant may have sprained or strained his neck, and there was no evidence of symptoms of numbness at that time.

Further, [MPIC's doctor] did not agree that the circumstances described by the Appellant and the medical information supported a diagnosis of a clinical radiculopathy at this stage, or that any association between the MVA and the symptoms described was suggested by the material on the Appellant's file.

Submission for the Appellant:

Counsel for the Appellant noted that throughout the Appellant's reporting of symptoms and his testimony there could be no question regarding his credibility. Evidence surrounding the

circumstances of the MVA indicated that there was suspicion of a neck injury. In the hours and days following, the Appellant suffered a great deal of pain. However, instead of being off work for several weeks, he missed only two days before returning to work.

The Appellant underwent chiropractic treatments until he felt that they were no longer necessary, calling his case manager and asking her to cancel the rest of his approved treatments. Then, when he began experiencing numbness in his hand and arm, he did not stop working, but rather arranged an accommodation with his supervisor so that he could continue to work. When he could no longer be accommodated, he took his employer's advice and applied for disability insurance benefits. When [Appellant's doctor #1] suggested that he could attempt to return to work in late June 2011, as his objective symptoms had improved, he immediately arranged another accommodation with his employer and has remained at work ever since. Counsel noted that the Appellant did not even apply for MPIC benefits until he was advised by his doctor that the numbness in his right hand was likely caused by injuries he had received in the MVA.

It was submitted that all of this evidence indicates that the Appellant is an honest, hard-working individual, and that, typical of individuals doing this kind of heavy work, he tries to work through the discomfort instead of "running to a doctor".

Counsel reviewed the medical evidence on file, which suggested a whiplash type injury in the MVA, resulting in pain to the neck and both shoulders, as well as injuries to his hip and lower back.

[Appellant's doctor #1's] evidence noted that had those injuries been short-lived, he might have considered them to be a result of the whiplash disorder, but as symptoms persist, he would lean towards a diagnosis of cervical radiculopathy.

Counsel noted that although the Appellant was investigated for a possible stroke (as a result of the numbness in his right hand and an episode of difficulty speaking) a CT scan performed did not show evidence of a stroke. Due to suspicion that perhaps he had experienced one or more TIAs, the Appellant was referred to the stroke clinic at [text deleted], but the conclusion of the neurology clinic was that he had not suffered a stroke. An MRI dated May 17, 2011 showed some problem in the left frontal lobe which could be due to remote trauma or stroke. However, [Appellant's doctor #1], in a chart note, dated June 16, 2011, noted that the location of these lesions did not correlate with arm symptoms.

Counsel relied on [Appellant's doctor #1's] reports and testimony which establish, he submitted, that cervical radiculopathy can be caused by compression, irritation of the nerve root, acute disc herniation or by aggravation of degenerative changes. In the case of aggravation of degenerative changes, it could take several months for the symptoms to appear, which was established by [Appellant's doctor #1's] evidence that the most probable cause of the Appellant's cervical radiculopathy was trauma from the MVA aggravating his pre-existing cervical degenerative condition. This opinion was based on the absence of symptoms prior to the MVA and the emergence of symptoms within a few months of the accident, with no intervening injury to the Appellant's neck.

Counsel submitted that the episodes of the Appellant having difficulty speaking had no connection to the cervical radiculopathy. Even the diagnosis of TIAs could not be confirmed,

and [independent doctor] had recognized that the TIAs would not result in any permanent damage. [Appellant's doctor #1] confirmed that the hand numbness was not consistent with a TIA in any event and that a TIA would not have aggravated the Appellant's cervical condition.

Counsel addressed [MPIC's doctor's] opinion that the Appellant's symptoms of neck and shoulder pain were not necessarily due to a radiculopathy. [MPIC's doctor] had also opined that the demands of daily living can contribute to the onset of cervical radiculopathy. However, counsel submitted that [MPIC's doctor] ignored the possibility that the whiplash type injury suffered by the Appellant is considerably more damaging on the spine. In the Appellant's case, it was severe enough to snap his head back through the rear window of the truck. He dismissed [MPIC's doctor's] concern that the Appellant's hand numbness was a result of a stroke or multiple TIAs. The evidence showed that a lesion in the frontal lobe would affect speech and thinking but not sensation in the hand.

Counsel noted that [independent doctor]'s opinion was based almost entirely on the evidence in the MRI, which both [Appellant's doctor #1] and [MPIC's doctor] testified could not rule out a cervical radiculopathy. He suggested that [independent doctor]'s report be given little weight.

Instead, counsel focused on the reports and evidence of [Appellant's doctor #1] as the treating physician who had spent considerable time assessing and treating the Appellant. He submitted that his opinion should be given more weight than that of [MPIC's doctor] or [independent doctor]. Therefore, he submitted that, on a balance of probabilities, the evidence points to the MVA as being the cause, or at least a major contributor, to the Appellant's right hand numbness. Accordingly, he requested that the Commission overturn the Internal Review decision of November 22, 2011 and determine that the Appellant's is entitled to Personal Injury Protection

Plan (PIPP) benefits regarding his right hand numbness. This would include Income Replacement Indemnity (IRI) benefits (including the top-up of wages and compensation for early lay-off and late call-backs) as well as a possible permanent impairment for loss of motor and sensory function. He acknowledged, however, that these elements would have to be assessed by a case manager and that the matter should be referred back to the case manager for a determination of benefit entitlement.

Submission for MPIC:

Counsel for MPIC disputed the Appellant's position that his right arm and hand numbness resulted from a cervical radiculopathy which developed when degenerative changes in the Appellant's cervical spine were aggravated by his MVA injury.

The medical evidence immediately following the MVA indicated that the Appellant was diagnosed with soft tissue injuries. Imaging was focused on his chest and abdomen and not his neck or head. There was no evidence that the Appellant was covered in glass and had blood on his head. A later suspected (by the chiropractor) neck fracture was ruled out by [Appellant's doctor #1] and the Appellant had a normal neurological examination by the chiropractor. There was no diagnosis of cervical radiculopathy at the time. Following testing, the Appellant was diagnosed with a Whiplash Associated Disorder with a good prognosis and told to see the chiropractor.

The Appellant then attended for chiropractic treatment, stopping treatment when he felt better. In the six months following the MVA he did not present with symptoms of a cervical radiculopathy and was not diagnosed with that by any professional treating him during that period.

He then developed new symptoms of hand numbness, along with speech problems. Although the evidence is not completely clear, there is some suggestion that this developed either in April, May or October after the MVA. Even if the Appellant began to experience numbness six months after the MVA, it was submitted that the length of time between the accident and the onset or expression of the symptom remained substantial rendering it more likely than not that the two events are not linked. As [MPIC's doctor] indicated in his evidence, once a nerve is perturbed one would know about it. This was not the case with the Appellant following the MVA.

Counsel reviewed the evidence of degeneration in the Appellant's cervical spine, and did not believe that this supported a finding of cervical radiculopathy.

Most concerning to [MPIC's doctor] was that many of the caregivers seemed to agree the Appellant had suffered multiple TIAs. The fine finger manipulation problems which the Appellant experienced, with no radiating pain, and numbness to the entire hand and shoulder, are not consistent, counsel submitted, with a cervical radiculopathy, according to [MPIC's doctor].

Counsel reiterated that the onus is on the Appellant to establish, on a balance of probabilities, that his injuries were caused by the MVA. It was his submission that the Appellant had failed to establish that he suffered from a cervical radiculopathy. More importantly, the connection between the MVA and the symptoms simply isn't there. Symptoms can arise on their own. It is human nature to search for patterns of connection and of cause and effect. But as both [Appellant's doctor #1] and [MPIC's doctor] indicated, it is difficult or impossible to point to a specific mechanism of injury for many patients with cervical radiculopathy. The Appellant's self-reports indicated that he had recovered from his WAD injuries early in 2010. The evidence

did not establish that it is more likely than not that the MVA caused the new symptoms of numbness or speech problems. Even though speech problems were among the new symptoms that arose, the Appellant did not take the position that this was due to the MVA. The same should be the case with the hand numbness symptoms.

Accordingly, counsel submitted that the Appellant's appeal should be dismissed.

Counsel also took the position, in the alternative, that should the Commission be inclined to allow the Appellant's appeal, the question of remedy should be referred back to the Appellant's case manager for benefit entitlement. Issues of IRI had not been factually established and any evidence regarding the nature of a permanent impairment at this point is questionable. Accordingly, the appropriate decision would be to remit the matter back to the case manager for determination of those issues.

Discussion:

The MPIC Act provides:

> **Definitions**
>
> 70(1) In this Part,
>
> **"bodily injury caused by an automobile"** means any bodily injury caused by an automobile, by the use of an automobile, or by a load, including bodily injury caused by a trailer used with an automobile, but not including bodily injury caused
>
> (a) by the autonomous act of an animal that is part of the load, or
>
> (b) because of an action performed by the victim in connection with the maintenance, repair, alteration or improvement of an automobile;
>
> **Application of Part 2**
>
> 71(1) This Part applies to any bodily injury suffered by a victim in an accident that occurs on or after March 1, 1994.

The onus is on the Appellant to show, on a balance of probabilities, that his right hand numbness was caused by the MVA, such that he is entitled to PIPP benefits in this regard. The panel has reviewed documentary evidence on the Appellant's file, as well as the testimony of the Appellant, [Appellant's doctor #1] and [MPIC's doctor] and the submissions of counsel. Based upon this evidence, the panel has concluded that the Appellant has met the onus upon him of showing that the Internal Review decision was in error and that the MVA caused or materially contributed to the Appellant's complaints.

In arriving at this conclusion, the panel gave careful consideration to the position of counsel for MPIC and the opinion of [MPIC's doctor] that the delay between the MVA and the onset of the Appellant's hand numbness was too long to establish a connection between the MVA and the numbness. We have also carefully reviewed [MPIC's doctor's] testimony that in his view the Appellant had suffered either from multiple TIAs or a stroke and that this was more likely to have some connection to the Appellant's difficulties with his hand than the MVA.

[MPIC's doctor] reviewed various risk factors that rendered the Appellant at greater risk of developing a TIA or a stroke. After reviewing the Appellant's reports of symptoms of slurred speech and right arm numbness, it was his view, expressed in a report dated August 29, 2014, that:

> … Based on documentation of multiple episodes of what was felt to be TIAs and evidence of persistent right hand numbness, in the absence of clinical findings supporting spinal nerve dysfunction (i.e., radiculopathy), it is not unreasonable to opine that [the Appellant] did experience a stroke at some stage.

[MPIC's doctor] testified regarding his view that the lesions on the Appellant's brain, found on imaging, showed either damage from multiple TIAs or stroke. He testified that something was

not right, which caused him concern, and that the TIAs and brain lesion were a bigger problem that was not being addressed. He would have wanted to investigate this further.

While the panel certainly appreciates [MPIC's doctor's] concern in this regard, it also had before it the report of the [hospital #3] dated July 8, 2011. This report describes an assessment of a [text deleted]-year-old male in clinic in September 2010 in regard to episodes of speech/tongue symptoms and right hand progressive sensory problems. The report states that the events were quite unusual and did not fit well with either ischemic causes or neuropathy. To investigate, an MRI of the brain and cervical spine was ordered.

Having also reviewed the MRI report of May 17, 2011, the Commission notes that some confusion may possibly have arisen from discrepancies between the MRI report and the stroke clinic reporting. Various questionable statements or errors regarding the left vs. right sided findings can be found and, as [independent doctor] pointed out in his report, these may have contributed to confusion. The panel did not find any evidence that [MPIC's doctor] or any other physician from Health Care Services followed up with the stroke clinic to inquire about their statements in this report. There was no evidence of any inquiry regarding the opinion of the stroke clinic that the Appellant had not suffered an ischemic event, that there was no cause of the dysarthria found, no motor symptoms and no need to follow the Appellant, beyond his follow-up with [Appellant's doctor #1].

This report, which [Appellant's doctor #1] reviewed, contributed to his ruling out stroke or TIA as a reason for the Appellant's continuing symptoms in his hand. Further, [Appellant's doctor #1] was of the view that frontal lobe lesions would not correspond to hand or arm numbness in the area of the right hand. Lesions in that area would not have anything to do with motor

function or sensation. This was documented in a chart note created by [Appellant's doctor #1] in follow-up on June 16, 2011. He noted that the cervical radiculopathy symptoms correlate with the MRI, and that frontal lobe lesions did not correlate with arm symptoms but may have a role with behaviour and memory.

[Appellant's doctor #1's] view that the Appellant's right arm numbness was not caused by stroke, TIA or frontal lobe lesions was confirmed by him in testimony before the Commission. The panel has relied upon this evidence.

Both [MPIC's doctor] and [independent doctor] also gave serious consideration to the delay between the MVA and the Appellant's reporting of right hand symptoms. Both clearly took the view that a significant injury to the cervical spine or the cervical nerve roots resulting in a cervical radiculopathy would have been expected to be immediately symptomatic and to have had persisting continuous symptoms over the following period. The initial reporting of any symptoms that could be ascribed to a cervical radiculopathy seemed not to occur until September 2010, eleven months post-MVA, or at the earliest, in the spring of 2010.

[independent doctor] noted that scientific literature reports the most common cause of cervical radiculopathy relate to degenerative changes in the cervical spine and not to trauma. However, in this case, he found no degenerative structural findings on the imaging which would account for the presence of right side radiculopathic symptoms. In his reports, [MPIC's doctor] did focus on the degenerative changes in the Appellant's spine, and, both in his reports and his testimony emphasized that patients often cannot connect cervical radiculopathy to any trauma or particular event. Further, in the Appellant's case, if such symptoms were connected to the MVA, they should have presented much earlier.

Yet, both [MPIC's doctor] and [Appellant's doctor #1] discussed the importance of clinical presentation and physical examination upon the assessment of a condition like a cervical radiculopathy. [MPIC's doctor] acknowledged that a diagnosis of cervical radiculopathy is based on history and physical exam. Both agreed that one cannot simply rely on the imaging for guidance, as results of physical tests and examination are a necessary part of the clinical picture and provide a more complete picture of the Appellant's condition and its causes.

[Appellant's doctor #1] had the opportunity, as did [MPIC's doctor] and [independent doctor], to review the medical information on the Appellant's file, including imaging and the reports of other health care providers. [Appellant's doctor #1], however, had the additional benefit of examining, assessing, treating and following the Appellant from his first reporting of the symptoms to caregivers. [Appellant's doctor #1] considered that patients may present with different manifestations of cervical radiculopathy through the course of the injury and that this may explain the lapse in the Appellant's presentation of symptoms. He stated:

> There is no evidence of any other reported mechanism of injury other than the MVA in question. This is upon review of the medical information available at this time.
>
> It is more probable rather than not that the noted collision was the cause of or would have contributed to the development of right cervical radiculopathy manifested as right hand hypoestesia or numbness.
>
> Cervical radiculopathy may present to clinic and health care practitioners as shoulder pain, upper back pain, jaw pain, upper arm pain, elbow pain, forearm pain or hand pain with or without perceived numbness. The writer's first consultation in regards to the MVA was on Dec. 9, 2009. [the Appellant] did not present initially with right hand numbness or tingling but did present in November of 2010 with reported months history of hand/numbness and tingling. Patients may present with different manifestations of cervical radiculopathy through the course of the injury as noted above. This may explain the lapse in presentation.

The Commission accepts [Appellant's doctor #1's] evidence that while there were degenerative changes in the Appellant's spine which pre-existed the MVA, it was a combination of the MVA

and these degenerative changes which caused his symptoms. [Appellant's doctor #1] relied on the fact that the Appellant was asymptomatic prior to the MVA and within months of the accident described numbness and tingling. While recognizing the existence and contribution of the degenerative changes based on his assessment and treatment of the patient, [Appellant's doctor #1] was of the view that these changes were previously asymptomatic and aggravated by the MVA. The panel has given greater weight to [Appellant's doctor #1's] evidence as the treating physician who also reviewed the material on the Appellant's medical file, and to his diagnosis of a cervical radiculopathy, which on a balance of probabilities was more likely than not, caused by the MVA.

The panel therefore concludes that it was the MVA which caused the Appellant's hand symptoms and materially contributed to the Appellant's condition. On a balance of probabilities, we find that his right hand numbness was caused by the MVA and that he should therefore be entitled to PIPP benefits in this regard.

The issue of the particular benefits to which the Appellant is entitled and the quantum of these benefits is hereby referred back to the Appellant's case manager for determination.

The evidence shows that there were periods when the Appellant was unable to work, lost income or seniority, or had to change jobs, resulting in lower hourly wages, earlier layoffs and later call-backs from shutdowns. The panel finds that as these losses were caused by the MVA related condition, he would be entitled to IRI benefits as a result. Accordingly, the question of the quantum of IRI benefits owed to the Appellant from the period between the MVA to date is referred back to the case manager for investigation and calculation.

The Appellant also sought a remedy for permanent impairment benefits pursuant to Division 2, Subdivision 4 of Regulation 41/94, for loss of motor and sensory function. The panel's finding that the Appellant's condition was caused by the MVA may well entitle him to additional PIPP benefits beyond IRI, such as permanent impairment. However, counsel for the Appellant acknowledged that further case management would be needed in order to fully determine the Appellant's possible entitlement to such benefits. Accordingly, the matter of permanent impairment benefits and any other PIPP benefits which may arise from this decision will be referred back to the Appellant's case manager for investigation and determination.

The Appellant's appeal is allowed and the Internal Review decision dated November 22, 2011 is therefore rescinded.

Dated at Winnipeg this 23rd day of March, 2018.

LAURA DIAMOND

KARIN LINNEBACH

JANET FROHLICH