Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-14-091; AC-16-086

PANEL:	**Ms Nikki Kagan, Chairperson** **Dr. Arnold Kapitz** **Mr. Brian Hunt**
APPEARANCES:	**The Appellant, [text deleted], appeared on his own behalf; Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Matthew Maslanka.**
HEARING DATE:	**November 22, 2019**
ISSUE(S):	**Are the Appellant's Permanent Impairment benefits calculated correctly, in particular:** **1) Are the Appellant's neck and back difficulties causally related to the motor vehicle accident;** **2) Is the Appellant's permanent impairment award under Division II (psychiatric condition, syndrome or phenomenon) correctly classified.**
RELEVANT SECTIONS:	**Sections 70(1), 71(1) and 127 of The Manitoba Public Insurance Corporation Act ('MPIC Act) and Division 11 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:

On March 30, 2007, [text deleted] (the "Appellant") was a passenger in a taxi involved in a motor vehicle accident (MVA). As a result of the accident the Appellant sustained multiple injuries including a skull fracture, subarachnoid hemorrhage, facial nerve injuries and a concussion.

The Appellant was hospitalized for several days. Upon release from hospital, he attended upon various physicians and received physiotherapy, psychology and speech therapy treatments.

The Appellant's permanent impairments were assessed and reassessed by MPIC as the Appellant continued to provide additional medical information. Multiple case manager's decisions were issued including the case manager's decision letters of September 12, 2013, February 14, 2014 and April 23, 2014.

In the case manager's decision of September 12, 2013, the Appellant was advised that he was entitled to the following permanent impairment awards:

INJURY/IMPAIRMENT	%	APPLICABLE SECTION	APPENDIX #
Cerebral concussion or contusion (previously paid)	1	Division 2: Subdivision 1, Item 1.1	Previously sent
Post-Traumatic Alteration of Tissue (previously paid)	5	Division 2: Subdivision 1, Item 1.2	Previously sent
Post-Traumatic Bony Alteration (previously paid)	2	Division 2: Subdivision 1, Item 2.1	Previously sent
Facial Alteration in Form & Symmetry (previously paid)	7	Division 13: Subdivision 1, Item 13.1	Previously sent
Facial Nerve (previously paid)	5	Division 2: Subdivision 3, Item 6	Previously sent
Ptosis (previously paid)	1	Division 2: Subdivision 3, Item 3(a)	Previously sent
Functional alteration of the brain/alterations of consciousness 4.7 (e) an alteration of consciousness, including adverse effects of medication, that impairs the person's ability to perform the activities of daily living but not to such an extent that he or she requires supervision" = 7.5%	**8**	**Division 2, Subdivision 1, # 4.7 (e)**	**6**
Total percentage using successive remainders	**26%**		

The Appellant experienced difficulties with his speech. In the case manager's decision of February 14, 2014, the Appellant was advised that his speech difficulties did not qualify as a permanent injury and therefore, he was not entitled to a further permanent impairment payment for speech difficulties.

In the case manager's decision of April 23, 2014, the Appellant was advised that MPIC's Health Care Services reviewed the medical information on file and concluded that the medical information did not contain information or reports of clinical findings that would confirm a disc herniation resulting from the accident. There was a diagnosis of sprain/strain after the accident, but not a herniation. The Appellant was advised that he did not qualify for a further permanent impairment payment for his neck or low back injuries other than previously awarded in the case manager's decision of September 12, 2013.

On March 3, 2014, the Appellant filed an Application for Review of the case manager's decision of February 14, 2014. On May 30, 2014, the Appellant filed an Application for Review of the case manager's decision of April 23, 2014.

The Appellant's Applications for Review of the case manager's decisions of March 3, 2014 and April 23, 2014 were heard by an Internal Review Officer. An Internal Review Decision was issued on June 9, 2014, which provided as follows:

> Essentially the medical evidence concludes that your speech issues are related to your cognitive injury which has already been addressed in your overall PI calculation. While I can appreciate your opinion that you feel you should receive a further payment for your speech issues, the fact remains that the cause of your speech issue is due to your head injury and has been identified in your PI calculation.

> The HCS opinion in regard to your current disc complaints notes a lack of medical evidence to relate your complaints to the accident. This is further supported by the previous HCS opinions of March [7] and April 16, 2013. In light of the opinions provided I am unable to accept that your current disc complaints are related and would qualify for a PI payment.
>
> I am in agreement that the PI payment has been correctly calculated and is accurate and consistent with the legislation and the medical information on file. I am therefore upholding the case manager's decisions letters of September 17, 2013 and April 23, 2014 and am dismissing your Applications.

It is from this decision that the Appellant filed a Notice of Appeal on June 20, 2014.

Prior to the appeal hearing, MPIC considered whether the Appellant qualified for a further permanent impairment benefit for his speech difficulties. The case manager's decision of December 4, 2018, MPIC determined that the Appellant was entitled to a further permanent impairment award for his speech difficulties that were classified as a communication disorder. The Appellant was advised as follows:

> Entitlement for the communication disorder has been provided at the percentage amount applicable at the time the disorder was identified and a ratable impairment under your claim. Therefore, the entitlement is 10% rather than 7.5% as indicated by the MPI Health Care Service Review.

This was pursuant of Division 2, Subdivision 1, Item 4.6 (d).

The Appellant was satisfied with this permanent impairment award and this issue was no longer part of the appeals before the Commission.

Issue one - Are the Appellant's neck and back difficulties causally related to the MVA

Decision:

The panel finds that the Appellant's disc herniation of his neck and back is not causally related to the MVA.

Submission and Evidence of the Appellant:

The Appellant was represented by legal counsel until 2012. Thereafter, he represented himself.

The Appellant provided evidence as to the serious nature of the MVA. He testified that he was rushed to the hospital by ambulance and remained in the hospital for several days. He described the embarrassment that he suffered from his speech impairment and from his visible facial and eye impairments. He was off work for approximately four months. He attended for physiotherapy treatment for 11 weeks.

The Appellant led the panel through numerous medical reports on file. He specifically referred to the following evidence in support of his position:

1. The Appellant's Application for Compensation dated April 10, 2007 stating that he experienced neck pain. The Appellant argued that the Application for Compensation completed 10 days following the MVA is evidence that he was experiencing neck pain immediately following the MVA and therefore the pain was caused by the MVA.

2. The X-ray report dated May 1, 2007 noting:

   Provisional diagnosis: Whiplash.

   Limited motion of the cervical spine in flexion and extension, however, no instability is demonstrated. No fractures are identified. Degenerative narrowing of the C5-C6 disc space is noted.

3. The handwritten note of [physical therapist] dated January 4, 2013, indicating a diagnosis of C6 and C7 disc herniation and chronic neck pain. This note also states that the Appellant was referred for physiotherapy treatments.

4. The numerous reports from [physiotherapy center] stating that the Appellant is suffering from neck and back pain and specifically, the report of April 24, 2013 wherein it is stated:

> … Treatment of neck/ back pain was initially delayed at time accident d/t treatment of other higher priority issues (ie. facial paralysis, speech improvement) which has likely contributed to a slower recovery d/t the chronic nature of the pain.

5. MRI of the thoracic and lumbar spine dated May 8, 2012 stating:

> In the lumbar spine, there are moderate disc degenerative changes at the L5-S1 level. Very minimal disc degenerated changes are noted at the L3-4 and L4-5 levels. At the L5-S1 level there is a small shallow left posterolateral disc herniation with a small high signal intensity annular tear. The disc material contacts the left S1 nerve root and I cannot exclude a mild degree of compression or irritating of the left S1 nerve root by the disc material. Clinical correlation is recommended. There is no evidence of central spinal stenosis.
>
> No other significant lumbar spinal abnormality is identified.

The Appellant expressed frustration that an MRI was not completed while he was in hospital following the MVA. The Appellant submitted that the findings of an MRI at or near to the date of the MVA would have been determinative of a finding of causation.

6. The Appellant's Manitoba Health summary (patient purges) noting that on September 26, 2003 he had a diagnosis of "sprain of back nec/nos". The Appellant submitted that other than this reference to back sprain, there were no other complaints of back issues on his patient purge summary from 2003 until the date of the MVA.

7. The report of [health care provider #1] dated March 13, 2013, stating:

> This patient was seeing me on numerous occasions starting from April 28th 2007. He mentioned his neck and back pain to me for the first time on April 2nd, 2008 and in several occasions thereafter.
>
> On examination, there was tenderness of his neck and lower back with restriction of range of motions, mainly back flexion.

8. The report of [orthopedic surgeon] dated September 10, 2013 stating:

> When examined by me he was concerned about his ongoing low back pain. Fortunately there was no radiation of pain to either leg. He stated that his low back pain started soon after his trauma in 2007. His back condition does not seem to be any worse than before.

The Appellant submitted that while he was hospitalized immediately following the MVA, he was receiving morphine as pain medication for his more severe injuries. He submitted that he may not have fully felt the full extent of the neck and back pain as these symptoms were masked by the morphine.

Additionally, the Appellant submitted that he had other priority medical issues that required more particular attention and therefore his neck and back issues were not investigated.

The Appellant submitted that he was motivated to return to work as quickly as possible so he "shouldered through" the pain, but that does not mean that he was not experiencing pain.

The Appellant submitted that his medical history set out in the patient purges confirms that he did not have a history of neck and back pain prior to the MVA. Therefore, the evidence of back pain immediately following the MVA is conclusive that his neck and back difficulties were caused by the MVA. For this reason, and based on the evidence stated above, the Appellant submitted that on a balance of probabilities, his neck and back difficulties were caused by the MVA.

Submission and Evidence of MPIC:

MPIC did not call evidence at the hearing and relied upon reports on file. MPIC submitted that [MPIC's HCS medical consultant] is the only doctor that addresses the issue of causation and

because no other contrary opinion was provided on the issue, it was not necessary to call [MPIC's HCS medical consultant] as a witness.

MPIC's position is that the evidence does not support a finding that the Appellant's neck and back difficulties were caused by the MVA and therefore the Appellant's permanent impairment benefits were calculated correctly.

MPIC submitted that the Appellant did not complain of neck and back pain immediately following the MVA. The Appellant's condition improved and he terminated physiotherapy treatments. He was able to return to work in a physically demanding position within approximately four months.

MPIC submitted that the first indication of the Appellant experiencing any neck pain was in the report of his physiotherapist, [text deleted] dated May 3, 2007. However, [Appellant's physiotherapist] did not document any clinical findings consistent with a finding of a cervical disc herniation at that time.

[MPIC's HCS medical consultant] conducted several forensic reviews of the medical evidence. MPIC submitted that the findings of [MPIC's HCS medical consultant] are determinative of the issue because of the analysis conducted by [MPIC's HCS medical consultant] to determine causation.

MPIC addressed the MRI of the thoracic and lumbar spine completed on May 8, 2012 and the MRI of the cervical spine completed on December 17, 2012 evidencing findings of disc degeneration and herniation. MPIC submitted that the MRIs were completed five and half years following the

MVA and therefore it was not possible to conclude that the degenerative changes and herniation were accident related.

MPIC acknowledged that it would have been helpful to have an MRI from a date closer to the MVA but perhaps an MRI was not completed sooner because the Appellant's symptoms did not warrant an MRI.

MPIC submitted that [Appellant's neurosurgeon] report of May 1, 2007, a date near the MVA, does not describe disc herniation and referred the Appellant for treatment for "whiplash-associated symptoms".

MPIC submitted that the report of [text deleted], the neurosurgeon that cared for the Appellant while he was an inpatient at [Hospital] immediately following the MVA did not identify any cervical disc herniation occurring as a result of the MVA.

MPIC referred to the Health Care Services' report prepared by [MPIC's HCS medical consultant] dated July 23, 2019 stating:

> … The fact that [the Appellant] was admitted under a neurosurgery service and was under the care of individuals trained in dealing with cervical disc herniation, the fact that they did not document a cervical disc herniation at any time, would lead the reviewer to determine that a cervical disc herniation likely did not develop as a result of the collision.

MPIC submitted that the medical information was reviewed by [MPIC's HCS medical consultant] on numerous occasions. [MPIC's HCS medical consultant] provided multiple reports dated March 7, 2013, April 16, 2013, March 25 2014 and July 23, 2019 as further medical information was provided to [MPIC's HCS medical consultant] from time to time.

MPIC submitted that [MPIC's HCS medical consultant]'s opinion throughout was unchanging, specifically, the Appellant's neck and back issues were not causally connected to the MVA.

MPIC submitted that in his report of April 16, 2013, [MPIC's HCS medical consultant] stated the following:

> In answering the second question posed by the case manager regarding the association between the lumbar spine disc herniation and the motor vehicle collision, the newly submitted letter from [health care provider #1] would indicate that the reports of lumbar spinal pain did occur closer to the motor vehicle collision than previously documented. However, the period of time from the motor vehicle collision to the reporting of lumbar spinal pain by [health care provider #1] in his narrative report would not change all of the other factors present in the previous memoranda on file that made an association between the development of the lumbar disc herniation and the motor vehicle collision improbable, in this reviewer's opinion.

MPIC submitted that there was a further review conducted on March 25, 2014 with updated medical evidence and [MPIC's HCS medical consultant]'s opinion did not change.

MPIC submitted that the matter was reviewed by [MPIC's HCS medical consultant] one further time on July 23, 2019 and [MPIC's HCS medical consultant]'s opinion again did not change.

MPIC referred the panel to sections of [MPIC's HCS medical consultant]'s report of July 23, 2019, as follows:

> … In determining causation, a systematic approach must be followed by the forensic third-party reviewer. This process requires the application of a cause (i.e. mechanism of injury) and effect (i.e. diagnosis of the resulting condition) review that determines the medical probability of each effect being related to a proposed cause. The determination of probability is based on the understanding of pathological processes and the concept of the likelihood of the two being medically related under any circumstance…
>
> …

> The determination of the effect of an injury does not only take into consideration the opinions forwarded by treating practitioners but also the clinical findings presented and the results of testing done to determine the effect of the injury. All of the medical information on file is reviewed and considered in formulating an opinion on causation. That being said, certain medical information carries more weight than other information. For example, reports that document clinical findings with symptoms, and physical findings that support the determined diagnosis are weighed as stronger evidence than reports that contain unfounded opinions in an attempt to advocate for benefits. Documents that provide pertinent information at the time of an assessment or a chronological progression of care reports outlining the history of the injury at the time of the injury and subsequent period of treatment are also weighted as stronger evidence than a later report that relies solely on historical descriptions to provide an opinion on diagnosis and causation.
>
> …
>
> For causation to be determined between a traumatic event and a later clinical finding, firstly, there must be documentation of symptoms attributable to that condition being present immediately following the trauma (i.e. the motor vehicle collision) In this case, there is no documentation of symptoms immediately following the motor vehicle collision that would be consistent with a disc herniation present in the information available for review. Secondly, the clinical findings must relate to a specific lumbar disc level where a disc abnormality is identified as being present. Again, this situation is not found in the medical information on file to review. Finally, if a chronic condition is said to be related to the effects of a disc herniation, there must be ongoing documentation of persistent clinical findings which would be attributable to that spinal segment and the effects of the disc herniation or finding on ablative testing that prove that the ongoing symptoms bear a relationship to the spinal level where the disc herniation is present. Again, this is not the case documented herein. For all these reasons, it cannot be concluded that the disc herniation identified five years following the motor vehicle collision bears a causal relationship to the motor vehicle collision in question.

MPIC argued that [MPIC's HCS medical consultant] is the only doctor that actually addresses the issue of causation and no other medical provider provided a contrary opinion. Counsel for MPIC submitted that based upon [MPIC's HCS medical consultant]'s review, the Appellant's neck and back difficulties are not causally related to the MVA.

Discussion:

Legislation

The relevant provisions of the MPIC Act are as follows:

> **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 [...]
>
> indemnity of not less than $500. and not more than $100,000. for the permanent impairment.
>
> **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 accident occurred on March 30, 2007.

There is evidence of an X-ray on May 1, 2007, which indicates degenerative narrowing of C5-C6 disk space.

There is an MRI report of May 8, 2012 of the thoracic and lumbar spine stating:

> In the lumbar spine, there are moderate disc degenerative changes at the L5-S1 level. Very minimal disc degenerated changes are noted at the L3-4 and L4-5 levels. At the L5-S1 level there is a small shallow left posterolateral disc herniation with a small high signal intensity annular tear. The disc material contacts the left S1 nerve root and I cannot exclude a mild degree of compression or irritating of the left S1 nerve root by the disc material.

There is an MRI report of December 17, 2012 of the cervical spine stating:

> At the C6-7 level there is a very small left posterolateral disc herniation. There is mild compression of the left lateral aspect of thecal sac without convincing

> compression of the left C7 nerve root. No other significant cervical spinal abnormality is identified.

The evidence supports that the Appellant suffers from a disc herniation. However, the issue on this appeal is whether the disc herniation resulted from the MVA. The Appellant bears the burden of proof and must establish that on a balance of probabilities that the disc herniation is causally related to the MVA.

The Appellant was able to provide evidence of back pain, and of disc herniation and degeneration, but evidence to support a link between the disc herniation and degeneration and the MVA was limited. The evidence that the Appellant was pain free prior to the MVA was not sufficient to conclude that the pain he experienced following the MVA resulted from the disc herniation. The intervening five and a half years between the date of the MVA and the diagnosis of disc herniation makes the Appellant's position untenable.

The medical evidence was reviewed by [MPIC's HCS medical consultant] on numerous occasions as further medical information was submitted. On each occasion, [MPIC's HCS medical consultant] was unable to conclude a causation between the presence of the disc herniation on the MRI spanning a time distance from vehicle accident and the MVA.

It is noted that the Appellant terminated physiotherapy treatments 11 weeks following the MVA and he was able to return to work approximately four months following the MVA.

In his report of July 23, 2019, [MPIC's HCS medical consultant] stated:

> There were also no initial clinical report of back dysfunction following the motor vehicle collision which would relate the development of the back pain to the motor

vehicle collision. As must be stated again for the reader, the effects of trauma occur instantaneously after the traumatic force has been applied. Thus, the conditions associated with trauma develop immediately or within a very short time following the application of traumatic force. The lack of any clinical finding that would be attributable to the later diagnosis of a lumbar disc herniation following the motor vehicle collision is strong evidence against a traumatic force (in this case, the collision) leading to the development of the back pain. In this regard, there is no supporting medical documentation indicating that the motor vehicle collision caused the low back pain. Rather, there is strong evidence indicating that the low back pain occurred spontaneously following the motor vehicle collision as is common in the general population. As such, there is no temporal relationship that would relate the development of the low back pain to the effects of the motor vehicle collision one year earlier.

With respect to disc herniations, disc herniations are common findings in the general population. Individuals, who are the age of [the Appellant] at the time of the motor vehicle collision, have the highest incidence of disc herniations. The simple development of back or neck pain and disc herniations a time distant from the motor vehicle collision would not indicate remote trauma to be the cause of these conditions. Rather, these conditions likely occurred spontaneously following the motor vehicle collision as is present in the general population. To attempt to relate the development of the disc herniations a time remote to the motor vehicle collision based solely upon the fact that it happened afterwards, would be a post hoc ergo propter hoc fallacy and would have no basis in pathological forensic reviews.

…

Any association between a later found condition and the collision must demonstrate temporality, biological plausibility, specificity and chronicity to be considered to have been caused by an event. In this case, the clinical submissions do not meet the above criteria and in fact shows that the initial development of the back pain did not occur shortly after the collision as [the Appellant] contests but rather was first documented in August 2008; greater that one year after the collision. No further information on file challenges this timeline of events or reporting. It is for these reasons that the lumbar disc herniation cannot be considered to be related to the collision.

The Commission considered the process to determine causation set out by [MPIC's HCS medical consultant] in his report of July 23, 2019 as set out above, and as follows:

> It is the role of a third-party forensic reviewer to consider the provided information and synthesize a clear and substantiated conclusion about the condition present. In determining causation, a systematic approach must be followed by the forensic third-party reviewer.

It was noteworthy that the Appellant was admitted to the hospital under a neurosurgery service. He was under the care of individuals with expertise in matters related to cervical disc herniation yet a cervical disc herniation was not investigated or documented at a time nearer to the MVA.

The Commission accepts the conclusions of [MPIC's HCS medical consultant]. The Commission determines that the Appellant has not provided persuasive evidence to conclude that on a balance of probabilities, his neck and back issues were causally related to the MVA.

Issue two - Is the Appellant's permanent impairment award under Division II (psychiatric condition, syndrome or phenomenon) correctly categorized

The MVA in question was serious in nature and resulted in a fatality. The Appellant experienced anxiety and trauma as a result of the MVA and attended for psychological counselling. The Appellant sought a permanent impairment award for cognitive impairment resulting from the MVA.

In the case manager's decision of January 5, 2015, the Appellant was awarded a Class 5 permanent impairment benefit as follows:

INJURY/IMPAIRMENT	%	APPLICABLE SECTION

Cognitive function, class 5 , requiring medication, psychiatric intervention or both on an occasional basis	**5**	**Division 11, Class 5**

The Appellant was dissatisfied with the Class 5 categorization, and sought a different classification and a corresponding greater permanent impairment award. The Appellant filed an Application for Review of the case manager's decision. An Internal Review Officer reviewed the issue. An Internal Review Decision of May 25, 2016 confirmed the case manager's decision and dismissed the Application for Review.

It is from this decision that the Appellant filed a Notice of Appeal dated July 7, 2016

Decision:

The panel finds that the permanent impairment award under Division 11, Psychiatric conditions, syndrome or phenomenon, was correctly categorized as Class 5.

Evidence and Submission of the Appellant:

The Appellant submitted that he experienced trauma and anxiety following the MVA. He felt very broken in dealing with his injuries and dealing with the fatality. It was significant to him that the young girl that passed away in the MVA was the same age as his daughter.

The Appellant submitted that prior to the MVA he had good self-esteem and many friends but this is no longer the case. The Appellant testified that he is trying to put the MVA behind him. The Appellant stated that he continues to see [psychologist] once every two months. He is concerned that if he attends less frequently, he may experience a setback.

The Appellant submitted that he was under the care of [psychologist] for the past seven years.

The Appellant relied upon the numerous reports of [psychologist] including the report dated January 16, 2017 wherein [psychologist] stated:

> You continue to struggle psychologically. You have a very strong sense that you are not the same as you were before, prior to the MVA, and this is troubling you.

The Appellant relied upon the report of [psychologist] dated April 3, 2017 stating the following:

> [The Appellant] is more unsettled, his mood is decreased, he is more dysphoric, there is decreased range of affect, and he appears less happy.
>
> …
>
> He carries with him frequently a newspaper picture of the destruction of the vehicles from the accident, and this has continued to be one of his issues he deals with, and most likely will continue to deal with.

The Appellant referred the panel to the aforesaid newspaper article and photo.

The Appellant argued that he should be entitled to a permanent impairment award for Psychiatric condition of 10%.

The Appellant relies upon the letter of [psychologist] dated December 30, 2015 stating as follows:

> On reviewing this situation, I am wondering as well under Division II, Cognitive Function, Mental Functioning System, he has been awarded, from what I have seen, a Division 11, Class 5, permanent impairment rating of 5%.
>
> Here, this is in regard to a mental health condition, syndrome, or phenomenon that causes for him issues and social functioning, his sense of well-being sufficient to require regular medicine or mental health treatment or both <u>on an occasional basis</u> (emphasis added by me), less than once per month. The rating here is 5% and this is, a precise fashion, accurate.
>
> However, I had recommended 6 sessions for myself to see him over the next year, once every two months. This is what he feels is sufficient and what I feel is sufficient.

> Here, the issue is going to be over the differential rating here as Class 4 with a 15% impairment rating is that he is seen or followed up on a monthly basis. Here, in some ways, leaving aside the precision of the statements, his rating may be midway between 5% and 15%, possibly 10%, as he is seen on an every month basis, less than once a month but, not on a monthly basis and not occasionally.
>
> I do not know whether there are gradations permissible between the 5%-15% of the Class 5 is precise, less than once a month, but does not capture the fact that this is more than episodic, more than occasional, is regular, will be every two months and is based on the approval that I received from MPI."

Based upon [psychologist]'s opinion, the Appellant sought a permanent impairment award for his psychiatric condition of 10%.

Evidence and Submission for MPIC:

Counsel for MPIC relied upon the report of [psychologist] of December 30, 2015 where [psychologist] stated "the rating here is 5% and this is, in a precise fashion, accurate". Counsel submitted that [psychologist] confirmed that the Appellant is only attending for treatment six times per year which fits the definition for a Class 5 classification.

Counsel for MPIC noted that as at the date of the within hearing on November 22, 2019, the Appellant had only attended three appointments with [psychologist] in the 2019 calendar year.

Counsel referred the panel to the Health Care Services review of July 22, 2016 prepared by [MPIC's HCS psychological consultant] stating the following:

> Based on a review of the file documentation it is this writer's opinion that the 5% psychological permanent impairment rating (class 5 under the Division 11) rendered October 24, 2014, and supported again in the May 13, 2016 review, would not change.
>
> As [psychologist] commented in his December 30, 2015 report:
>
> *"The rating here is 5% and this is, in a precise fashion, accurate"*

> [Psychologist] then goes on to say that likely the rating falls between 5% and 15%. Given there is no rating classification between 5% and 15%, and the fact that [the Appellant] does not meet the criteria for a Class 4, Division 11 impairment rating of 15%, the rating of 5% stands.

Counsel for MPIC submitted that based on [psychologist]'s evidence, the Appellant's permanent impairment award was accurately categorized as Class 5. Further, although [psychologist] suggested that the Appellant's injuries fall between Class 4 and Class 5, the legislation does not provide for a classification in between two classes. Counsel for MPIC argued that in any event, based upon the evidence, the Appellant's injuries fell appropriately within the Class 5 category.

Discussion:

Legislation

The relevant provisions of the MPIC Act are as follows:

> **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.

Division 11 governs permanent impairment awards for psychological issues, which reads as follows:

DIVISION 11: PSYCHIATRIC CONDITION, SYNDROME OR PHENOMENON

Class	Symptom or condition	Impairment rating
Class 4	A psychiatric condition, syndrome or phenomenon that, including adverse effects of medication, impairs the person's ability to perform the activities of daily living, ability to function socially or sense of well-being, to such an extent that he or she requires psychiatric follow-up on a monthly basis.	15%
Class 5	A psychiatric condition, syndrome or phenomenon that, including adverse effects of medication, impairs the person's ability to perform the activities of daily living, ability to function socially or sense of well-being, to such an extent that he or she requires regular medication, psychiatric intervention or both on an occasional basis (less than once per month).	5%

The Appellant submitted that based on [psychologist]'s recommendation, his permanent impairment should fall midway between Class 4 and Class 5 as 10%.

MPIC submitted that because the Appellant received psychological counselling no more than six times per year, the permanent impairment rating falls accurately under Class 5. Further, the legislation does not provide for a permanent impairment rating between Class 4 and Class 5.

It is an unusual case wherein both parties rely upon the same medical expert to support their position. The evidence of [psychologist] is undisputed.

In advocating for the Appellant, it appears that [psychologist] is trying to account for the fact that it is difficult to classify psychological conditions precisely within the definitions provided in the legislation. He makes reference to the fact that psychological conditions may be more "episodic". The panel acknowledges [psychologist]'s comments that in his view, the Appellant's rating should be between Class 4 and Class 5, but the evidence does not support this finding.

This is consistent with [psychologist]'s report that the Appellant received psychological counselling six times per year. By November 2019, the Appellant had only three counselling sessions with [psychologist].

In assessing whether the Appellant's permanent impairment award was correctly classified, both parties emphasized the frequency of the Appellant's attendance for psychological counselling. Other symptoms or conditions in the classifications of Division 11 were not addressed.

The evidence is undisputed that the Appellant attended for psychological counselling less than once a month. This falls accurately within the Class 5 classification.

Accordingly, the Appellant's appeals are dismissed and the decisions of the Internal Review Officer of June 9, 2014 and May 25, 2016, are upheld.

Dated at Winnipeg this 8th day of April, 2020.

NIKKI KAGAN

DR. ARNOLD KAPITZ

BRIAN HUNT