Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-15-060

PANEL:	**Laura Diamond, Chairperson** **Pamela Reilly** **Lorna Turnbull**
APPEARANCES:	**The Appellant, [text deleted], appeared on his own behalf; Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Andrew Robertson.**
HEARING DATE:	**August 7, 2020**
ISSUE(S):	**Whether the Appellant's permanent impairment award was properly assessed and calculated and whether the medication Endocet is medically required for the treatment of a motor vehicle related injury.**
RELEVANT SECTIONS:	**Section 127 and 136 (1) of The Manitoba Public Insurance Corporation Act ('MPIC Act'), Section 5 and 38 of Manitoba Regulation 40/94 and Schedule A, Division 1, Subdivision 1, Items 1.2 and 1.5 of Manitoba Regulation 41/94**

Reasons For Decision

Background:

The Appellant was injured in a motor vehicle accident (MVA) on May 27, 2011. He sustained numerous injuries such as rib fractures, transverse process fractures, a fracture of the left scapula and several areas of scarring. He required surgery for a chest tube insertion and was hospitalized for several days, until June 9, 2011, receiving pain and other medications during this period.

After discharge from hospital, the Appellant continued to receive physiotherapy treatment and attended at his family doctor for further treatment, including medication for pain relief.

His treating physiotherapist completed an assessment report which assessed and measured his permanent impairments as a result of the MVA. His case manager, in a decision dated December 24, 2014, then determined his entitlement to a Permanent Impairment (PI) award based upon this assessment. The total PI award (with the application of successive remainders) amounted to 34% of the maximum indemnity. While it covered many impairments such as spinal impairment, fractures and scarring, the Appellant disagreed with some aspects of the assessment and award. He filed an Application for Review with MPIC, seeking additional PI benefits. In an Internal Review Decision (IRD) dated January 29, 2015, an Internal Review Officer (IRO) for MPIC found that the Appellant was not entitled to further impairment benefits.

The Appellant filed a Notice of Appeal with the Commission on February 26, 2015. A lengthy and detailed case management process was then undertaken by the Commission. Through this process, and through further investigation by MPIC, further PI awards were provided to the Appellant by MPIC. In particular, after it was determined that he had suffered a loss of range of motion in his shoulder as a result of the MVA and a fracture injury to his scapula, the Appellant was awarded a higher benefit of 8%, bringing his PI award total to 40% of the maximum.

Through the case management process, and at the appeal hearing, the Appellant took the position that he should still be entitled to a higher PI award for his shoulder injury, as well as PI awards for left hip, knee and lower back problems. MPIC took the position that the Appellant had received the appropriate PI award for his shoulder, that his knee had not sustained an injury in the MVA, and that his left hip and lower back issues were not causally related to the MVA.

In addition, during the Commission's case management process and through MPIC's further investigations, the Appellant was provided with another case management decision, dated August 23, 2017. This decision found that the Appellant was not entitled to reimbursement for the medication Endocet, which he had been taking for pain management. MPIC took the position that this medication was prescribed for the Appellant's back pain, which was not causally related to the MVA. Further opinions provided by MPIC's Health Care Services team added that the medication was not medically required for his MVA related shoulder injury, as it was not a safe and effective long term treatment for his compensable injury. This issue was, by agreement, added to the questions to be determined by the Commission.

It is from these decisions of MPIC that the Appellant has now appealed to the Commission.

Issues:

The issues before the Commission included the question of whether the Appellant's left hip condition was causally related to the MVA, thereby entitling him to further PI awards and reimbursement for the medication Endocet. The Commission also considered whether the Appellant had established an injury to his left knee, and whether his lower back pain was caused by the MVA, thereby entitling him to reimbursement for Endocet. The Commission also considered the question of whether the Appellant should be entitled to a greater PI award for his left shoulder injury (which was caused by the MVA) and whether the medication Endocet is medically required for treatment of his shoulder condition.

Determination:

Following its review of the documentary evidence on file, the testimony of the Appellant and the submissions of both parties, the Commission determined that:

- The Appellant's lower back and left hip condition were not causally related to the MVA and he is not entitled to further PI awards or reimbursement for medication in that regard;
- The Appellant has not established that his left knee was injured in the MVA or that he is entitled to a PI award for his left knee;
- The PI benefit awarded to the Appellant by MPIC for his left shoulder condition was appropriate, and;
- The medication Endocet was prescribed by his doctors for treatment of MVA injuries including his compensable shoulder injury and is considered medically required for treatment of that condition.

Evidence

Evidence for the Appellant:

Documentary Evidence

Reports from the [hospital] following the MVA were provided to the panel as well as a letter to the Appellant from Employment and Income Assistance, confirming his eligibility for assistance in the disability category. The Appellant provided chart notes and reports from his family doctor, [text deleted], reports from his surgeon, [text deleted], and from a family practice consultant, [text deleted]. He provided physiotherapy reports and imaging such as X-ray and MRI reports.

[Family doctor]

On September 6, 2011 the Appellant's family doctor referred him for physiotherapy treatment for her diagnosis of:

> Tender/tight to left ribcage and back/left shoulder post MVA; LBP [lower back pain] with sciatica symptoms.

Chart notes show that [family doctor] continued to follow and treat the Appellant and to prescribe medications for his injuries and pain.

On July 19, 2011 a clinical note recorded that in regard to his MVA injuries, the Appellant:

> Continues to have some pain and pain to left side of chest, especially with sleeping. Wants to RTW August 8. Using Percocet 3-4 tablets with Tylenol #3 PRN daily.

A note of November 1, 2011 stated:

> Staying at new place…Was down to four per day of endocet but needed to move his furniture himself the last few weeks. Increased pain to chest and back.

[Family doctor] reported to MPIC on February 1, 2012. She described the Appellant's MVA injuries, indicating that he continued to have left lateral chest pain with intermittent exacerbation. He had been referred to physiotherapy for muscle spasms of his chest wall and was using Percocet and Tylenol 3, with a maximum of eight tablets per day combined, for pain. The Appellant also had ongoing lower back pain relating to a possible nerve impingement to the right leg and the MVA could have exacerbated this pain. She described continued ongoing intermittent pain in the chest wall, inability to tolerate work activities, the need for continued physiotherapy and the regular use of pain medication.

The family doctor reported again on April 24, 2012. She described improvement in the Appellant's condition, although attempts to increase his range of motion had exacerbated symptoms of shoulder pain and muscle spasm. The doctor had discussed this with an orthopedic specialist who advised her to refer him to a general surgeon. She noted that the Appellant's progress for recovery was guarded depending upon the surgical consult and stated that he did not

have any pre-existing conditions to that joint which would impede recovery. The Appellant was currently taking Endocet 1-2 tablets, with Tylenol #3, 1-2 tablets, to a maximum of eight tablets per day, with intermittent use of anti-inflammatories and other medications.

On April 28, 2012 [family doctor] referred the Appellant to a surgeon for ongoing left shoulder pain.

A further report from the family doctor was dated March 19, 2015. She indicated that the Appellant had been having increasing difficulties with his left groin and leg since his MVA, and recorded as follows:

> He relates a sciatica type pain from the left hip radiating to the internal groin. Prior to his accident, he did have right sided sciatica type pain that was being investigated at that time. He is unable to bend over to put his socks on the left side or foot wear due to the pain. He has paresthesia to the same area. ….
>
> …
>
> As well, his left shoulder blade area continues to cause pain especially with turning his upper body to look back, either right or left side. He did have a fracture to the lower blade.
>
> …
>
> Currently he is taking endocet, meloxicam for ongoing pain and to help him function daily.

On September 6, 2016, [family doctor] reported that the Appellant continued to have ongoing pain to the left shoulder blade, left hip and knee since his 2011 accident, and stated as follows:

> … He continues to take percocet and naprosyn daily for the pain in order to function daily. He has seen physiotherapy regularly prior, to minimal effect. He continues to have problems with dressing and bending over daily, inability to r\turn (sic) much to the left due to the shoulder blade causing a pinching and painful sensation.
>
> I believe he will continue to take the medications long term.

A clinical chart note created by the family doctor on April 3, 2018 described the Appellant's chronic pain and arthritis and noted:

> … Oxycocet to 7/d; discussed opiod guidelines. RTC as directed

[Appellant's surgeon]

The surgeon, [text deleted], reported on July 25, 2012. He described a sustained fracture of the scapula at the inferior pole which had been treated conservatively with physiotherapy. He described the results of his examination and review of the X-Ray with a plan to send the Appellant for an MRI of the left shoulder to rule out rotator cuff tendonosis versus tear.

The surgeon reported to [family doctor] on July 5, 2012. He described the Appellant's history of shoulder pain following the MVA and the fracture to the scapula. He described the results of his physical examination and advised the family doctor that he was sending the Appellant for an MRI of the left shoulder and would report back following that investigation.

On January 22, 2013, the surgeon reported that the left shoulder MRI showed no obvious abnormality and the rotator cuff was intact. The Appellant had described significant improvement after physiotherapy and the surgeon encouraged him to return back to normal activity, and continue with his strengthening exercises.

MRI Reports

An MRI report dated August 29, 2018 looked at the Appellant's left knee and hip. The impression of the knee was of a "normal knee". As for the left hip, a comparison of the 2013 image showed:

> … Mild to moderate narrowing of the left hip joint space is present superiorly and posteriorly with progression since 2013. Marginal osteophytes at the femoral head/femoral neck junction have enlarged mildly. Somewhat more subchondral bone edema is present at the acetabulum. There is degenerative change and the labrum without any clearcut tear. Minimal joint effusion is present.
>
> The right hip joint space is much better preserved. There is minimal osteophyte formation at the right femoral head. The SI joints are grossly normal.
> IMPRESSION: Increasing changes of osteoarthritis of the left hip now moderate in degree. Minimal OA at the right hip.

An MRI report dated September 24, 2019 of the left hip showed

> There are severe osteoarthritic changes involving the left hip. The right hip joint spaces maintained width and no secondary arthritic changes are evident.

[Family practice consultant]

The Appellant's family doctor also referred him for a consultation with [family practice consultant]. He reported on the Appellant's left hip and groin pain of long-standing duration following an assessment of January 28, 2019. [Family practice consultant] noted the MVA of several years prior with documented injuries to the Appellant's left side of the body and treatment focused at that time on his shoulder, with the Appellant suffering ongoing hip and groin pain since. Following his examination of the patient, [family practice consultant] diagnosed "left hip arthropathy which is posttraumatic in nature". He referred the Appellant to an osteoarthritis clinic for multi-disciplinary assessment, education and treatment.

Occupational Therapist

The most recent permanent impairment assessment of the Appellant's shoulder injuries and range of motion was provided by the occupational therapist, [text deleted] on July 24, 2018. The assessment included the following:

> **Injuries (as per referral):** Left shoulder, multiple lacerations, fracture to scapula, rib fractures

Range of Motion

The following measurements were obtained using goniometer and measured three times in degree of active range of motion while in standing.

Shoulder	Right	Left	Normal Values
Flexion		90/85/95 = 90	180 degrees
Extension		30/25/30 = 28	60 degrees
Abduction		70/95/95 = 87	180 degrees
Adduction		30/20/30 = 27	50 degrees
Internal Rotation		65/60/65 = 147	70 degrees
External Rotation		50/55/45 = 50	90 degrees

These measurements were then applied by MPIC in an Impairment Assessment dated September 4, 2018 which resulted in an 8% entitlement, determined as follows:

ENTITLEMENT # 11 (Previously Partially Paid)

Division 1: Subdivision 1, Item 1.5
Loss of Range of motion left shoulder

(a)(ii)Flexion/ Extension = 118° = 5%
(b)(ii)Abduction/ Adduction = 114° = 3%
(c)(iv)Internal/ External Rotation = 197° = 0%

Percentage to be used for application of successive remainders = **8%**

This was then reflected in the final PI Entitlement case manager's decision of September 25, 2018 which allowed 8% for "Loss of Range of motion left shoulder".

Employment and Income Assistance

The Appellant also submitted a letter dated August 20, 2019 from [text deleted] stating that an assessment of the medical information determined that he was eligible for Income Assistance, after a medical review panel found him eligible in the disabled category.

Testimony of the Appellant

The Appellant testified at the appeal hearing and was cross-examined by counsel for MPIC.

He explained that when he first saw a specialist following the MVA the only diagnosis for his left shoulder was of three torn tendons. He received two or three weeks of physiotherapy for that diagnosis, but the fracture to his shoulder blade was not diagnosed until later. The undiagnosed fracture continued to cause sharp pain, and in fact has gotten worse. The Appellant now believes he must just learn to live with it.

He explained that ever since the MVA he has continued to complain to [family doctor] that there is something wrong with his hip. He cannot put his shoes or socks on his left foot and has been asking for physiotherapy on that hip since 2013. MPIC always took the position that this was not caused by the accident so over the years, without treatment, it has gotten worse. X-ray and MRI investigation, and consultation with [family practice consultant] confirmed a diagnosis of osteoarthritis and, in [family practice consultant]'s opinion, it is post-traumatic arthritis. The Appellant explained that before the MVA he had been very active and had no problems at all with his hip. Unlike his back and sciatic pain, which had been there for a long time, he had no problems with pain or motion in the hip before the MVA. He enjoyed sports, playing baseball and hockey. The Appellant loved his job as a healthcare aid for 15 years. However since the

accident he can no longer do the necessary transferring and positioning of patients, so he is now on disability.

The Appellant explained that his whole left side was damaged from the MVA; that is, from his head to his toes, including breaking six ribs and his scapula. He explained that he sought help from the [text deleted] and follows an exercise plan that they recommended to treat his painful arthritis.

The Appellant testified that he has been using opioids since 2011. He took four Tylenol #3 per day for sciatica before the MVA. Following the MVA, he initially took eight Endocet per day, until 2016. Then, because of the opioid crisis, his caregivers considered putting him on something else. He resisted, indicating that he had been on this medication for six years and was afraid to try a new one which might mess him up. They agreed to reduce the dose to four pills per day. He explained that on six Endocet per day he feels better and can still avoid feeling like a zombie.

On cross-examination, the Appellant confirmed that he had been taking eight Endocet per day right after the MVA. Then, as reflected in chart notes from November 1, 2011, he was down to four per day within about six months after the MVA. He confirmed that an improvement in his shoulder range of motion led [family doctor] to reduce the Endocet dosage, but after a flare up moving furniture it was increased to eight per day. He explained that at eight per day he was too medicated to feel fully functional and might as well stay home, but that at four or six per day his pain was tolerable and he was functional.

The Appellant confirmed that the noted sciatic pain (shooting down his leg with tingling), was on the right side and that after the MVA the sciatica continued on the same side. He still continues to have this right-sided sciatic pain. In his view, the left groin pain radiating down his leg, as described in clinical notes dated July 11 and September 5, 2013, came from his left hip arthritis. Although these appeared to be the first clinical notes of pain radiating down the left leg, the Appellant could not explain why the doctor would not write down his prior complaints, which he believed he first reported to [family doctor] somewhere in 2012. He admitted the pain had come on gradually.

When asked why the physiotherapist had not mentioned leg pain in his reports, the Appellant said that the physiotherapist was too focused on his shoulder and scapula and did not give any attention to his hip or leg pain, although he knew about it. Nor did the physiotherapist treat the Appellant's back pain.

The Appellant was asked about [family doctor]'s chart notation of July 11, 2013 regarding chronic knee pain. The Appellant maintained that he had reported knee pain to her "from day one". Although it might not have been written down earlier, he again noted that arthritis takes many years to develop and he was sure he had told her about it before 2013.

When asked about his discussions with the surgeon, the Appellant indicated that all the surgeon wanted to look at and discuss were the three tendons in his shoulder.

When asked about comments made by the Appellant and recorded in the Reasons for Decision in his previous Commission appeal in AC-13-104, the Appellant indicated that at that time, in 2014, everything was gradually getting worse and he was asking for more physiotherapy. The medical

reports at that time talked about the three tendons but didn't deal with his hip and knee or even his scapula fracture. When asked whether at the time he had taken the position that the hip pain was new compared to the scapula pain, the Appellant indicated that no, arthritis doesn't happen overnight. When asked if the chart notes of [family doctor] showed that the first mention of left sciatic pain, hip and knee pain were in 2013 (when his condition changed from what it had been before) the Appellant replied that he had no idea.

Evidence for MPIC:

Documentary Evidence

Along with a review of the hospital and clinic chart notes on file and the reports of the Appellant's caregivers, MPIC relied upon reports from the physiotherapists who assessed and treated the Appellant's injuries, as well as the occupational therapist who assessed him. In addition to these, MPIC relied upon reports from physiotherapy and medical consultants of its Health Care Services team. In particular, file review reports by physiatrist [text deleted], an MPIC Health Care Services medical consultant, were submitted to support MPIC's assessments and position.

Physiotherapist and Physiotherapy Consultant

The Appellant was treated by physiotherapist [text deleted]. [Physiotherapist] reported to MPIC on March 5, 2012 identifying treatment for multiple rib fractures as well as a fracture of the scapula, and noting complaints of lower back issues. He recommended a structured rehab program.

MPIC's physical therapy Health Care Services consultant approved further treatment and requested further investigation regarding the scapula fracture, in a report dated March 8, 2012.

Physiotherapy continued and the physiotherapist submitted a report dated June 22, 2012 after measuring the Appellant's scars.

A Health Care Services medical consultant report dated July 4, 2012 reviewed the materials and concluded that the Appellant's scapula fracture and shoulder problems were caused by the MVA. This was reflected in a case management decision dated July 24, 2012 which related the scapular injury to the MVA and provided the Appellant with some Income Replacement Indemnity (IRI) benefits.

On August 14, 2012, the Health Care Services physiotherapy consultant reviewed the physiotherapy reports and concluded that although the surgeon was continuing to follow up with a MRI of the shoulder, the Appellant's range of motion and strength were normal and additional physiotherapy treatment was not medically required.

MPIC's physiotherapy consultant reviewed the file again on July 16, 2015 to advise whether the treatment plan recommended by [family doctor] was medically required and MVA related. The consultant reviewed [family doctor]'s reports, including references to the MRI of the left knee. He concluded that the ongoing left sided groin and leg difficulties were not MVA related, and that the lower back and sciatica pain, pre-existed the MVA. He recommended that the CT scan be reviewed by a medical consultant, but advised that as the Appellant had completed a course of Category 2 physiotherapy treatment, additional physiotherapy was not medically required, as there did not appear to be a change in the diagnosis which would result in a change in category.

The physiotherapist reported again on August 27, 2015 in response to a request for ROM measurements of the Appellant's left shoulder. He replied that the Appellant had good ROM and

since there was no deficit he did not see a need to actually measure the ROM, which was symmetrical to the right.

Occupational Therapist

An occupational therapist, [text deleted], assessed active ROM of the left shoulder and reported on November 24, 2015. He provided the following measurements:

Shoulder	**Right**	**Left**	**Normal Values**
Flexion		160°	180 degrees
Extension		45°	60 degrees
Abduction		160°	180 degrees
Adduction		35°	50 degrees
Internal Rotation		60°	70 degrees
External Rotation		75°	90 degrees

In regards to deformity, he commented that the left scapula was mildly altered in shape, which may reflect abnormal healing of the fractured left scapula.

This assessment was then factored into an Impairment Assessment by MPIC dated December 18, 2015, which added a further PI of 1%, for the shoulder, for an overall PI award of 35%.

Following another occupational therapist assessment of July 24, 2018 by [occupational therapist], the Appellant was provided with a new Impairment Assessment dated September 4,

2018 which set out greater entitlement of 8% (up from 1%) for the loss of range of motion in the Appellant's shoulder, bringing his total PI award to 40%.

Medical Consultants

On September 19, 2012, a Health Care Services medical consultant reviewed the file and determined that the medications which had been prescribed for the Appellant (Endocet, Tylenol #3, non-steroidal anti-inflammatories and Cyclobenzaprine) were not medically required in the management of an MVA related condition. The consultant stated as follows:

> The understanding that these medications are generally prescribed to minimize symptoms arising from musculoskeletal conditions and are considered an elective treatment option. The medical evidence does not indicate [the Appellant] developed a medical condition as a result of the incident in question that would in all probability deteriorate if the above noted medications were not taken.

Although noting that MRI investigation was still upcoming regarding the Appellant's shoulder pain and a possible rotator cuff injury, he opined that:

> In the majority of cases, patients with rotator cuff tears do not require ongoing use of multiple medications in order to help minimize symptoms. It is not unreasonable to assume that [the Appellant] might use occasional over-the-counter analgesic medication to help minimize symptoms that can wax and wane based on the amount of activities he performs during the day.

On May 29, 2017, MPIC's medical consultant requested clinic notes from the family doctor so that he could provide an opinion as to whether the Appellant's hip and knee problems were related to the MVA. The commentary noted that:

> The patient probably has degenerative arthropathy of the left hip, with a lack of clarity as to the cause of his condition. It is often idiopathic. The family physician states that the patient has had trouble this (sic) since the collision in question, but the notes on file do not indicate clinical signs or symptoms of probable hip pathology. The physiotherapist notes on file also do not indicate probable hip pathology for the first year after the event in question.

Upon receiving further medical documentation, the medical consultant reported again on August 14, 2017, regarding the relationship between the Appellant's hip and knee pain and the MVA, as well as whether his prescription for Endocet medication was medically required in relation to a MVA related diagnosis.

In regard to the knee, he concluded:

> The medical information does not indicate probable left knee or hip injuries were sustained in the event in question. They are not referenced with the original physiotherapy or medical documentation.
>
> No probable left knee diagnosis has been established. The MRI is normal.

In regard to the hip and sciatica he concluded:

> No probable left hip diagnosis related to the event in question has been established. … Sciatica has been considered. The MRI reveals early osteoarthritis. There is no probable left hip injury which would have lead (sic) to the development of arthritis.

In regard to medication, the consultant stated:

> The endocet is being taken for back pain, according to the patient's declaration. Back pain does not appear to have been accepted as a compensable injury. The patient is described as having sciatica prior to the event in question.

Following receipt of further information from MPIC's legal counsel, the consultant provided a further report dated May 8, 2019. He was asked to review clinic notes and X-rays in order to determine any additional PI entitlements of the left hip and knee, whether the Appellant's back symptoms were connected to the MVA, and his entitlement to funding for Endocet.

The consultant noted as follows:

> This review of compensable injuries does not include that low back pain was probably an original symptom. The patient had prior low back pain and was

> using opiate analgesics. The natural history of opiate analgesic use is tolerance, dependence, and increasing usage over time.

Upon review of the history, X-rays and CT of the Appellant's hip, he concluded:

> With the passage of time, and the development of left hip arthritis, this probably represented a degenerative cyst in the patient's left femur. This was probably a pre-accident manifestation. This vulnerability probably led to the patient's degenerative left hip arthrosis.

After further document review, the consultant noted that*:*

> At this phase, eight months after the event in question, a probable permanent worsening of low back pain, a probable left hip injury, and probable left knee injury was not articulated. A definite demonstration of a probable degenerative cyst in the patient's left femur was present, and this was not accident related. It does not appear to be worsened by the crash at this point."
> …
>
> The patient has had a left knee MRI which fails to reveal any intra-articular pathology which could be probably causally related to the event in question."

Moving on to consider the request for coverage for Endocet, the consultant stated:

> The patient has been using Endocet, an opioid analgesic for over eight years, and used them prior to the event in question. Opioid analgesics are not indicated for this type of pain in the long term. They cause more harm than benefit.
>
> The patient's low back pain does not appear to be probably causally related to the event in question. I would note that Endocet has also been prescribed for the patient's shoulder pain which is probably causally related to the event in question.

Finally, the medical consultant was provided with [family practice consultant]'s report (January 28, 2019), the letter from Employment Income Assistance (August 20, 2019), [Appellant's surgeon]'s report (January 22, 2013), the occupational therapist's PI report (July 24, 2018) and MRI reports (August 29, 2018 and September 24, 2019). He was asked whether any of these documents would lead him to change the opinion he had previously provided.

In his report dated April 27, 2020, the consultant noted that [family practice consultant] had clearly related the Appellant's left hip degeneration to the MVA, but queried whether he had conducted a forensic review of the evidence of chronology of hip symptoms including the presence of the degenerative cyst which was probably present in the head of the femur prior to the MVA stating:

> … I would be interested in his forensic review of this material.

The consultant further noted that [Appellant's surgeon]'s report did not establish probable compensable injuries to the left hip or knee, and that the occupational therapist report did not mention them. The MRI reports showed a normal left knee and a hip with progressive hip joint degenerative disease without establishing a probable cause and he was further unable to find that the degenerative disease was related to the MVA.

In regard to medication, the consultant opined that:

> Endocet, a short acting opioid analgesic, has not been established as a safe and effective long term treatment for the compensable injuries. Tolerance, dependence, opioid induced hyperalgesia and significant side effects exist which limit its effectiveness.

Submission

Submission for the Appellant:

The Appellant submitted that he should definitely be entitled to a greater PI award for his shoulder. He did not understand why MPIC provided only a 5% award when he felt it should be more than 50% of the maximum. He believed he should get the maximum possible PI benefit for the definite loss of range of motion from the fracture. He understands that this may cause more complications in the long run and that he will have to live with it. He has been trying to lose weight, do exercises and build muscle but still he cannot turn properly or move his arm without

pain. He said that the pain from the scapula fracture is like somebody constantly stabbing him in the back.

The Appellant disagreed with MPIC's position that his left hip problems were not caused by the MVA. Before the MVA he was really into sports and was healthy. He knew something was wrong from day one of the MVA, and that this problem was from the MVA and not from his previous back problems. He has had MRI and CT scans and they've always showed his left hip getting gradually worse. Before the MVA he was a healthcare aide. He loved the work and wishes he could go back to it, so it was very frustrating to have to stop.

The Appellant could not understand how MPIC's doctor could say his left hip problem was not caused by the MVA when they had never seen him. [Family doctor] had both seen him and diagnosed the osteoarthritis, which can be caused by an MVA. Further, [family practice consultant]'s report of January 28, 2019 stated that the problem was from osteoarthritis which was post-traumatic in nature. The Appellant submitted that there had been nothing wrong with his hip before 2011 and now everything has gotten worse, since the MVA. There is no evidence to say that he had any arthritis before the MVA and now, today, he is disabled. He is a young man, cannot work and is very stressed about this.

The Appellant felt that a lot of his knee problems were caused by his hip, noting that on some days his hip is so bad that he has to use a cane. For someone so young, he says this is difficult on the psyche.

The Appellant submitted that his need for Percocet/ Endocet was because of the MVA. Before the MVA, he took some T3's for his back pain. He knows what medications can do to you,

having worked at a hospital for 10 years. But, after the MVA he was in such pain that he found he needed the Endocet. He explained that his day would not function without a pain killer. His daily living is diminished and his activities of daily living are now very limited. He submitted that six Endocet per day take the pain away. He explained that he wished he had also filed an appeal for other drugs he needs such as Biaxin, which he requires frequently, every year, as he constantly gets pneumonia because of his punctured lung. He confirmed that he takes Endocet every day and that if he didn't take it, he would have pain in his shoulder. It's something he needs, not something he wants. He is not a fan of it, but he has to live like this every day.

Submission for MPIC:

Counsel for MPIC addressed the question of whether the Appellant's back pain was causally related to the MVA, whether Endocet is medically required for MVA injuries, and whether the Appellant is entitled to further PI benefits for his shoulder, hip or knee.

Back Pain

Counsel addressed [family doctor]'s suggestion that while the Appellant suffered from back pain and sciatic pain on his right side before the MVA, it presented on the left side after the MVA, and whether this represented an exacerbation of the back pain. Counsel began by reviewing medical reports and clinical notes that touched upon the Appellant's back condition.

A chart note dated May 6, 2011 (before the MVA) reviewed a CT scan showing S1 nerve root irritation and diagnosing right sciatic pain. No similar opinion was provided regarding post-MVA back pain. The only diagnosis of nerve root irritation existed pre-MVA.

A chart note dated August 9, 2011 (after the MVA) noted the Appellant was feeling worse with pain to his ribs and shoulders with recent tingling to right lower back.

In a report dated March 19, 2015, [family doctor] reported increasing difficulties with left groin and leg since his MVA with a sciatica type pain from the left hip radiating to the internal groin. Prior to the MVA he had right-sided sciatica type pain that was being investigated.

No mention of back pain was found in her report of April 24, 2012.

Chart notes from July 11, 2013 and September 5, 2013 showed a change in back symptoms from his right to left side. This is when his symptoms also begin to show up in the chart notes, with notes of the left hip and groin pain and left knee pain, suggesting that the Appellant's sciatic symptoms were related to his hip condition and not an exacerbation of his lower back pain condition.

Nor was there any indication in the physiotherapist's reports of any back pain complaints.

MPIC's healthcare services consultant, [MPIC Health Care Services medical consultant], reviewed the question of the Appellant's lower back pain in a report dated August 14, 2007, and concluded that back pain was not accepted as a compensable injury.

A more detailed review was conducted on May 8, 2019. [MPIC Health Care Services medical consultant] indicated that the review of the compensable injuries did not conclude that low back pain was an original symptom. The patient had prior low back pain and was using opiate analgesics (T3). He noted that eight months after the MVA, a probable permanent worsening of

low back pain was not articulated. He came to the conclusion that the patient's low back pain did not appear to be probably causally related to the event in question.

In this way, counsel submitted, [MPIC Health Care Services medical consultant] had strengthened the argument that there was no probable worsening of the Appellant's low back pain because of a change in the sciatica condition. The medical notes did not even show any change until 2019. The fact that symptoms do not manifest until two years post-MVA suggest that they are not related to the MVA. [MPIC Health Care Services medical consultant]'s review had access to all of the materials on file and correlated all the materials of the Appellant's caregivers, which counsel submitted strengthens his conclusions regarding causation.

Endocet

Another MPIC healthcare services medical consultant, [text deleted], considered the use of medication such as Endocet for the Appellant's shoulder condition in a report dated September 19, 2012. He noted that patients with rotator cuff tears under investigation do not require ongoing use of multiple medications in order to help minimize symptoms and it was not unreasonable to assume that the Appellant might use occasional over-the-counter analgesic medication to help minimize symptoms that can wax and wane based on the amount of activities he performs during the day.

In his reports of May 8, 2019, [MPIC Health Care Services medical consultant] also opined that opioid analgesics such as Endocet are not indicated for this type of pain as in the long term they cause more harm than good.

Finally, in his final report dated April 27, 2020, [MPIC Health Care Services medical consultant] made the general statement that:

> Endocet, a short acting opioid analgesic, has not been established as a safe and effective long-term treatment for the compensable injuries. Tolerance, dependence, opioid induced hyperalgesia and significant side effects exist which limit its effectiveness.

Counsel submitted that [family doctor] has not provided evidence to address these potential concerns or why this medication is being prescribed for the Appellant.

Permanent Impairments

Counsel explained that under the MPIC Act, entitlement to lump sum impairment awards are set out in the Regulations. A one-time lump sum award goes to victims who suffered specific, identified injury or loss of function. MPIC accepts that the Appellant has suffer injuries as of the MVA and PI benefits have been paid. While it was accepted that the Appellant has pain, it was submitted that the medical evidence on file shows that he has received the PI award to which he is entitled.

Shoulder

Counsel noted that PI benefits for the fracture and loss of range of motion to the Appellant's shoulder had previously been accepted and paid. In the course of the pre-hearing process at the Commission, the Appellant indicated that his shoulder had worsened, so a reassessment was performed and provided on July 24, 2018. The updated information was then obtained by MPIC, which then paid a PI benefit on that basis, after considering MRI investigation that showed no obvious abnormality demonstrated in the shoulder, with an intact rotator cuff.

Therefore, counsel submitted that the Appellant's left shoulder conditions have been properly identified and he has already received the appropriate PI award, with no evidence to show entitlement to any award beyond that.

Hip

Counsel for MPIC did not disagree with the Appellant that he suffered from arthritis in his hip. However, he did not agree that this was MVA related so as to entitle the Appellant to a PI award. He submitted that the medical evidence showed a lack of complaints regarding the left hip until mid to late 2013, about two years post MVA. This suggests that the hip condition is not causally related to the MVA, but rather is a degenerative process.

Counsel began by reviewing the June 9, 2011 hospital discharge summary which showed no indication of left hip problems as part of the diagnosis.

Similarly, [family doctor]'s report of April 24, 2012 did not mention hip symptoms, while discussing a return to work plan. Her report of September 6, 2016 did note that the Appellant had been suffering from left shoulder, left hip and knee problems since the accident. However, this does not seem to be supported by her own prior reports or chart notes. Her first mention of left hip complaints is found in a chart note dated September 26, 2013. There is a significant gap in time between the MVA and the first time symptoms are noted. The Appellant indicated that he did tell [family doctor] about this pain from the beginning, but as she did not have a diagnosis she did not record it. But such records are not diagnostic tools alone, they also set out the subjective complaints of the patient during that visit. The fact that a complaint is not listed suggests that no such complaint was discussed.

The physiotherapist, [text deleted], did not mention hip pain in his reports.

A CT of the pelvis taken on the same day as the accident noted a 10 mm well defined cyst within the left femoral head.

There was no further investigation until September 14, 2013 when mild osteoarthritis was noted.

In considering [family practice consultant]'s report of January 28, 2019 which attributed the Appellant's hip pain to post-traumatic left hip arthropathy, counsel submitted that the doctor had not submitted any rationale as to how he came to this conclusion. There is no indication of what prior reports were available to him, and no indication that he relied on the previous CT imaging that had been done. Counsel submitted that the Appellant had specifically told [family practice consultant] that this was caused by the MVA and [family practice consultant]'s conclusion that it was "posttraumatic" seems to be a repeat of information provided by the Appellant, rather than a conclusion he came to himself.

Counsel also addressed the Appellant's submission that his entire left side was injured in the MVA. It is true, he acknowledged, that the ribs and scapula fracture occurred on his left side, but there was no documentation of other injuries to the lower left side of the Appellant's body. To find causation, there must be some evidence that the specific injuries were caused by the MVA other than that they are simply on the same side of the body as other injuries that are compensable.

Counsel relied upon [MPIC Health Care Services medical consultant]'s report of May 29, 2017 which concluded that the Appellant probably has degenerative arthropathy of the left hip with a lack of clarity as to the cause of this condition, which is often idiopathic.

Further, in his report of May 8, 2019, [MPIC Health Care Services medical consultant] reviewed the CT scan showing the cyst and advised that:

> With the passage of time, and the development of left hip arthritis, this probably represented a degenerative cyst in the patient's left femur. This was probably a pre-accident manifestation. This vulnerability probably led to the patient's degenerative left hip arthrosis…

He went on to note that at this phase, a month after the event in question, a probable left hip injury was not articulated and that:

> …A definite demonstration of a probable degenerative cyst in the patient's left femur was present, and this was not accident related. It does not appear to be worsened by the crash at this point.

Finally, in reviewing [family practice consultant]'s comments, [MPIC Health Care Services medical consultant] noted in his report of April 27, 2020 that the patient has definite left hip degenerative joint disease. Although [family practice consultant] related it to the event in question, it was not clear to [MPIC Health Care Services medical consultant] that [family practice consultant] had conducted a forensic review of the evidence regarding the chronology of hip symptoms, including the presence of the degenerative cyst which is probably present in the head of the left femur prior to the crash. He indicated that he would be interested in [family practice consultant]'s forensic review of this material. However, counsel noted that the Appellant had chosen not to request or provide such a follow up report from [family practice consultant]. Therefore, given the lack of hip pathology and the presence of the cyst at the time of the

accident, counsel submitted that the Commission should accept [MPIC Health Care Services medical consultant]'s opinion that the left hip condition was not caused by the MVA.

Left knee

Counsel submitted that many of the same arguments would apply to the Appellant's knee condition. The hospital discharge summary of June 9, 2011 indicated that there was some tenderness to the knee but that there was good range of motion. [Family doctor] does not note left knee symptoms in her report of April 24, 2012. Nor does the physiotherapist refer to left knee pain or weakness. No imaging was conducted of the Appellant's left knee. [Family doctor]'s comments in later reports that the Appellant had suffered left knee pain since the accident are not supported by her chart notes or earlier reports.

Further, unlike the hip condition which had been diagnosed, no actual condition of the left knee has been identified. The MRI report of August 29, 2018 found the knee to be normal. [MPIC Health Care Services medical consultant]'s report of August 14, 2017 opined that with a normal MRI the medical information does not show that a left knee diagnosis had been established. Any range of motion restriction of the left knee was not connected to the MVA. Then, in his report of May 8, 2019, [MPIC Health Care Services medical consultant] noted no left knee condition was articulated within eight months following the MVA and confirmed that the MRI of the left knee failed to reveal pathology that could be causally related to the MVA.

Therefore, counsel submitted that the Appellant had not established entitlement to further PI awards for the shoulder, hip or knee.

Appellant's Reply

In reply, the Appellant indicated that he could not understand how a doctor such as a Health Care Services consultant could form an opinion on his case without ever seeing him. He also took issue with an MPIC doctor being the only one to identify and relate the cyst to his hip issues.

His frustration also extended to the physiotherapist focusing only on the tendons in his shoulder and ignoring the issues with his shoulder blade, hip, back and knee.

He urged the panel to prefer the evidence of [family doctor] and [family practice consultant], who had examined him and formed diagnostic opinions.

Discussion

The MPIC Act and Regulations provide for the following benefit entitlements:

> **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
>
> **Reimbursement of victim for various expenses**
>
> 136(1) Subject to the regulations, the victim is entitled, to the extent that he or she is not entitled to reimbursement under *The Health Services Insurance Act* or any other Act, to the reimbursement of expenses incurred by the victim because of the accident for any of the following:
>
> (a) medical and paramedical care, including transportation and lodging for the purpose of receiving the care;
>
> (b) the purchase of prostheses or orthopedic devices;
>
> (c) cleaning, repairing or replacing clothing that the victim was wearing at the time of the accident and that was damaged;
>
> (d) such other expenses as may be prescribed by regulation.

Regulation 41/94 sets out:

DIVISION I: THE MUSCULOSKELETAL SYSTEM

Subdivision 1: The Upper Limb
0.1 Definition
In this Division, "**non-specified abnormal healing**" means an anatomic abnormality at the end of the expected healing process, which is not specified elsewhere in the Schedule, such as the change in angulation of the fracture fragment, rotational abnormalities or shortening.

1.2 Fractures
(a) fracture of the sternum, clavicle, scapula
or humerus with non-specified abnormal healing 1%
1.5 Range of motion loss of the shoulder joint complex
(a) flexion-extension (motion in the scapular plane):
Combined range of motion in degrees: Normal total range of motion for this plane is 230 degrees.
(i) less than 61 . . . . . 9%
(ii) 61 to 120 . . . . . 5%
(iii) 121 to 180 . . . . . 2%
(iv) greater than 180 . . . . . 0%

(b) abduction-adduction (motion in the coronal plane):
Combined range of motion in degrees: Normal total range of motion for this plane is 230 degrees.
(i) less than 61 . . . . . 6%
(ii) 61 to 120 . . . . . 3%
(iii) 121 to 180 . . . . . 1%
(iv) greater than 180 . . . . . 0%

(c) internal rotation – external rotation:
Combined gleno-humeral range of motion in degrees: Normal total range of motion for this plane is 180 degrees.
(i) less than 46 . . . . . 6%
(ii) 46 to 90 . . . . . 3%
(iii) 91 to 135 . . . . . 1%
(iv) greater than 135 . . . . . 0%

Regulation 40/94 sets out:

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

> (a) when care is medically required and is dispensed in the province by a physician, nurse practitioner, clinical assistant, physician assistant, paramedic, dentist, optometrist, chiropractor, physiotherapist, registered psychologist or athletic therapist, or is prescribed by a physician, nurse practitioner, clinical assistant, or physician assistant;
>
> (b) when care is medically required and dispensed outside the province by a person authorized by the law of the place in which the care is dispensed, if the cost of the care would be reimbursed under *The Health Services Insurance Act* if the care were dispensed in Manitoba.
> M.R. 125/2010
>
> **Medication, dressings and other medical supplies**
> **38** The corporation shall pay an expense incurred by a victim for the purchase of medication, dressings and other medical supplies required for a medical reason resulting from the accident.

The onus is on the Appellant to show, on a balance of probabilities, that the IRD and subsequent case management decisions resulting from the appeal management process, were in error. In particular, he must establish that the evidence shows he suffered from injuries to his hip, knee and back as a result of the MVA which entitle him to further PI awards, that he is entitled to a greater PI award for his loss of shoulder range of motion, and that Endocet is medically required for a compensable injury sustained in the MVA.

The Appellant presented his evidence in a credible and reasonable manner. His testimony and submission established that he was healthy and active before the MVA, although sometimes troubled by pre-existing lower back pain. He worked hard as a healthcare aide and participated in a variety of sports. The panel recognizes that he then suffered a serious MVA, and that as a result, he has had to live with a good deal of residual effects and pain since that time. He described significant pain from his hip, shoulder and knee and described how this negatively affects his activities of daily living.

The panel has carefully reviewed the documentary evidence on file, in addition to the Appellant's testimony at the hearing and the submissions of the parties. This has been weighed in accordance with the onus upon the Appellant to show, on the evidence before us and on a balance of probabilities, that he is entitled to additional benefits as a result of injuries arising out of the MVA.

PI Entitlements:

Left Knee

The documentary evidence on file did not support a diagnosis of MVA related injury to the Appellant's knee. Although [family doctor] noted left knee symptoms in July 2013, her earlier reports and chart note entries following the MVA made no mention of it.

The physiotherapist did not note it and imaging of the knee showed a normal knee.

The Appellant argued that he had left knee problems, connected to his left hip problem, but there was little, if any medical evidence to establish this.

The panel agrees with the assessment of [MPIC Health Care Services medical consultant] that the medical evidence fails to reveal pathology in the knee that could be casually related to the MVA.

Accordingly the Commission finds that the Appellant has not met the onus upon him to show, on a balance of probabilities that he is entitled to a PI award for his left knee.

Left Hip and Lower Back

During the hearing, the Appellant acknowledged that he did have pre-existing lower back pain, but said that he now believed it was worse because of his hip problem.

The Appellant submitted that he did not have pre-existing hip pain prior to the MVA. He acknowledged that his hip pain stemmed from osteoarthritis in his hip, but maintained that there is no evidence that he had any arthritis before the MVA. He is too young to be disabled by arthritis and submitted that the arthritis was post–traumatic and caused by the MVA. This was supported by [family practice consultant]'s report of January 28, 2019 which stated that he has "left hip arthropathy which is posttraumatic in nature."

Although the panel has carefully considered this statement by [family practice consultant], we have also considered [MPIC Health Care Services medical consultant]'s questioning regarding the level of analysis by [family practice consultant] in arriving at this conclusion. His report does not reflect or mention any review of the Appellant's history and chronology of complaints. More importantly, it does not address the CT scan taken on the day of the MVA which showed that the Appellant already had a degenerative cyst which had developed and according to [MPIC Health Care Services medical consultant], was "probably present in the head of the left femur prior to the crash."

Although [MPIC Health Care Services medical consultant] invited forensic review or comment from [family practice consultant] on this aspect of the material, the panel was not provided with such evidence.

Accordingly the panel concludes that although the Appellant's hip may not have been symptomatic prior to the MVA, the weight of the medical evidence on file supports the conclusion that the Appellant's hip complaints are a result of degenerative disease in the hip which was not causally related to the MVA. Therefore, the Commission finds that the Appellant has failed to establish on a balance of probabilities that he is entitled to a PI award for his hip as a result of injuries arising from the MVA.

Left Shoulder

The Appellant submitted that he should be entitled to a maximum PI award for his left shoulder condition, at a rate of somewhere between 21% and 50 % of the maximum.

The Appellant`s shoulder condition was reviewed and revised by MPIC as the appeal progressed, following further assessment of his ranges of motion and other relevant factors, as measured by an occupational therapist and set out in her Permanent Impairment Report of July 24, 2018. MPIC ultimately provided him with an award of 8% for his shoulder condition.

Although the Appellant testified regarding his ongoing pain, reduced range of motion and difficulties with his shoulder and scapula, the panel agrees with counsel for MPIC that PI benefits for the fracture and loss of range of motion to the Appellant's shoulder have been fully investigated, assessed, and accepted. We agree that the Appellant's left shoulder conditions have been properly identified and he has already received the appropriate PI award, in accordance with the provisions of the MPIC Act and Regulations, which dictate the specific amount of PI awards for various injuries. The documentary evidence has established that the assessment and calculations of the occupational therapist and case manager correctly reflect this legislative

scheme. The Appellant has not met the onus upon him and has failed to submit specific evidence to show entitlement to any additional PI awards for his shoulder condition.

Endocet:

The Appellant testified regarding his pain, including his MVA-related shoulder pain, and described how he and his doctor have worked together over the years since the MVA to arrive at a dosage level of the medication Endocet which allows him to function, controlling his pain without interfering with his ability to function cognitively, and manage his activities of daily living. He described attempts to lower the dosage from eight pills a day to four and the consequences of that, which led to his current level of six tablets per day. His testimony was supported by the reports and chart notes of [family doctor], who followed and treated him throughout this time.

These assessments and treatments were recorded and reported in clinical notes and narrative reports from [family doctor] dated July 19, 2011, November 1, 2011, February 1, 2012, April 4, 2012, March 19, 2015 and September 6, 2016.

The Appellant also described trying other medications, such as anti-inflammatories, which were not covered by MPIC and are not the subject of this appeal, but appear to be part of the management of his shoulder condition. He also testified regarding his need for Biaxin to deal with frequent bouts of pneumonia which he believed were connected to the punctured lung he suffered in the MVA. The question of reimbursement for these medications was not the subject of this appeal and are not before this panel, but the Appellant was advised that he could still make a separate claim with MPIC for reimbursement for these medical expenses and could

contact his case manager to have the use of these medications, their possible connection to his MVA injuries and whether he is entitled to reimbursement, considered by MPIC.

When the surgeon was investigating the possibility of whether the Appellant's shoulder complaints might involve a rotator cuff tear, [MPIC healthcare services medical consultant #2] reported on September 19, 2012 that patients with rotator cuff tears do not require ongoing use of multiple mediations to minimize symptoms, and that occasional use of over the counter analgesic medication should suffice.

The panel has also given careful consideration to [MPIC Health Care Services medical consultant]'s comments regarding the use of opioid medications. Some of his comments related to use of such medication for the Appellant's back pain and the non-compensable nature of that condition, which pre-existed the MVA. However, the panel accepts the testimony of the Appellant that he also uses this medication for shoulder pain, and [MPIC Health Care Services medical consultant]'s report of May 8, 2019 recognized that "the Endocet has also been prescribed for the patient's shoulder pain which is causally related to the MVA."

On April 27, 2020, [MPIC Health Care Services medical consultant] addressed this again, stating that:

> Endocet, a short acting opioid analgesic, has not been established as a safe and effective long term treatment for the compensable injuries. Tolerance, dependence, opioid induced hyperalgesia and significant side effects exist which limit its effectiveness.

The Appellant described his experience with trying other forms of medication and pain control, such as anti-inflammatories, and the described side effects he experienced. He displayed an awareness of the possible side effects which can result from the extended use of opioids. He said

that while working in the hospital system he had seen the possible problems that can arise and that he had discussed this with his doctor. On April 3, 2018, [family doctor] recorded a clinical note reflecting her discussions with the Appellant regarding his use of the medication and guidelines for opioid use

> … Oxycocet to 7/d; discussed opioid guidelines. RTC as directed.

The panel appreciates [MPIC Health Care Services medical consultant]'s comments regarding the general safety and effectiveness of opioids as well as his concern for potential side effects. We do not minimize these genuine, well-recognized concerns. However, the evidence shows that the Appellant's doctor has closely followed and managed this aspect of his care and treatment. The Appellant's awareness of the potential side effects reflects this consultation, which was documented in her clinical notes. His doctor has had the advantage of assessing and treating the Appellant over time, evaluating the effect of medication at various levels and she has continued to prescribe Endocet for him at the current level. While [MPIC Health Care Services medical consultant]'s evidence addresses general concerns with this medication, these concerns have not been directly applied to the particular circumstances of the Appellant's condition. The evidence shows that his own doctor has addressed these general concerns with him, while continuing to prescribe the medication at levels which she has determined through ongoing treatment, assessment and consultation with her patient.

Accordingly, with this evidence, the Commission finds that the Appellant has met the onus upon him of showing, on a balance of probabilities that Endocet medication, as prescribed for him by his doctor for management of his shoulder condition, is medically required as a result of injuries sustained in the MVA. He is therefore entitled to reimbursement for expenses and ongoing funding of this medication. The matter will be referred back to his case manager for a

determination of the amount of reimbursement owed. The Commission will retain jurisdiction should the parties have any difficulty at arriving at or agreeing to the appropriate amounts owing.

Disposition

The Commission therefore upholds the Internal Review Decision dated January 29, 2015 and case manager's decision dated September 25, 2018. The Appellant's appeal seeking further Permanent Impairment awards for his shoulder, hip and knee is dismissed.

The Commission finds that the decision dated August 23, 2017 should not be upheld and that the Appellant's appeal seeking funding for the medication Endocet, as prescribed by his doctor, is allowed. The Appellant will be entitled to reimbursement and ongoing funding for these medical expenses, and the matter shall be referred back to his case manager for assessment of the amounts owed to the Appellant in this regard.

Dated at Winnipeg this 7th day of October, 2020.

LAURA DIAMOND

PAMELA REILLY

DR. LORNA TURNBULL