Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-15-189

PANEL:	**Laura Diamond, Chairperson** **Janet Frohlich** **Guy Joubert**
APPEARANCES:	**The Appellant, [text deleted], appeared on his own behalf (assisted by his daughter, Appellant's daughter)** **Manitoba Public Insurance Corporation ('MPIC') was represented by Steve Scarfone.**
HEARING DATE:	**February 12, 2020 and February 13, 2020**
ISSUE(S):	**Whether the Appellant's current medical condition and supporting medical evidence on MPIC's claim file establishes a causal relationship between the injuries the Appellant sustained on October 18, 2004 which in turn would allow for entitlement to PIPP benefits including IRI.**
RELEVANT SECTIONS:	**Section 70(1), 71(1) and 110(1) of The Manitoba Public Insurance Corporation Act ('MPIC Act')**

AICAC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE APPELLANT'S PRIVACY AND TO KEEP PERSONAL INFORMATION CONFIDENTIAL. REFERENCES TO THE APPELLANT'S PERSONAL HEALTH INFORMATION AND OTHER PERSONAL, IDENTIFYING INFORMATION HAVE BEEN REMOVED.

Reasons For Decision

Background:

The Appellant was injured in a motor vehicle accident (MVA) on October 18, 2004. As a result, he reported low back pain radiating down the left leg as well as swelling to the left lower leg.

On November 6, 2004, a lumbosacral spine X-ray indicated mild disc narrowing at the L4-5 level with mild osteophyte formation throughout the lumbar spine but no significant abnormality detected in the facet joints. On November 17, 2004, a second lumbar spine X-ray showed discopathy at the L5 level.

The Appellant had a history of being treated for gout of the lower left extremity for years before the MVA. He experienced flare ups of symptoms which could often be acute. He had also been diagnosed with osteoarthritis of the left knee. On November 6, 2004, a left leg venogram was also conducted. Test results showed no evidence of deep venous thrombosis.

At the time of the MVA the Appellant was a car salesman whose tasks included the sale and leasing of vehicles. He had been working with the same company since May 2001 and continued to report to work following the MVA until November 13, 2004. He was then classified as a full-time earner for receipt of Income Replacement Indemnity (IRI) benefits from MPIC.

The Appellant's injury was treated with physiotherapy and chiropractic care and by his family physician with medication. He was seen by an orthopedic surgeon and also received treatment for his gout. A gradual return to work program was initiated in February and March 2005. The Appellant did well but experienced some mild residual pain. In June 2005 he was able to be at work at full function with symptoms and was advised to incorporate frequent postural changes and to use an Obus form when sitting at work.

In September 2005, the Appellant's family physician, [text deleted] documented further radicular pain and symptoms and the Appellant's work hours were decreased to half-time as a result. Further relapses of acute symptoms, including radiculopathy and back pain (as well as flare ups

with left lower extremity and gout) continued in the intervening years and interfered with the Appellant's ability to work.

In December 2007, the Appellant was involved in another MVA which exacerbated his lower back symptoms, left leg pain and paresthesia. The Appellant experienced further periods where he was unable to work.

On October 3, 2008, MPIC conducted a Residual Capacity Determination which set out the Appellant's ability to work on a sedentary basis. Based upon his work related experience, level of function, skills and abilities, alternate employment as a "mortgage broker" was determined for him and he was provided with IRI benefits for a period of one year to accommodate job search (until October 3, 2009). However, the Appellant does not appear to have ever been employed as a mortgage broker following this determination. He continued to try to work as a vehicle salesman.

The Appellant continued with treatment from his family physician and attended for chiropractic treatment. On May 4, 2010, [Appellant's family physician] indicated that the Appellant would not be capable of performing any duties greater than sedentary work due to significant pain symptoms which required him to avoid sitting for long periods of time and difficulty driving due to pain in his back and leg. He had authorized time off related to the MVA since March 22, 2010.

A medical consultant with MPIC's Health Care Services team reviewed the Appellant's file on July 6, 2010 and opined that the Appellant could and should return to active employment and that he was able to perform the required tasks of a mortgage broker. A multi-disciplinary assessment at [rehabilitation center] in August 2010, resulting in a discharge assessment by [text

deleted], physiatrist, on December 1, 2010 indicated that the Appellant's physical abilities were consistent with the ability to undertake sedentary office work on a full-time basis without restrictions, having achieved the medium level of strength allowing for lower levels of physical ability on a day-to-day basis.

In July 2011 a second reconditioning and work hardening program was also set up for the Appellant at [physiotherapy center]. A discharge report dated August 22, 2011 indicated that the Appellant could return to light duties, including lifting up to 10 pounds, with no reduction in work hours.

MPIC's medical consultant then reviewed these reports and indicated that the Appellant was capable of returning to the workforce.

The Appellant was involved in a further MVA in December 2011. This was followed by a relapse and symptoms and the Appellant remained off of work through August 2012.

A further review by MPIC's medical consultant indicated that there was no documented indication as to why the Appellant currently remained off work in September 23, 2013. An Independent Medical Examination (IME) was conducted by [text deleted], physiatrist, on March 27, 2014. [Physiatrist #2] indicated that based on his review of the file and his examination, he would not place restrictions on the Appellant's ability to work on a purely musculoskeletal basis, as he could not relate his current presentation to the MVA of October 18, 2004. This was reviewed by an MPIC medical consultant who concluded that in her opinion there was no collision related medical condition precluding the Appellant from returning to full-time sedentary employment. However, the Appellant continued to receive biweekly IRI benefits. The

file was then reviewed again by the medical consultant on March 3, 2015. She noted that the Appellant had required medical attention for a chronic unrelated painful condition of multi-joint gout but that [physiatrist #2] had found no significant clinical evidence of neurological or musculoskeletal pathology to account for the Appellant's lower back disability. She was unable to account for the Appellant's ongoing disability being the result of MVA related injuries.

This was followed by a case manager's decision dated April 21, 2015 ending the Appellant's Personal Injury Protection Plan (PIPP) benefits, with an extension of IRI benefits to August 20, 2015 to assist in the transition to an alternate means of financial assistance, such as Canada Pension Plan Disability (CPPD) benefits.

The Appellant sought an internal review of his case manager's decision. [Appellant's family physician] provided a narrative report dated July 6, 2015 which indicated that there was a causal relationship between the Appellant's MVA and his low back pain with radicular symptoms. This impairment prevented him from returning to his previous work. He opined that the Appellant was currently unable to perform any heavy work or work that would require prolonged walking, standing, repetitive bending, twisting or crouching.

The Appellant's chiropractor, [text deleted], also provided a report dated July 1, 2015 indicating that the Appellant had significant impairment related to his two MVAs, was not able to work and was permanently disabled as a result of the MVAs.

An Internal Review Officer (IRO) for MPIC provided an Internal Review Decision (IRD) on July 22, 2015 which upheld the case manager's decision. She noted that the Appellant had been determined into a sedentary job and found that his MVA related injuries did not prevent him

from working as a mortgage broker. Any ongoing disability in the last number of years was a result of an unrelated chronic painful disease condition and was not MVA related.

It is from this decision of the IRO that the Appellant now appeals.

Issue Under Appeal:

The issue before the Commission is whether the Appellant's current medical condition (after April 20, 2015) was causally related to the injuries sustained in the MVA of October 18, 2004, which in turn would allow entitlement to PIPP benefits following that date, including IRI after August 20, 2015. The Appellant's position is that the December 2007 and December 2011 MVAs further impacted his 2004 MVA related injuries.

Disposition:

The Commission finds that the Appellant has not met the onus upon him of establishing that his condition after April 21, 2015 was caused by MVA related injuries or that he should be entitled to further PIPP benefits in this regard.

The Appeal Hearing:

Preliminary and Procedural Matters

At the hearing into his appeal, the Appellant was assisted by his daughter, [text deleted], ["text deleted"]. She also testified as a witness at the hearing. Because the Appellant required her assistance, both parties agreed that [text deleted] would remain in the hearing room while her father testified and that there should be no exclusion of witnesses in the circumstances.

Evidence and Submissions for the Appellant:

Documentary Evidence

The Appellant relied upon various documentation and medical reports contained in his indexed file including the following:

a) [Hospital] X-ray reports:

- November 6, 2004 showing mild disc space narrowing at L4-5 with mild anterior osteophyte formation and no significant abnormality in the facet joints.
- November 29, 2004 showing posterior wedging of disc space at L5, small area of radiolucency, apparent annular tear at L4, shallow lordosis. Impressions were of discopathy L5, facet asymmetry, altered lordosis and listing of the thoraco/lumbar spine.

b) [Text deleted], physiotherapist, report dated November 22, 2004 with diagnosis of low back strain with dural tension, indicating poor tolerance to driving and prolonged standing.

c) [Text deleted], family physician, reports:

- Primary Health Care report dated November 24, 2004 diagnosing L5/S1 disc prolapse.
- Chart note dated January 18, 2005 indicates the Appellant is suffering from left sided radicular pain clinically and on CT scan.
- Progress report dated July 20, 2005 describing decreased range of motion in lumbar spine and dural tension on the left; diagnosing left L5/S1 disc prolapse with nerve root irritation.
- Notes recommending the Appellant be off work or work part time at various periods, and dated: September 6, 2005, September 20, 2005, September 28, 2005, March 22, 2006,

May 24, 2006, September 12, 2006, October 18, 2006, June 19, 2007, July 12, 2007, August 13, 2007, and July 19, 2008.

- Notes recommending chiropractic and laser treatment for the Appellant, and dated: July 14, 2009, November 24, 2009, September 21, 2010, and November 24, 2010.
- Report dated September 1, 2006 describing ongoing lower back pain with radiation of the symptoms down the back of the left leg and pain in the lateral aspect of the right leg with subjective feeling of weakness in the leg. Examination noted slightly antalgic gait on the left side with range of motion in the lumbar spine diminished by about 50% and some dural tension on the left side. These findings continued to be compatible with his previous disc lesion as a result of his MVA. Consultation with [physiatrist #3] was recommended as well as possible consideration to a reconditioning program.
- Report dated March 9, 2010 describing ongoing back pain with intermittent severe episodes. At a recent visit on February 3, 2010 there was a severe flare of his low back pain with radiation to the left leg, gait slightly antalgic on the left side, range of motion of the lumbar spine slightly decreased and normal neurologic exam. [Appellant's family physician] opined that the Appellant continued to be impaired due to low back pain related to either or both of his MVAs while noting significant benefit from chiropractic therapy with laser treatment. He reported that the Appellant had attempted to return to work selling recreational vehicles but had been only able to tolerate return for half days.
- Report dated May 4, 2010 referencing intermittent back pain since MVAs in 2004 and 2007 with symptoms which have increased significantly and persisted since February 2010. Follow-up appointments in March 2010 showed increasing symptoms in the low back and left leg. [Appellant's family physician] opined that he believed these symptoms were causally related to the MVA of 2004 and that the Appellant has been having

intermittent back pain since that time with physical findings correlating with his subjective complaint and limitations. Physiotherapy reports finding myofascial tenderness in the low back area indicate this may be responsible for some of the radicular symptoms. His ongoing difficulties with back pain have significantly limited him in his work and a measurable impairment with decreased range of motion in the lumbar spine and pain symptoms was identified. At this point, the Appellant would not be capable of performing any duties greater than sedentary work but must avoid sitting for long periods of time due to pain symptoms. [Appellant's family physician] had authorized time off related to the MVA since March 22, 2010. As far as his ability to return to a sedentary job, much of this limitation was based on symptoms. If symptoms should resolve significantly, he would authorize return to sedentary duties based on the physical findings as the Appellant was certainly capable of sedentary work. Significant symptoms of late precluded any lengthy travel and would affect his ability to function even at a sedentary job, currently.

- Report dated March 22, 2013 diagnosed ongoing back pain related to the Appellant's MVA, which at that time was associated with a disc prolapse. Physiotherapy treatment and strengthening exercises were recommended and symptomatic benefit with laser treatment noted. It did not appear that the Appellant had a permanent impairment resulting from the MVA, however, he did seem prone to relapses of the back pain caused by the original MVA.
- Report dated July 6, 2015 referenced treatment for low back pain with radicular symptoms to the left leg since MVAs in 2004 and 2007. Since that time the Appellant has had an impairment due to his low back pain and decreased range of motion in the lumbar spine as well as symptoms of radiculopathy into the left leg, for which the doctor

believed the Appellant had been awarded a permanent impairment from MPIC. He noted objective evidence of decreased range of motion in the lumbar spine as well as a CT scan revealing disc lesions at L4, L5 and S5, S1. He opined that there continued to be a causal relationship between the Appellant's MVAs and his low back pain with radicular symptoms, which represented an impairment preventing him from returning to his previous work. He was currently unable to perform any heavy work or work that would require prolonged walking, standing, repetitive bending, twisting or crouching. The doctor acknowledged concerns that the Appellant's current impairment was related to gout rather than the back injuries he sustained in the MVAs but did not agree with that assessment, as the back pain, radicular symptoms and CT findings were all chronologically related to the MVAs. He stated that while the Appellant does suffer from gout on an intermittent basis, mostly with flares in his knees and ankles, he would not expect gout to cause low back pain with radicular symptoms. He concluded that the Appellant had a permanent impairment related to his low back pain that is causally related to his MVAs and the fact that he also suffers from gout should in no way detract from the impairment that he sustained during the MVAs.

d) [Text deleted], orthopedic surgeon, reports:

- Report dated April 13, 2007 described the continuation of back pain and radiating left leg pain after the MVA of October 2004. He reviewed a CT scan showing early stenosis centrally at L4/5 and more crowded lateral recess stenosis at 4/5 with a central bulge at S/1, but no significant entrapment. The Appellant's continued attempts to work as a car salesman with great difficulty walking or sitting, bending straining and lifting were described, as well as pain down his left leg toward the left ankle. The doctor described

spine compression discomfort and some tenderness. He advised that he was not convinced the Appellant needed surgery.

- Report dated July 9, 2007 indicated the Appellant's X-rays showed degenerative wear especially at L4/5 and L5/S1 but no instability on flexion/extension views. His June 19, 2007 MRI did not show any significant intra-spinal canal pathology or nerve entrapment that would suggest surgery to help. The doctor recommended continuing to work on building up core abdominal and back muscles.

e) [Text deleted], physiatrist, report dated October 28, 2006, diagnosed a central L5-S1 disc herniation with a symptomatic recurrence of S1 radicular pain. After describing objective clinical findings and therapeutic recommendations, [physiatrist #3] indicated that the Appellant's condition did not preclude travel to and from the workplace or interfere with the essential tasks of his occupation. He indicated that it was improbable that participating in the essential tasks of the occupation of salesperson would adversely affect his long-term prognosis but that it was possible, as is consistent with patients who have disc herniation, that he would become increasingly symptomatic if required to sit for prolonged periods.

f) [Text deleted], Health Care Services team medical consultant, email and file notes dated February 10 and September 27, 2012 described L5/S1 disc herniation with S1 radicular pain from the 2004 MVA, with several relapses over the years. Advice from chiropractor [Appellant's chiropractor] on January 4, 2012 that the Appellant was temporarily disabled from employment was considered. [MPIC's HCS medical consultant] advised that the medical information was consistent with relapse and the period of January to May was reasonable for being unable to

work. It was also reasonable to extend this back from December 15, 2011 to January 2012 when he was first able to see the chiropractor for assessment.

g) [Text deleted], Director of Health Care Services, report dated November 4, 2005 indicating that the nature of the Appellant's back condition (stemming from the MVA) can result in periodic flare up of pain and it was therefore plausible that periodic time loss could occur.

h) [Text deleted], [medical clinic], report dated December 28, 2012 described the Appellant's main complaint of lower back pain and cough and reported history of suffering an MVA with persistent lower back pain ever since. The Appellant also reported having an MVA in December 2011 and since then developing pain on the left side of his back that radiates to his left leg. The diagnosis of chronic lower back pain, L1 and L2 compression fracture with possible nerve root irritation was provided. It was noted that he has L1 and L2 compression as well as facet degeneration and will be left with these permanent changes.

i) [Text deleted], medical consultant with Health Care Services, report dated March 19, 2014 confirming MVA related injuries of L5-S1 disc herniation with S1 radicular pain and ongoing sciatic pain down the right leg. A Permanent Impairment (PI) benefit of 3% was awarded to the Appellant for these injuries.

j) [Text deleted], chiropractor, reports:

- Chiropractic track reports dated November 18, 2010 and July 27, 2012 described symptoms of lower back and hip, left leg and mid back pain which the chiropractor believed showed the patient had reinjured his 2004 MVA back injuries. The patient's ongoing symptoms of neck pain, lower back pain, left leg pain, upper back pain and knee

pain responded well to treatment in February 2012 but then the patient deteriorated. A chiropractic track report dated August 28, 2014 also diagnosed radicular back pain and compensating mechanical SI pain.

- Report dated July 1, 2015 summarized chiropractic treatment to the Appellant since he first attended [Appellant's chiropractor]'s office in January 2006 for complaints related to a 2004 MVA. His most prominent injury was lower back pain and left leg pain, and a CT scan completed in December 2004 revealed a small disc herniation contacting his S1 nerve root. He thought the Appellant had disc irritation with nerve root compression in 2006. Following the Appellant's second MVA he reported moderate to severe left back pain with left leg pain and an obvious L5-S1 nerve root irritation. The subsequent diagnosis was disc irritation L5-S1 nerve compression (left) and myofascial tension. He continued to suffer from left leg and lower back pain with left sciatic leg pains and reduced left ankle reflex. [Appellant's chiropractor] had examined the Appellant over the last nine years with findings always consistent with L5-S1 radiculopathy. His neurological condition deteriorated slowly over the nine years, with more expansive leg symptom deterioration now. He had bilateral piriformis muscle hypertonicities and considerable difficulties walking and getting up from a seated position. He was unable to lift or carry anything heavy and had a significant impairment related to the two MVAs that he was involved in. As such, he was not able to work and was permanently disabled as a direct result of the MVAs.
- Report dated July 8, 2018 reviewed the Appellant's background as well as [physiatrist #2]'s IME report, and provided comments. [Appellant's chiropractor] disagreed with [physiatrist #2]'s conclusions emphasizing a lack of pre-existing disc narrowing, clear rapid deterioration of the lower L5-S1 disc and lack of normal ankle reflex on the left

side. A February 2016 MRI was also reviewed, which confirmed deterioration of the disc from a small herniation to a broad-based protrusion with both nerve roots now affected. [Appellant's chiropractor] concluded that the Appellant was injured in 2004 when he injured his lower disc. Since the MVA his disc had been symptomatic and deteriorated. This worsening caused him to lose functional ability in his lower back and he continued to suffer from this lower back injury. In his view, the lower back was limiting the Appellant and still a result of the MVAs. The Appellant had quite a clear picture of deterioration of a damaged disc for which he received an impairment award. He has had difficulty working and been unable to work because of his back injury, as sedentary or sitting is difficult for lower disc injuries and not recommended or advisable.

- Report dated March 13, 2019 reviewed an independent chiropractic examination report from [chiropractor #2]. [Appellant's chiropractor] reiterated that the Appellant's ankle neurology deteriorated over time as a function of his lower disc continuing deterioration. The Appellant had responded symptomatically to regular chiropractic care although the lower disc was damaged and did deteriorate. [Appellant's chiropractor] noted the Appellant's probable depression and anxiety as consequences of his four MVAs and his plight in continually trying to prove he was injured to MPIC, referencing probable PTSD. Once again, he referred to new information in the February 2016 MRI which revealed a deterioration in the Appellant's lower spine disc. He indicated that the Appellant was receiving non-curative chiropractic care in a supportive role.

Evidence of the Appellant

The Appellant testified at the hearing into his appeal. He described the MVA of October 18, 2004 when his car was T-boned. At that time he was working as a car salesman and was the top

salesman at his dealership. He had been attending a chiropractor regarding a subluxation on his right side due to an earlier (1995) [province] MVA injury. After the October 2004 MVA he saw his chiropractor, who took X-rays and identified that the right subluxation had now become left sided. He attended for physiotherapy and then saw his family doctor. He also had assessment for a blood clot to his legs, which was negative.

He indicated that the chiropractic treatment was not working for him and that is why he went to see his family doctor. By the week after the MVA he could not walk straight because of his leg and back, and he could not work at all. He had some treatment with the physiotherapist [text deleted] and then went back to work at the dealership before 2007, although he could not remember exactly when.

He was in another MVA in 2007 for which medication (Arthrotec) was prescribed, along with exercises. He was in another MVA in December 2011.

At this point he was working half days and receiving IRI benefits for half-time. In 2008 he had been determined by MPIC as a mortgage broker, but he was still working as a car salesman with some reduction of IRI. In 2012 he went to work for a different dealership for a while. He was also suffering some symptoms in his big toe, as a result of his gout, but [rheumatologist #1] was helping with that.

The Appellant recalled his independent examination with [physiatrist #2] in 2014. He explained that he was in a lot of pain that day. His chiropractor, [text deleted] did not agree with [physiatrist #2]'s report.

The Appellant recalled receiving a permanent impairment benefit of 3% from MPIC. But he was not working in April 2015 due to his back and sacroiliac problems. He said that he did not have gout in 2015 and that he did not have depression at that time. He was receiving laser treatment from [Appellant's chiropractor], which helped. He had another MVA in 2017 but had not seen [Appellant's chiropractor] since that time as he does not have money and is destitute. He has not worked since then and cannot work because of his injuries.

On cross-examination, the Appellant confirmed that he went to [hospital] after the October 2004 MVA for a venogram, as [Appellant's family physician], from the [medical center] was concerned about a blood clot. He said [Appellant's family physician] was his wife's doctor. He also had chiropractic treatment. He confirmed that he worked for a few days after the MVA and saw his chiropractor but did not go to see [Appellant's family physician] for a few months. He worked on and off, selling cars but not full-time, until about November 13, 2004.

When asked whether he had been treated for gout by [Appellant's family physician] and before the 2004 MVA, the Appellant was not responsive to counsel for MPIC's questions. He finally confirmed that he had been treated with Colchicine for gout. He stated that he was not happy with [Appellant's family physician]'s mismanagement of his gout condition.

The Appellant confirmed that he suffered from sciatica in his left leg and that this prevented him from working at times, missing 2 to 3 days per month due to the sciatic problems. When asked about a chart note on the index file from [Appellant's family physician] dated February 22, 2000 which recorded impressions and recommendations suspecting a persistent low grade gout condition affecting his ankles and toe, the Appellant stated this must be for his big toe. He denied having experienced the mild to widespread osteoarthritis referred to and also denied the

reference to mechanical neck and lower back pain, indicating that he had had no neck pain since he hurt his neck in the 1995 [province] MVA.

The Appellant confirmed that his duties at the dealership involved selling or leasing cars to customers. He had his own office with a computer and would meet customers on the lot and in his office. He would take them out for demo test drives, negotiate prices and get instructions from the manager's office. He would prepare lease and sale documents for signing by the customer, often handwritten. He had some duties moving, washing and clearing snow off cars, prepping them for delivery to customers and filling up the gas tank.

The Appellant was asked about a previous job as a mortgage broker in [province] and he described difficulties in doing that job without a license, which would require him to work for somebody else. He confirmed that he had never sought an Internal Review to challenge the decision determining him as a mortgage broker. He was asked to describe his 2007 MVA when he was stopped at a light and rear ended, hurting his lower back again. He reported this to MPIC and continued treatment with [Appellant's chiropractor].

He described his 2011 MVA when he hit a parked vehicle and his front bumper was damaged. He hurt his back again but did not attend for physiotherapy. He did some home exercises and saw [Appellant's chiropractor] twice a week which was later reduced to once a week. He maintained that he still routinely does home exercises. However, he disagreed that before these relapses his back pain was improving. Treatment was not helping.

The Appellant confirmed that in March 2005 he returned to work half days on a part-time basis. He had an assistant to help him with duties but his symptoms returned, he couldn't work and his

IRI was reinstated. He hurt his back again, at work, in 2012 while demonstrating a standard transmission for a customer. He went off work again, but indicated that his benefits were not reinstated. Counsel for MPIC reminded him that he was paid benefits until 2015, but that a Health Care Services report dated March 2015 indicated that he had made no visits to his doctor about his MVA injuries for at least two years. The Appellant disagreed, indicating that he had received medication from [Appellant's family physician] and complained about his MVA injuries to his manager at the dealership at that time.

The Appellant confirmed his attendance at [rehabilitation center] and the strength and exercise routine there. When asked about [physiatrist]'s conclusion that he had reached a medium strength level upon discharge, the Appellant indicated that the report is wrong and he did not agree, because he didn't finish his rehabilitation.

When asked about his case manager's recommendation that he explore disability benefits with the government of Canada, the Appellant indicated that he did not apply because his doctor was asking for the paperwork and he had not provided it. He indicated that it was difficult to deal with these matters and the paperwork involved because he was on his own and living alone.

Evidence of [text deleted] (Appellant's Daughter)

The Appellant's daughter, [text deleted], testified at the appeal hearing. She indicated that she wished to give an impression of how her father was before the MVA and how he is today, to show the impact of the MVAs. She recounted her memories of him prior to October 2004 when she was living at home with her younger sister and her father had been working in car sales in Canada for a long time. Prior to that he had worked for the [text deleted] in [city] and then [province] and she remembered him doing very well working at various dealerships in car sales.

It was a seven day a week job and the family was well provided for, with her father working eight hour days and late evenings, even taking calls from clients at home. It was physically and emotionally demanding and involved working evenings, weekends and holidays but he was very independent in his work and had a good working history with the owner of the dealership. He was involved in the [text deleted] community, had a strong work ethic and was in good health. He had no problems overall. He was a very social man involved in community events and the family would take long family drives out west for vacations, which he tolerated with no problems.

After the MVAs he experienced a lot of back pain, muscle aches and difficulty sitting for long periods of time without repositioning. He had difficulty working long hours sitting as a salesman and attending to details like taking snow off the cars and moving them. He couldn't even sit through church services. Because of the pain, he needed to rest a lot and attend a lot of medical appointments for treatments. He uses heating pads, lumbar supports and medication. Even today his kitchen table is loaded with pill containers. He suffers from insomnia and a lack of restful sleep, he is easily agitated and not the happy, friendly type of man he used to be.

After the first MVA, [text deleted] no longer lived in the house and her mother was diagnosed with rheumatoid arthritis, which added to their hardship. She noticed a difference in her father's ability to carry her young children, comparing it to how it used to be with the older children of her brother. He had weakness in his arms and legs and pain. She feared he may be suffering from PTSD. He is struggling and in pain, needs treatment for his back and without income and benefits. The family is not able to provide for him. It is now 2020 and he has been without income since 2015. No assistance was given to her father to become a mortgage broker as determined. At 65 this would be a difficult new occupation and big transition. Car sales is

physically demanding and the stress of loss of income and loss of meaningful work has drained her father.

On cross-examination, [text deleted] admitted that she had never worked with her father and could not give first-hand information about what it is like to be a car salesman. But she noted that her parents would come home and talk about their jobs and she had been to the dealership on various occasions.

She also admitted that even before the second MVA, when she was still living in the home, her father often had to get up and move around during church services, due to his symptoms. He wouldn't have been able to sit comfortably for an extended period of time. She noted that during the appeal hearing, she could see signs of his discomfort when sitting. She had seen more deterioration than improvement over the years between 2006 and the present date. She admitted that her father is also more easily agitated than he used to be, which could in part be a result of his not sleeping well.

Evidence for MPIC:

Documentary Evidence

MPIC relied upon various documentation and medical reports contained in the Appellant's indexed file, including the following:

a) [Text deleted], orthopedic surgeon, reported on July 9, 2007 indicating that the Appellant's April X-rays showed degenerative wear but no instability on flexion oblique extension views. The MRI of June 19, 2007 did not show any significant intra-spinal canal pathology or nerve

entrapment that would suggest surgery. He advised that it was critical for the Appellant to continue to work on building up his core abdominal and back muscles.

b) [Text deleted], physiatrist, report dated October 28, 2006 diagnosed a central L5-S1 disc herniation with a symptomatic recurrence of S1 radicular pain. Epidural injections were recommended for symptoms. [Physiatrist #3] opined that the Appellant's current condition did not preclude travel to and from the workplace or interfere with the essential tasks of his occupation. He indicated that it was possible that the Appellant will become increasingly symptomatic if he was required to sit for prolonged periods, as is consistent with patients who have disc herniation

c) Senior case manager's Determination of Employment Based on Residual Employment Capacity dated October 3, 2008 noted that the Appellant's injuries prevented him from returning to his pre-accident employment as a salesperson and that a residual earning determination had been completed based on his residual capacity to hold alternate employment. Referencing a transferrable skills analysis and labour market survey which had been completed by a vocational rehabilitation consultant, alternate employment opportunities were identified that the Appellant had the capacity to hold. In order to determine suitable alternate employment, work history, education, transferable skills and physical abilities were identified. Based upon the Appellant's work experience, level of function, and skills and abilities suitable, the alternate employment was identified from the National Occupational Classification (NOC) and determined as a "Mortgage Broker". (The Appellant did not seek an internal review to challenge this decision regarding determined employment.)

d) [Text deleted], MPIC Health Care Services medical consultant, reports:

- Report dated July 6, 2010 noted the Appellant's prior history of mechanical lower back pain and his long-standing relationship with [Appellant's family physician] between 2000 and 2004. Although the Appellant reported being significantly disabled since the 2004 MVA, the underlying cause of his failure to improve was not evident from the documentation review. Due to an absence of objective findings, there was little or no organic pathology to explain the persistence of the Appellant's reported back symptoms and left leg referral pain and a paucity of objective findings to dissuade the Appellant from attempting active rehabilitation and effort to return to gainful employment at least at a sedentary level. This would include the required tasks of a mortgage broker.
- Report dated October 19, 2011 reviewing the Appellant's work on improving his functional capabilities with the goal of returning to the workplace in a sedentary capacity. Opinions from [rehabilitation center] ([physiatrist] and his team) and by physiotherapist [text deleted] indicated that the Appellant was capable of returning to the workforce. A return to work was well within his physical capabilities and would be the next appropriate step for him.
- Report dated September 23, 2013 noting that there was no documented indication as to why the Appellant currently remains off work and that there had been no change in his collision related medical status that would render him work disabled for an extended period of time.
- Report dated June 17, 2014 reviewing the IME report completed by [physiatrist #2], indicating that there was no collision related medical condition precluding the Appellant from returning to full-time sedentary employment.
- Report dated March 3, 2015 noting that the Appellant had not perceived a need to visit [Appellant's family physician] in the past couple of years for injury secondary to the

MVA. She noted that he required medical attention for a chronic unrelated painful condition of multi-joint gout, with documented support for the gout condition being painfully disabling. She once again noted [physiatrist #2]'s opinion that there was no significant clinical evidence of neurological or musculoskeletal pathology to account for the Appellant's lower back disability and as such, based on a medical document review, she was unable to account for the Appellant's ongoing disability being the result of MVA related injuries. In particular, with the extensive passage of time since the MVA, during which he required active treatment for an unrelated chronic painful disease condition, the Appellant presented as having an unrelated chronic disabling medical condition.

e) [Rehabilitation center] reports:

- Reconditioning Program Discharge Report dated November 28, 2010 and clarification letter dated December 1, 2010 indicated that following a reconditioning/rehab program the Appellant demonstrated increased physical abilities with an overall functional level increased from sedentary to medium level. His job was rated as sedentary in terms of physical demands and he would be physically capable of returning to that job from a musculoskeletal point of view. The clarification letter noted that at the time of discharge the Appellant's physical abilities would be consistent with being able to undertake sedentary office work on a full-time basis without restrictions. As he had achieved the medium strength level, this would mean that lower levels of physical ability would be easy for him to manage on a day-to-day basis.

f) [Text deleted], physiotherapist, [physiotherapy center], discharge report dated August 22, 2011, (following a reconditioning program) indicated that the Appellant was able to complete all

exercises asked of him. His reports of left leg radiating pain were not supported by the assessment findings and did not always match the functional ability of the patient. Based on his ability to complete the exercises and weights asked of him and his demonstration of correct body mechanics, the physiotherapist recommended that he returned to light duties, including lifting up to 10 pounds. No reduction in his work hours was recommended at that time.

g) [Text deleted], physiatrist, IME report dated March 27, 2014, following a file review and examination of the Appellant. [Physiatrist #2]'s impressions included the observation that at this examination, he was unable to determine an impairment and subsequent disability on a purely musculoskeletal basis. Given the examination, he was unable to determine a pathoanatomical basis for the persisting symptoms. Upon a review of the medical information submitted, he concluded that it was more likely than not that the Appellant has episodes of gout and subsequent polyarthalgia, although there was no further evidence on a clinical basis of gout or a lumbar radiculopathy at the examination.

[Physiatrist #2] noted that the Appellant had not reported the MVA in visits to the ER, family physician or walk-in physician shortly after the date of the MVA. Given the lack of a pathoanatomical diagnosis at that time and the temporal incongruities, he was unable to relate to the Appellant's current presentation to the MVA of October 18, 2004. Although the Appellant had documented episodes of gout and radiological findings of degenerative changes, these did not appear to be clinically apparent during the examination. Given this examination, [physiatrist #2] would not place restrictions on a purely musculoskeletal basis.

h) [Text deleted], chiropractor, Third Party Chiropractic Examination report dated December 13, 2018, following a review of the file and examination. [Chiropractor #2]'s impressions included

reference to the MVA of October 18, 2004 when the Appellant apparently sustained soft tissue injuries, primarily in the left lower back region, with evidence of a disc protrusion at L5-S1 as seen on diagnostic imaging. Only one of his caregivers reported a neurological deficit. He was involved in three subsequent MVAs with an exacerbation of symptoms. [Chiropractor #2] assessed widespread pain in the neck and upper back regions along with the lower back area on both sides. A number of non-organic physical signs were listed. He concluded the Appellant had chronic benign recalcitrant pain, primarily in the left lower back which has now migrated to the right lower back, right upper back, right upper limb and right neck.

[Chiropractor #2] also noted a significant past history of problems relative to his right sacroiliac and sciatica prior to the 2004 MVA. He noted problems with the left knee associated with gout, but no mention of back pain or an MVA in the clinical handwritten medical notes from October 22 and November 15, 2004. Emergency attendance notes from November 2004 made no mention of his MVA.

[Chiropractor #2]'s diagnosis was of a soft tissue injury consistent with Whiplash Associated Disorder II followed by a likely exacerbation of symptoms in three subsequent accidents. The response to all forms of care had been poor with recalcitrant pain; he had reached maximum therapeutic benefit and maximum medical improvement.

While noting the 3% impairment awarded by MPIC for an L5-S1 disc herniation, [chiropractor #2] noted that, regarding the issue of disability, the Appellant was having significant problems with polyarticular lower limb arthritis secondary to gout, at the time of the accident, which would be a co-morbid condition which has affected him throughout the years. Depression was

also noted as a co-morbid condition with consideration urged for a psychiatric evaluation as depression and sleep disturbance can enhance pain and disability.

i) [Text deleted], rheumatologist, [hospital], reports:

- August 29, 2007 queries possible diagnosis of gout, medication prescribed, and bloodwork.
- November 7, 2007 diagnosis hyperuricemia and gout, prescribed increase in medication and follow-up
- December 12, 2007 gouty arthritis with hyperuricemia, elevated uric acid level, recurrent gouty attacks and erosive changes on X-ray, prescribed increase in medication.
- June 4, 2008 polyarticular gout, emphasized importance of taking medication as prescribed, expected uric acid level to be high.
- August 13, 2008 hyperuricemia/gout, advised Appellant to bring medication to next visit to review dosage.
- September 17, 2008 continued recurrent attacks of gout, increased medication.
- February 25, 2009 follow-up for gout flare up over the last three months.
- July 3, 2009 episodes of pain in the right knee. Attempts to explain the management of gout to the Appellant without success were noted, especially regarding taking medication on a regular basis. Failure to do so can have quite detrimental effects and compliance with medication was emphasized for the Appellant, whose uric acid levels increased between August 2007 and February 2009, due to suspected non-compliance with the medication.

j) [Text deleted], rheumatologist, [medical center #2], reports:

- November 21, 2011 reports four year history of gout with increasing episodes and additive joint involvement. Polyarticular gout with elevated uric acid. The Appellant has been taking his Allopurinol medication intermittently and inappropriately. It was explained to him that he needs to take the medication on a consistent basis, as the fluctuations in the uric acid level are the main cause of acute flares.
- July 16, 2012 the Appellant was doing well as far as gout and should remain on the medication. He was encouraged to remain active and do regular stretching and strengthening exercises.
- March 18, 2013 unfortunately the Appellant discontinued his medication sometime in mid-January 2013 and began having pain in knees and ankles. Without significant relief he was admitted to [hospital]. On exam he looked haggard and pale and mobilized with difficulty. He was counselled to be compliant with his medication.
- June 3, 2013 the Appellant was feeling better with some discomfort in knees, ankles and feet. He still was not compliant with Allopurinol medication, and [rheumatologist #2] expressed frustration. It was recommended that he continue on his other medications while the Allopurinol is titrated and that it should not be discontinued.

k) [Text deleted], [hospital], report dated March 13, 2013 describes the Appellant's admission to hospital for decreased mobility and painful joints as a result of acute gouty poly arthropathy. It was recommended that he restart his Allopurinol medication once symptoms settle.

l) [Text deleted], chiropractor, Health Care Services report dated March 26, 2019 reviewing reports of doctors [MPIC's HCS medical consultant #3], [chiropractor #2], [physiatrist #2], [Appellant's chiropractor] and [Appellant's family physician] and concluding that the Appellant

had reached maximal medical improvement, noting poor response to a robust trial of treatment over a lengthy period as well as a co-morbid history of gout and pre-accident history of lower back/sciatic problems.

m) Letters written by the Appellant and sent to his case managers.

Submission for the Appellant:

The Appellant's submission was presented by his daughter, [text deleted]. She submitted that the medical letters and reports on file are in conflict with the IRD stopping the Appellant's IRI and PIPP benefits. She noted a large amount of documentary evidence showing that the Appellant experienced pain and injuries from the 2004 MVA. In mid 2015, when his benefits ended, he was still experiencing pain enough to prevent him from working and requiring treatment related to the MVAs.

In support, she referred to [Appellant's chiropractor]'s report of July 1, 2015 which indicated that he had been treating the Appellant since 2006 for complaints related to the 2004 MVA. He identified reduced left ankle reflex which showed disc irritation with nerve root compression. [Appellant's chiropractor], she noted, has a long history with the Appellant and was consistent in seeing his condition not long after the MVA and in later years. He reported the Appellant was suffering leg pain and L5-S1 nerve root irritation following the second MVA. His reports showed that the Appellant continued to suffer from back and sciatic problems in January 2012 and low back left leg pain with further neurological deterioration into July 2014. His statement that he has examined the Appellant for nine years and that he has always consistently shown problems with back pain and neurological deterioration over the nine years supported his

conclusion that the Appellant had a significant impairment related to the MVAs, was not able to work and was permanently disabled as a direct result of the MVAs.

A later report from [Appellant's chiropractor] dated July 8, 2018 reviews his history of attending the Appellant, going all the way back to the initial examination. This provides consistency of reporting over the years. The report confirmed that a disc injury can get worse and deteriorate over time and that the Appellant's subsequent injuries seem to have made his lower disc worse and worse over time. The report confirms the relationship of the Appellant's condition to the MVAs and he comments upon [physiatrist #2]'s views, with which he disagrees. [Appellant's chiropractor] points out CT scan evidence of herniation contacting the nerve root in December 2004. Later, in 2005, a CT found deterioration and compression. This contrasts with [physiatrist #2]'s comment that the Appellant did not have deterioration or degeneration in his lumbar spine. [Appellant's chiropractor] also disagreed with [physiatrist #2]'s comment that the Appellant had normal reflexes on repetitive testing, stating that the Appellant has never had a normal ankle reflex on the left side. He disputed [physiatrist #2]'s finding of full lumbar range of motion, concluding that the Appellant's disc was symptomatic and deteriorated, a current condition related to the MVAs. He was unable to work because his back injury prevented him from sitting for long periods.

[Appellant's chiropractor]'s report of March 13, 2019 reviewed [chiropractor #2]'s report but noted that the Appellant had a damaged and deteriorated lower disc, confirmed by a February 2016 MRI, for which he received an impairment award from MPIC. He also described the Appellant's probable depression and anxiety, as well as probable PTSD, relating to the MVA and his plight with MPIC.

[Appellant's family physician]'s reports also provided support for this position. She pointed to his report dated July 6, 2015 which indicated that he had been treating the Appellant since the MVAs of 2004 and 2007. [Appellant's family physician] opined that there continued to be a causal relationship between the Appellant's MVAs and his low back pain with radicular symptoms which represented an impairment preventing him from returning to his previous work. This was supported with objective evidence and he concluded that the Appellant has a permanent impairment related to his low back pain that is causally related to his prior MVAs. The fact that the Appellant also suffers from gout should in no way detract from his impairment that he sustained involving the low back during his MVAs in 2004 in 2007.

[Text deleted]'s report of December 28, 2012 diagnosed chronic lower back pain with compression fracture and possible nerve root irritation.

[MPIC's HCS medical consultant]'s report dated October 2, 2012 confirmed an L5/S1 disc herniation with S1 radicular pain from his 2004 MVA, with several relapses over the years. He agreed that the file information was consistent with relapse due to another MVA and that it was reasonable to extend benefits from December 15, 2011 through to May 2012. He also pointed to physiotherapy reports which showed improvement with some continuing subjective pain and [Appellant's chiropractor]'s reports of success with laser therapy.

In contrast, [text deleted] characterized [physiatrist #2]'s report as an outlier. When taken into consideration with the other reports on file, [physiatrist #2]'s report seems inconsistent with the findings by various other physicians who had greater knowledge of the Appellant's history, have treated him over the course of his MVAs and found impairment related to the MVAs. [Physiatrist #2] conducted only a single examination and even then, downplayed the Appellant's reports of

lower back pain. It is not surprising then that the Appellant was emotionally devastated after reviewing the conclusions in this report. He shared it with [Appellant's chiropractor] who provided his own report with his own observations and opinions.

[Text deleted] noted that the Appellant and his family were grateful for the benefits which he did receive from MPIC, but that the MVAs and the injuries sustained had a great impact upon the Appellant and the whole family and that he required further support from MPIC.

Submission for MPIC:

Counsel for MPIC noted that the issue in this appeal is whether the injuries sustained in the 2004 MVA and exacerbations from subsequent MVAs prevented the Appellant from returning to work in a full-time sedentary position in 2015. The question was whether the case manager and IRO had sufficient evidence before them to terminate the Appellant's benefits in 2015. Section 110 of the MPIC Act provides for the termination of IRI benefits, among other things, when the victim is able to hold the employment he held when the MVA occurred or is able to hold employment determined for him, which is what happened here. The Appellant was sufficiently recovered to perform the duties of the determined employment of mortgage broker. If he had no desire to perform those duties, that does not mean he is still entitled to receive IRI benefits.

Counsel submitted that it was important to note that both sciatica and lower back pain were pre-existing conditions for the Appellant. [Appellant's family physician]'s chart notes for the period between February 22, 2000 and August 23, 2005 noted lower back pain and widespread osteoarthritis with mechanical neck and lower back pain as early as 2000. Also of great significance, he submitted, is the Appellant's pre-existing condition of gout, which is another form of arthritis that causes acute bouts of pain in the joints

Counsel for MPIC suggested the Commission examine whether the Appellant was sufficiently recovered from his MVA injuries to perform as either a car salesman or a mortgage broker. We know from the evidence, he submitted, that the Appellant did begin a gradual return to work as a car salesman in February or March 2005. Unfortunately, he worked too many hours a day at the outset, which did not work out well, but then began to work at a more reasonable pace of five hours a day and was able to return to work full-time in April, bringing his IRI benefits to an end by April 6, 2005. His IRI benefits were then reinstated a few months later when [Appellant's family physician] recommended he work half days because he had been missing a few days a month as a result of sciatica and lower back pain. IRI top up was provided. A relapse occurred while the Appellant was employed at another dealership in 2006. He went back to his earlier employer who was happy to accommodate his doctor's request that he work half days. IRI top up was provided for time missed. He stopped work again for a period, then started again on half days in June 2006 but was then off again full-time in May 2007 due to a relapse which occurred while demonstrating a vehicle with a manual transmission.

After another MVA in December 2007 he was again off work. He was off work in February 2008 when his case manager made notes of a telephone conversation with him where he indicated he had been involved in another MVA on December 4, 2007 but had not put in a claim because he didn't feel it had much of an impact on his back condition. His physiotherapist was now recommending he put in a claim as she believed the subsequent MVA aggravated his sciatic problem and setback his recovery. In contrast, the Appellant wrote to his case manager on April 23, 2008, indicating that the MVA of December 4, 2007 had "aggravated his condition and this was reported and being treated by my [hospital] physiotherapist" The Appellant was in receipt of full IRI benefits again at this point.

This on-and-off again employment continued through 2011, with relapses causing him to miss work. For example, a letter to his case manager dated November 23, 2009 from the Appellant described a total relapse in March 2009 while demonstrating a manual transmission vehicle, as had been earlier described in May 2007.

Another letter written by the Appellant to his case manager on August 1, 2007 was referred to by counsel for the Appellant as an example of the letters which the Appellant took the time to write. These show him to be an articulate, intelligent man and a strong advocate for his injury claim. This is repeated throughout the index with several lengthy well-written and articulate letters to case managers. He contrasted this with the Appellant's testimony at the appeal hearing where it was difficult to get him to admit anything to the panel in terms of what he did for a job, his duties and employment history. All these things, which were articulated very well throughout his injury claim, were things he was not prepared to discuss on cross-examination and the panel should note his evasive demeanour in this regard.

The Appellant was in receipt of good benefits from MPIC and continued to advocate for the continuation of his IRI. But the longer the claims proceeded, the truth was revealed that it was the Appellant's gout that was debilitating for him and not the MVAs. Counsel submitted that it took the IME by [physiatrist #2] to reveal this.

Counsel noted that the Appellant was taken to hospital by ambulance for five days in March 2013. The medical evidence shows that this was clearly for a gout related issue yet in an email message to his case manager on March 26, 2014 he told MPIC that the time in hospital was because of the MVA.

[Chiropractor #2], in his third-party examination report, also describes asking the Appellant to tell his story again. He described hitting his head on the window in the 2004 motor vehicle accident but his report back in January 2005 (when his memory would have been better) said that the only thing that happened was that he struck his head on the mirror.

Counsel submitted that the Appellant is either a poor historian or has learned to embellish.

Counsel noted that the Appellant had not sought a review or appealed his determination as a mortgage broker. He did still try to work as a car salesman. He submitted that he was able to do either job and there were lots of examples of him working as a car salesman after 2004. He had relapses but continued to return to work. When [chiropractor #2] examined him, he told him that he could still sell cars and that the main impairment from doing so at that time was a problem with his driver's license.

Counsel submitted that the medical evidence regarding the Appellant's underlying issue of gout was overwhelming. [MPIC's HCS medical consultant #3] described it as a chronic disabling condition that persisted and would have persisted regardless of the motor vehicle accidents. There are numerous reports from [rheumatologist #1] trying to manage the condition and help the Appellant comply with his prescribed medication regime. There are reports from the [hospital] and [text deleted], regarding his hospitalization and discharge due to gout, in March 2013. There are reports from [rheumatologist #2] regarding gout flare ups which express frustration with the Appellant's noncompliance with his medication routine, discontinuing Allopurinol against medical recommendations.

By September 2013, [MPIC's HCS medical consultant #3] was starting to wonder why the Appellant's MVA injuries had not yet resolved. Her report dated September 23, 2013 noted that the medical file did not indicate why the Appellant remained off work. Counsel submitted that this was the first indication from a doctor that something else must be at play, keeping him off work. As a result, MPIC sought an IME from [physiatrist #2].

[Physiatrist #2]'s report of March 27, 2014 indicated that he was also unable to determine an impairment and subsequent disability on a musculoskeletal basis. He was unable to determine a patho-anatomical basis for persisting symptoms beyond the Appellant's previous gout and low back problems which were there before the 2004 MVA. Based on the lack of a diagnosis and the temporal incongruities he was unable to relate the Appellant's current presentation to the 2004 MVA.

These two opinions eventually led to the termination of the Appellant's IRI benefits in June 2014, based on the conclusion that there was no MVA related condition preventing him from returning to work full-time at sedentary employment. A final report from [MPIC's HCS medical consultant #3] dated March 3, 2015 identified the Appellant's gout condition as the probable chronic disabling medical condition preventing him from working. Counsel submitted that this opinion was supported and borne out by the Appellant's admission on cross-examination that he had not had a need to visit [Appellant's family physician] in for the two years prior to that for any MVA related injuries. He required medical attention, but that had been for his multi-joint gout which was painfully disabling for the Appellant.

Counsel addressed [Appellant's family physician]'s letter dated July 6, 2015 which took issue with [physiatrist #2]'s report and the termination of the Appellant's IRI. He stated that it was his

opinion that there was a causal relationship between the MVA and the Appellant's symptoms and impairment. He goes on to say that the Appellant was unable to do heavy work with walking standing or repetitive twisting. But nobody had suggested that the Appellant should go back and do heavy work or jobs with repetitive bending etc. Although [Appellant's family physician] had been advised of the Appellant's determination into the sedentary job of a mortgage broker, and had previously opined that he could do this work, many of his reports addressed the Appellant's inability to do heavy work or work with repetitive twisting and bending. It had been [Appellant's family physician]'s opinion at one point that once the Appellant's symptoms had waned when he was doing better he was certainly capable of sedentary work and clearly by 2013, counsel submitted, the Appellant's symptoms had waned.

Counsel also addressed reports from the Appellant's chiropractor [Appellant's chiropractor], suggesting that the panel dismiss his references to PTSD, as he is not an expert in that area and there is no evidence of psychological injury before the panel. His reports were characterized by counsel as straying into the role of advocate without the indifference and impartiality which should be expected of an expert. Both [MPIC's HCS chiropractic consultant] and [chiropractor #2] believed the Appellant had reached maximum medical benefit for chiropractic care and that he had plateaued.

Counsel addressed the report of [text deleted], a medical consultant with the Health Care Services team, which confirmed a permanent impairment award for the Appellant's lower back injury. Counsel submitted that this does not mean that he could never work again in a sedentary fashion. There was evidence that his range of motion was somewhat impacted by the MVA injuries but those injuries had healed sufficiently to allow him to perform sedentary work.

Counsel submitted that the evidence was overwhelmingly in favour of upholding the IRD. The Appellant had not come close to discharging his onus on a balance of probabilities. He acknowledged that early on in the file the Appellant had suffered injuries from the MVA but that those had healed. What was later revealed was the chronic disabling condition of gout which prevented the Appellant from being employed. He suffered from relapses and hospitalization which were in part his own fault for not complying with his medication regime. By 2013 any remnants of the MVA were gone, but MPIC erred on the side of caution and provided benefits for a further period. During this time, [MPIC's HCS medical consultant #3] provided reports, which relied upon independent medical examinations, ultimately leading to the termination of the Appellant's IRI benefits. This termination was based upon medical evidence in the file and medical reports which considered them and should be upheld by the Commission.

Appellant's Reply:

In reply, it was noted that the Appellant had not always obtained significant relief from Allopurinol. [Appellant's family physician] had recognized in his report that the Appellant suffered from gout on an intermittent basis, but he was clear that he would not expect gout to cause low back pain with radicular symptoms. Even though the gout and lower back pain existed to some degree before 2004, he did not miss any work and it was not an issue prior to the MVA. This supports the Appellant's position that after the MVA there was a difference in that his injuries were the cause for missing work.

In 2015, both [Appellant's family physician] and [Appellant's chiropractor] were clear that the Appellant's problem were MVA related.

[Text deleted] agreed that in some of his written communication throughout the course of the file, the Appellant's presentation came across. He is an educated former diplomat and was an engaging salesman, active in his community, but as time goes on people change and their minds grow in different directions. Her father's personality had been affected by the focus and obsession with the traumatic event of the MVA and his physical pain.

Discussion:

The panel has reviewed the documentary evidence, the testimony of the witnesses at the hearing and the submissions of the parties. We have accepted the submission of counsel for MPIC that when his benefits were terminated, it was not the musculoskeletal effects of the MVAs which were affecting the Appellant and his ability to work, but rather the unrelated gout condition which was aggravated by the Appellant's failure to comply with his medication regime.

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, but not including bodily injury caused
>
> **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.
>
> **Events that end entitlement to I.R.I.**
>
> 110(1) A victim ceases to be entitled to an income replacement indemnity when any of the following occurs:

(a) the victim is able to hold the employment that he or she held at the time of the accident;

(b) the victim is able to hold the employment referred to in subsection 82(1) (more remunerative employment);

(c) the victim is able to hold an employment determined for the victim under section 106;

(d) one year from the day the victim is able to hold employment determined for the victim under section 107 or 108;

(e) the victim holds an employment from which the gross income is equal to or greater than the gross income on which victim's income replacement indemnity is determined;

(f) the victim is entitled to a retirement income under section 103;

(g) the victim dies.

The onus is on the Appellant to show, on a balance of probabilities, that there is a causal relationship between the injuries he sustained in the MVAs and his current medical condition which would entitle him to continue receiving PIPP benefits (including IRI) after April 2015.

Testimony:

Although the Appellant was forthcoming in some of his evidence and gave lengthy responses to some questions (both on direct and on cross-examination) his answers were often not responsive to the questions being asked or the issues being addressed. Certain points which were clearly of great importance to the Appellant were repeated by him over and over, but frequently addressed topics entirely unrelated to the question being asked or the subject matter under discussion at the time.

The Appellant's daughter provided a written statement and testified at the hearing. Her evidence was given in a forthright, sympathetic and credible manner. She described the Appellant's pain,

his experiences in the workplace and his distress, noting the diminished capacity she had observed. The panel was led to appreciate the effects of the Appellant's deterioration over time on his work and family life, as well as on his overall mental and physical health. However, although she attributed all of these difficulties to the MVAs, she was not entirely familiar with the medical aspects of his various conditions, including his gout and depression, their possible causes and treatment or their impact on the medical evidence which attributed the majority of the Appellant's difficulties in 2015 to non-musculoskeletal causes.

Documentary Evidence:

The panel's review of the documentary evidence also leads us to conclude that the weight of the medical evidence supports MPIC's position that the Appellant's MVA injuries were no longer preventing him from working, particularly in the sedentary employment which had been determined for him.

[Appellant's family physician]

A review of reports provided by [Appellant's family physician] shows that on May 4, 2006, he noted decreased range of motion and measurable impairment. The Appellant was unable to tolerate full-time duties at that time. He was unable to tolerate prolonged standing, sitting or walking as well as repetitive bending and heavy lifting. Although the case manager's letter to [Appellant's family physician] dated April 9, 2010 (setting out certain questions regarding his capacity and his relapses) advised that the Appellant had been determined (through a Residual Capacity Determination on October 3, 2008) into the sedentary employment of a mortgage broker, [Appellant's family physician]'s response of May 4, 2010 stated that the Appellant's symptoms were causally related to the MVA and that he would not be capable of performing any duties greater than sedentary work. Again he strongly advised against him returning to a

workplace that required repetitive bending, twisting or certain heavy lifting. As far as his ability to return to a sedentary job, [Appellant's family physician] indicated that much of this limitation was based on the Appellant's symptoms. If symptoms should resolve significantly, then he would authorize his return to sedentary duties based on physical findings, as the Appellant was certainly capable of sedentary work.

The Appellant's case manager wrote to [Appellant's family physician] on January 22, 2015 requesting chart notes concerning the Appellant. These chart notes were provided and showed that the Appellant had attended the [medical clinic] on February 15, 2013 and January 4, 2015 primarily for gout related issues. A review of these chart notes did not indicate that the Appellant attended to the clinic at that time to see a doctor in regard to complaints of back pain and he does not appear to have seen [Appellant's family physician] during this period. The Appellant himself testified that he did not see [Appellant's family physician] for a period of two years because he had "tried to kill me with 50 mg of prednisone and so I ended up in hospital". In spite of this, the Appellant requested that [Appellant's family physician] provide a letter on his behalf for the review of his MPIC claim, as was indicated in [Appellant's family physician]'s letter to the IRO dated July 6, 2015.

[Appellant's family physician]'s report of July 6, 2015 noted the Appellant's low back pain with radicular symptoms to the left leg since the MVAs of 2004 and 2007. He also noted that MPIC had awarded a permanent impairment for these symptoms. The impairment was supported with objective evidence of decreased range of motion and a CT scan revealing disc lesions. Treatment through injections, physiotherapy and chiropractic care was also described. He concluded:

> In my opinion there continues to be a causal relationship between [the Appellant]'s motor vehicle accidents and his low back pain with radicular symptoms. His low back pain represents an impairment which prevents him

> from returning to his previous work. He is currently unable to perform any heavy work or work that would require prolonged walking or standing or any repetitive bending, twisting or crouching
>
> …
>
> … it is my opinion that [the Appellant] has a permanent impairment related to his low back pain that is causally related to his prior motor vehicle accidents. The fact that [the Appellant] also suffers from gout should in no way detract from his impairment that he sustained involving the low back during his motor vehicle accidents in 2004 and 2007…"

This report seems to address the Appellant's inability to perform twisting bending and other duties addressed in the doctor's earlier letter. However, it fails to address the residual capacity determination of the Appellant into the sedentary position of mortgage broker and his ability to perform those duties. Nor does it address the lack of evidence of back pain complaints to [Appellant's family physician] or his colleagues at the clinic for two years prior to the relevant period in 2015.

[Appellant's chiropractor]

[Text deleted] was the Appellant's chiropractor who treated him for over 10 years and provided over 100 treatments. These concentrated primarily on laser treatment for his back. The chiropractor provided detailed medical reports dated July 1, 2015, July 8, 2018 and March 13, 2019. He commented upon the state of the Appellant's back and the degeneration or deterioration which he had followed and treated over the years. [Appellant's chiropractor] attributed these issues to the MVAs.

While the July 1, 2015 report focuses primarily upon the Appellant's history of low back and left leg pains following the MVAs over the last nine years, it also addressed a deteriorating neurological condition with more expansive leg symptom deterioration and a significant

impairment in 2015. He points out considerable difficulties walking and getting up from a seated position and an inability to lift or carry anything heavy.

In his 2018 report [Appellant's chiropractor] reviews the Appellant's updated medical status as well as a report from [physiatrist #2] and MRI of February 2016. He finds further evidence of deterioration in the Appellant's back, indicating that since the MVA of 2004 his disc has been symptomatic and deteriorating. He disagrees with [physiatrist #2]'s conclusions regarding the Appellant's lower spine, stating that in his view his lower back is still limiting him and it is still a result of the MVA. He notes that the Appellant has difficulty working and has been unable to work because of his back injury. Working in a sitting job was not considered advisable. He was heavily critical of [physiatrist #2]'s assessment.

[Appellant's chiropractor]'s final report reviews an independent assessment by another chiropractor, [chiropractor #2], in the report which followed. He indicated that the Appellant had actually responded symptomatically to regular care but that his lower disc was damaged and did deteriorate. The panel has noted however that some of [Appellant's chiropractor]'s findings were not reproducible by [physiatrist #2] or by [chiropractor #2].

In addition, [Appellant's chiropractor] did not address the Appellant's other medical conditions, like gout or possible heart problems and deconditioning, which in any event do not fall within his area of expertise as a chiropractor. He did refer to "probable depression and anxiety" as a result of the consequences of his four MVAs and "his plight in continually trying to prove he was injured to MPI", stating that the Appellant probably has PTSD. However, the panel does not consider [Appellant's chiropractor] to be a qualified expert regarding issues of depression,

anxiety, insurance claim management or PTSD, and has given very limited weight to these comments.

Other Experts

The panel prefers and has given more weight to the evidence of [physiatrist], physiotherapist [text deleted], [physiatrist #2], [MPIC's HCS medical consultant #3] and [chiropractor #2]. With the exception of [MPIC's HCS medical consultant #3], all assessed and examined the Appellant. [Physiatrist] and [Appellant's physiotherapist] worked with the Appellant measuring his difficulties and tracking his progress in spite of his less than perfect attendance at times. [Physiatrist] concluded that the Appellant could work at a medium strength job. The physiotherapist, [text deleted], concluded that he could work without restrictions, on a full-time basis.

According to [physiatrist #2] he was "unable to determine an impairment and subsequent disability on a pure musculoskeletal basis." He was unable to determine a "pathoanatomical basis for the persisting symptoms" and given the lack of a pathoanatomical diagnosis and temporal incongruities, he was "unable to relate the current presentation to the Motor vehicle accident of October 18, 2004." [Physiatrist #2] indicated he would not place restrictions on a purely musculoskeletal basis.

The physiotherapist, [text deleted], stated on August 22, 2011 that:

> … His reports of left leg radiating pain were not supported by the assessment findings. In the physiotherapist's experience, the level of rated pain does not always match the functional ability of a person. That is to say, some patients may report very different levels of pain but can perform the same tasks, while others may report the same pain level, but cannot perform the same tasks. Based on [the Appellant]'s ability to complete the exercises and weights asked of him and his demonstration of correct body mechanics, it is my recommendation that

> he return to light duties. This includes lifting up to 10 lbs. No reduction in his work hours are recommended at this time.

In his report of December 13, 2018, [chiropractor #2] diagnosed soft tissue injuries, primarily in the left lower back region, with evidence of a disc protrusion at L5-S1 as seen on diagnostic imaging. His assessment found widespread pain in the neck and upper back regions, along with the lower back area on both sides. Although he found soft tissue injuries from the MVAs and pain, [chiropractor #2] did not find any specific neurological deficits.

> In essence, he has chronic benign recalcitrant pain, primarily in the left lower back, which has now migrated to the right lower back; right upper back; right upper limb; and right neck.
>
> Of note, he has a significant past history… relative to his right sacroiliac and sciatica…

[Chiropractor #2] concluded that the Appellant had recalcitrant pain refractory to the treatment he has had to date and that he has reached maximum therapeutic benefit and maximum medical improvement. He added:

> … Regarding the issue of disability, at the time of his accident, he was having significant problems with polyarticular lower limb arthritis secondary to gout. This would be a co-morbid condition which has affected him throughout the years…

MPIC recognized the injuries which the Appellant suffered in the MVA. He was provided with a permanent impairment benefit for loss of range of motion and IRI benefits for approximately 11 years. However, through various exacerbations over the years, and following the provision of treatment modalities and attempts at rehabilitation, MPIC's Health Care Services team concluded that the issue from which the Appellant suffered primarily in 2015 and ongoing, was not the MVAs but was rather primarily related to his gout. It was this condition which prevented him

from full-time employment in 2015 and his condition was exacerbated by his lack of compliance with his prescribed medical regime.

[MPIC's HCS medical consultant #3] expressed this opinion after fully reviewing and considering the medical reports and opinions provided by [Appellant's family physician] and [Appellant's chiropractor], but also by [physiatrist #2] and [chiropractor #2]. Her conclusion was that:

> Based on the totality of my reviews and reinforced by the results of [physiatrist #2]'s March 2014 assessment, in my opinion, there is no collision-related medical condition precluding the claimant from returning to full-time sedentary employment.

She also opined, on March 3, 2015 that:

> Based on medical document review, I am unable to account for the claimant's "ongoing disability" being the result of the MVC-related injuries; in particular with the extensive passage of time since the MVC, during which he has required active treatment for an unrelated chronic painful disease condition.…

The panel, following an extensive review of the documentary evidence and testimony at the hearing, accepts this assessment and finds that the Appellant has failed to establish, on a balance of probabilities, that the IRO erred in accepting the opinion of MPIC's Health Care Services' consultants and of the independent medical assessors, to conclude that the Appellant's medical symptoms and condition in April 2015 and following were not caused by injuries sustained in the MVAs.

The Commission therefore finds that the Appellant has failed to establish a causal relationship between his medical condition and the injuries sustained in the MVAs. We find that he is not

entitled to further PIPP benefits. The IRD dated July 22, 2015 is upheld and the Appellant's appeal is dismissed.

Dated at Winnipeg this 22nd day of April, 2020.

LAURA DIAMOND

JANET FROHLICH

GUY JOUBERT