Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-12-181

PANEL:	**Laura Diamond, Chairperson** **Janet Frohlich** **Dr. Sharon Macdonald**
APPEARANCES:	**The Appellant, [text deleted], was represented by Claimant Adviser Ken Kalturnyk;** **Manitoba Public Insurance Corporation ('MPIC') was represented by Steve Scarfone.**
HEARING DATE:	**November 30, 2021; December 1, 2021; December 2, 2021; December 3, 2021**
ISSUE(S):	**Whether the Appellant is entitled to IRI beyond May 11, 2012.**
RELEVANT SECTIONS:	**Sections 70 (1) and 81(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 on a motor vehicle accident (MVA) on November 21, 2010. She reported soft tissue injuries to her neck and low back, and headaches.

At the time of the MVA, the Appellant was employed as a [text deleted]. Her injuries prevented her from returning to work and she was in receipt of IRI benefits from MPIC.

She received treatment from her family doctor, as well as MPIC funded physiotherapy. When she had made limited progress in her rehabilitation, a more structured work hardening/reconditioning program was recommended. She was referred to [rehabilitation consultants] for 8 weeks (two 4 week programs) of work hardening and reconditioning. At the end of the programs, the rehabilitation team concluded she was fit to return to work on a graduated return to work basis. Her family doctor did not agree that she could return to work in any capacity and she continued to receive IRI benefits.

The Appellant was also referred to a physiatrist, [text deleted], by her family doctor, and by MPIC for an Independent Medical Examination (IME) by another physiatrist, [text deleted]. Both of their reports were reviewed by the MPIC Health Care Services medical consultant, who agreed with the [rehabilitation consultants] team that there was no physical diagnosis to account for the Appellant's widespread symptomatic presentation.

Psychological treatment was recommended by a psychologist who assessed the Appellant. MPIC referred the Appellant to [neuropsychologist] for a neuropsychological assessment. The neuropsychologist did not find that psychological factors were limiting her return to work as a [text deleted].

The MPIC psychological consultant opined that she did not have an MVA-related psychological condition.

The case manager ended the Appellant's entitlement to IRI, noting that her ongoing back complaints and pre-existing cervical and lumbar dysfunction were not causally related to the MVA.

The Appellant sought internal review of this decision. She submitted that she was in constant pain, with sleep disruption and that the MVA had exacerbated her pre-existing fibromyalgia. She complained of numbness in her arms, hands, face and both feet.

The Internal Review Officer (IRO) reviewed reports from the [rehabilitation consultants] team, the physiatrists who had reported, the family doctor and other caregivers, and the MPIC consultants. They concluded that the Appellant had initially sustained an exacerbation of a pre-existing cervical and low back condition, but then her symptoms had become more widespread and severe, which is atypical for a trauma induced injury. The case manager's decision was upheld and the Application for Review was dismissed.

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

Issue

The issue before the Commission was whether the Appellant was entitled to IRI beyond May 11, 2012. The parties agreed that the Commission may consider both the Appellant's ability to work as well as the causation of injuries.

Disposition

The Commission finds that the Appellant has failed to show, on a balance of probabilities, that on May 11, 2012, she was still suffering from a condition caused by the MVA that entitled her to further IRI benefits.

Preliminary Matters

In preparation for the appeal hearing, the Commission sought reports from an Occupational Therapist (OT), [text deleted]. She reviewed the materials on the Appellant's file and met with the Appellant, leading to two reports which were filed with the Commission. The reports looked at both the Appellant's injuries and the requirements of her occupation, to consider whether the Appellant was prevented by her injuries from returning to work as a [text deleted]. The Appellant also sought to call the OT as a witness at the hearing, as an expert in occupational therapy and as a Work Capacity Evaluator. Her curriculum vitae (CV) was provided.

Prior to the hearing, counsel for MPIC objected to the admission of the OT's reports, and to her expert qualifications. While he agreed that she was qualified as an OT, he did not agree with her expertise as a Work Capacity Evaluator, and wished to question her training in the area of forensic file review.

As a result, the Commission held a *voir dire* prior to her testimony, on the issue of her qualifications. Her reports were not included in the indexed file at that point, but rather submitted as exhibits.

The panel then reviewed [OT]'s CV and heard direct and cross-examination evidence from her, as well as submissions from counsel, regarding her expertise and experience.

Counsel for MPIC took the position that the OT was not competent to answer the questions which the Commission had asked her to address in her report.

He submitted that she is not a medical doctor and does not have the necessary knowledge or experience in reviewing medical files. Therefore, because she was not qualified to perform the review, she came to the wrong conclusions. The Commission should not allow her reports into evidence or qualify her testimony as expert in workplace evaluation.

The panel considered the submissions of the parties and concluded that it would allow the reports and testimony of the OT into evidence.

The Commission relies on expert reports and testimony from a variety of disciplines:

> ***6. A Properly Qualified Expert Witness***
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> **§12.41** An expert is usually called for two reasons. The expert provides to the court basic information necessary for its understanding of scientific or technical issues involved in the case. In addition, because the court is incapable of drawing the necessary inferences on its own from the technical facts presented, an expert is allowed to state his or her opinion and conclusions. The expert's usefulness in this respect is circumscribed by the limits of his or her own knowledge. Before a court will receive the testimony on matters of substance, it must be demonstrated that the witness possesses special knowledge and experience going beyond the trier of fact. The test of expertise so far as the law of evidence is concerned is skill in the field in which the witness's opinion is sought. The admissibility of such evidence does not depend upon the means by which that skill was acquired. As long as the court is satisfied that the witness is sufficiently experienced in the subject-matter at issue, the court will not be concerned whether his or her skill was derived from specific studies or practical training, although that may affect the weight to be given to the evidence…..

See The Law of Evidence in Canada, 2d ed, 1999, p. 622-623.

Expert witnesses before the Commission are qualified on the basis of their education and experience.

The parties agreed that by virtue of her education and experience, the witness is qualified as an expert OT and that she has training and experience as a Work Capacity Evaluator. But they differed in regard to her experience or expertise in reviewing medical files and making assessments on this basis.

Counsel for MPIC contrasted this with the work of the MPIC medical consultants. Although he conceded that not all of the consultants had formal training, certification or designation in the area of file review, he submitted that they had acquired such expertise through their work with the corporation.

The witness provided evidence that she has done several file reviews throughout her career. Some of these occurred at the report stage without progressing to hearing, but she has also testified before the Commission on several occasions.

The panel found that the OT has education, experience and expertise in the field of occupational therapy and work capacity evaluation, and has established that she has the capacity and experience to provide evidence in medical/legal settings such as before this Commission.

The OT was qualified as an expert witness in the areas of occupational therapy and work capacity evaluation. Her reports were found to be admissible.

The panel acknowledged that some of the witness's comments may contain opinion evidence, but reminded the parties that this will not be a substitute for the conclusions of the panel, which did not intend to delegate its responsibility as the trier of fact in this appeal.

Counsel for MPIC may still have relevant comments regarding perceived flaws in her reports or testimony, which may stem from lack of assessment or other factors. The panel will take such comments into consideration when weighing the evidence before us.

Documentary Evidence

The Appellant's indexed file contained relevant documentary evidence from the management of her claim, including pre-MVA medical history, job descriptions, clinical notes and reports from her caregivers and opinions and assessments from specialists and experts.

These included:

- Medical evidence from previous claims with the Workers Compensation Board (WCB) for workplace injuries.
- Documents concerning injuries sustained by the Appellant in a previous MVA in 1996.
- Clinical notes from her family doctor at the [medical clinic].
- Reports from the [hospital] following the 2010 MVA.
- OT assessments and reports from another OT, [text deleted], regarding the Appellant's entitlement to Personal Care Assistance (PCA) benefits following the MVA.
- Reports from the OT, [text deleted], assessing the conditions and duties of the Appellant's job as a [text deleted].
- Physiotherapy reports.
- Reports from her family doctor, [text deleted].

- Reports from a subsequent MVA on February 14, 2011.
- Report from the physiatrist, [text deleted] dated March 7, 2011, diagnosing myofascial pain in the cervical muscles and spondylosis secondary to degenerative disc disease. The doctor did not assess the Appellant's ability to perform her job duties at that time, but did opine that she did not think she would have a permanent impairment (PI) and should continue with stretching and strengthening.

  A second report from [physiatrist] dated July 7, 2011 noted unexpected examination results, with surprising areas and levels of pain, weakness and tenderness. She indicated she was not aware of a pre-existing condition responsible for delaying recovery or limiting the ability to participate in a GRTW program, found no PI and recommended psychological assistance.
- Report from the physiotherapist [text deleted], dated March 24, 2011 advising that she was making limited progress and needed a structured work hardening/conditioning program.
- A physiotherapy report dated April 5, 2011 noted chronic cervical and lumbar dysfunction and discharged the Appellant from physiotherapy care.
- Reports from [family doctor] indicating that the Appellant was unable to attend a graduated return to work (GRTW) program, dated March 28, 2011 and May 12, 2011.
- [Rehabilitation consultants] multi-disciplinary assessments, progress reports, GRTW schedule, work hardening discharge report, and report recommending further rehabilitation (during the period identified by [family doctor] when she should not work).
- [Rehabilitation consultants] further rehabilitation plans, assessment report and work hardening discharge report were also reviewed. These ranged from April 6, 2011 to June 23, 2011.

- Report from neurologist [text deleted] dated July 14, 2011 which found no obvious impingement or distortion of neural structures.
- Psychological report from [psychologist] indicating that the Appellant believed her pain was physical, not psychological but that she could benefit from psychological treatment.
- Reports from the family doctor, [family doctor] dated August 29, 2011, September 15, 2011, October 3, 2011, December 21, 2011 and June 13, 2013, advising that the Appellant continued to complain of pain (including ongoing neck and back pain related to the MVA) and was not able to return to work as a result.
- Report from the [clinic] dated December 8, 2011 indicating a normal electrophysiology report, with an impression of mild focal ulnar neuropathy in the left elbow.
- [Text deleted] neuropsychologist IME dated December 16, 2011. [Neuropsychologist] reviewed the psychological reports and her own assessment of the Appellant, concluding that there were no obvious signs of psychological disturbance and making no treatment recommendations.
- [Physiatrist #2] IME report dated February 10, 2012 describing widespread symptomatic complaints and deconditioning. He related some complaints to pre-existing conditions such as fibromyalgia, prior lower back pain and ulnar neuropathy and did not find her condition to be related to the MVA, aside from possible delays in recovery due to her deconditioning.

  After reviewing further material, [physiatrist #2] provided an addendum report dated July 31, 2015, noting the Appellant's persistent symptoms prior to the MVA and concluding that a significant contribution to her most recent symptoms by the MVA is not supported by the available medical file information.

- MPIC medical consultant review dated March 27, 2012 reviewing the file and the reports of [physiatrist], [physiatrist #2] and [neuropsychologist], and concluding that the Appellant's compensable injuries had resolved by the time of [physiatrist #2]'s assessment and were due to a symptom complex not associated with the MVA, in spite of [family doctor]'s comments.

  A follow up report dated September 26, 2013 noted significant differences in the file materials regarding causation, but did not find a correlation between her diagnoses and ongoing pain, and noted her prior WCB injury and myofascial pain.

  His report dated March 12, 2015 considered additional reports and maintained the view that the Appellant's condition was no longer casually related to the MVA.
- MRI (thoracic spine) report of October 30, 2012 identifying no abnormality.
- EMG lab assessment report from [text deleted] dated October 31, 2012 indicating a normal assessment and suggesting consideration of treatment for fibromyalgia.
- Report from pain specialist [text deleted], dated March 18, 2013 diagnosing fibromyalgia, myofascial pain syndrome, taut bands and trigger points and recommending a trial of gabapentin and needling by [pain specialist #2].

  [Pain specialist] reported again on May 7, 2015 diagnosing myofascial pain syndrome and fibromyalgia, casually related to the MVA
- Report from pain specialist, [text deleted] dated March 21, 2013, noting pain, degenerative changes and restrictions. [Pain specialist #2] diagnosed chronic whiplash syndrome (WAD II), chronic mechanical low back pain syndrome (beginning after the 1996 MVA and aggravated by the 2010 MVA) and fibromyalgia, recommending trail local injections and manual therapy.

- Report from [doctor] of the [health centre] dated February 4, 2015 diagnosing chronic myofascial pain and dysfunction in the presence of deconditioning. He opined that this was not caused by the Appellant's pre-existing fibromyalgia or WCB injury, but rather was caused by the MVA causing a significant worsening of the restrictions that arose after the 1996 MVA. He indicated that the Appellant was no longer capable of employment as a [text deleted] without risk of significant aggravation or re-injury.
- [OT #2] provided a Physical Demands Analysis (PDA) report for the position of [text deleted], dated January 24, 2019. The report set out the demands and duties of the position, identifying medium demands with confirmation from the employer that sedentary duties could be accommodated.
- A report from OT [text deleted] dated December 29, 2019 reviewed the Appellant's file along with information obtained from the Appellant and the review of the job duties to assess whether the Appellant was able to perform the full-time duties of a [text deleted] at the time her benefits were ended after the completion of her rehabilitation program. She disagreed with some of [rehabilitation consultants]'s assessment methods, such as the absence of end feel testing. The OT concluded that no significant musculoskeletal changes were achieved through the rehabilitation program that would have significantly altered the Appellant's lifting, carrying, pushing and pulling ability, such that her functional abilities remained the same following the program such that she was not able to perform the demands of a [text deleted].

Evidence for the Appellant

Testimony of the Appellant

Direct Evidence

The Appellant described the MVA and its aftermath, including injuries which led to her assessment at the hospital in [text deleted] after the MVA and by her family doctor in [text deleted]. She provided some details about her previous MVA in 1996, indicating that she had never fully recovered and always had some symptoms, but that they were manageable, so that after a period of time she was able to go back to her full duties at work.

A second MVA in 1997 caused some irritation to her neck and back injuries but she went back to work.

However, she said that prior to those MVAs she had loved to participate in sports such as curling, baseball and golf. After the MVAs, although she tried, her body wouldn't allow it and she couldn't do sports because of pain in her neck, back and arms.

She also described some time off work after injuring herself, carrying some laundry detergent at work, in a WCB related injury. She then returned to work doing light (office) duties for a few months before gradually returning to her regular duties, without restrictions.

The Appellant then discussed some of her experiences in the [rehabilitation consultants] rehabilitation program, following the 2010 MVA. She described being assigned exercises to do mostly on her own with some floor staff supervision, while she filled out her own forms, logs and diaries. Although she said [rehabilitation specialist] was not around much, she did complain to the staff about increasing pain with many exercises and movements and was advised to talk to her doctor about this. The staff wold tell her to just do what she could, which ended up mostly just being the warm up exercises.

When the work hardening program was extended by an additional 4 weeks, she told MPIC that it was making her condition worse. She couldn't recall anything specific in the rehabilitation program that may have caused her left arm problem. Rather, it gradually got worse as she did different things with her arm like reaching and stretching. [Rehabilitation specialist] did comment about her left shoulder range of motion (ROM) at one point, but she did not recall him putting his hands on her to examine it. He did not examine her upon discharge from the program either.

The Appellant explained that, although [physiatrist] did examine her briefly in her second visit in June of 2011, she made her feel like she was wasting her time and did not do a lot. She did not perform the same tests that [neurologist] performed, such as tests for passive and active ROM and pressure point tests.

The Appellant recalled that [physiatrist #2] also performed such tests, which led to his finding that she had some impingement in her shoulder and problems with her left elbow. [Doctor] did a full hands-on examination.

The Appellant explained that as a result of her injuries and pain, she really has to watch what she does and be very careful, which limits her daily quality of life. She said that she has to be careful with what she does and know her limitations because if she pushes too hard she gets frustrated and aggravated and is not mobile for a few days, but "does not give up on still doing my own stuff".

She continues to consult with her family doctor regularly, both in person and by telephone. She takes extra-strength Tylenol and sometimes a muscle relaxant at bedtime when her sleep is disrupted.

The Appellant said that although she did not want to, she had to take retirement from work because her back was so bad and this presented potential safety issues with the [text deleted] at work. She said she was never offered modified or alternate duties, so in order to receive a partial pension, she retired on October 31, 2013. She denied that she was ever reluctant to work at the new [text deleted] that was opened. Rather, she said that she had been looking forward to working in a bigger newer [text deleted], and the chance for promotions that would have offered.

Cross Examination

Prior MVAs

On cross-examination, the Appellant was asked a series of questions regarding her previous MVAs in 1996 and 1997. She agreed that she had filled out forms after the 1996 MVA which indicated that her injuries were a sore neck, lower back and bruising to her left arm, but maintained that her whole body was "tormented". She admitted that she had thought her neck was broken but that there was no was fracture, and that it was "severe whiplash". Although a report from [neurologist #2], who examined her, stated that she told him she had been referred to him due to a disc problem in her neck, she did not recall that and said her understanding was that she was referred because of the MVA. When asked about reports from [neurologist #2] regarding his impression of a mild problem with her neck which would continue to improve, she said that she was not aware of that and it was not discussed with her.

The Appellant admitted that at the time she had been hesitant to go back to work. Working at a [text deleted] can require quick response times and she needs to be physically capable of doing 100% of her job.

The Appellant was asked about reports of headaches and increased problems with her neck when she tried to return to work, and said it was probably because of the heavy doors she had to open there. She agreed that she had not complained of headaches in the forms filled out 4 days after the MVA, but indicated that there was a lot of stuff they don't write down. When asked if she was pain free when she finally did return to work, the Appellant said that she was not, but that she didn't go to her doctor every time she had pain, as you just have to work with it.

She acknowledged that she was off work for a period of time after the 1997 MVA which caused a brief flare up or relapse of her headaches. She said that because the headaches had never really stopped, even that small MVA jolt felt like a major MVA to her.

Workplace Incidents

The Appellant was also asked about a workplace incident where her head was pulled forward by a [text deleted] with a towel. This hurt her neck, which was already aggravated and injured by the 1996 MVA. However, she returned to work.

Another workplace incident, which was reported to WCB, occurred while carrying a heavy box of detergent upstairs, injuring her neck and lower back. The Appellant said that this also partially injured her shoulder.

Some questions were raised regarding difficulties with the Appellant's return to work following this injury. She was asked whether she had insisted on avoiding night shifts and indicated that she had injured herself while stocking during the night shift and that her doctor had advised her not to work night shifts. She agreed she had said that working nights would worsen her fibromyalgia, and that the doctor didn't want her working nights because it made it worse. She admitted to calling in sick for her first scheduled shift back to work and then worked with restrictions for some time, which included light office duties at the [text deleted] for 3 or 4 months before returning to work at the [text deleted].

2010 MVA

The Appellant was asked about her initial reports to her doctor following the MVA, of pain in her neck and back. Then, reports of new pains were added as time progressed, including headaches, numbness to the left side of her head, left buttock pain with tingling in her fingers and legs, low back pain radiating down into her left leg, knee, and elbow pain. She said that her doctor was always aware of these problems. When asked why they had not been recorded in the early days following the MVA she said that MPIC may not have documented it, but that she had explained everything. She testified that she reported the pain in her left elbow, hips, knees and lower back to each and every doctor, but that all of them failed to document it. She said that the pain got worse depending upon what she did. This is still the case.

[Rehabilitation Consultants] Programs

The Appellant acknowledged that during her [rehabilitation consultants] rehabilitation program she drove to [text deleted] from [text deleted], often staying at a motel. When asked about [rehabilitation specialist]'s notation that at the end of the first 4 week program she seemed quite negative about the MVA and getting back to work, she said that she was negative about the

MVA but not about getting back to work. The comment in the [rehabilitation consultants] discharge summary that she did not want to participate on the rehabilitation program due to subjective pain was not true. She said that she did want to participate but that her body would not let her. Her arm was bad and so, instead of full participation, they told her to just do the warm up. She recalled telling [rehabilitation specialist] that it didn't matter that she wanted to return to work because she was not physically capable. [Rehabilitation specialist] knew that she wasn't using her left arm, but he did not examine her to determine whether she was capable or not. So, with her left arm getting worse and [rehabilitation specialist] telling her that she was ready to go back to work, she went to see [family doctor] who gave her a sick note to remain off work until May 27, 2011.

At this point, the Appellant developed some trust issues with both her case manager and [rehabilitation specialist] and began recording some of their conversations, but she attended at [rehabilitation consultants] for another 4 weeks, and had some good days and some bad ones.

The Appellant was asked about her participation levels in the second 4 week [rehabilitation consultants] program. She did not recall being unable to complete the many tasks noted as such, but did recall that when she returned home after these days, her arm was so bad that she had to put it in a sling. She could not recall a specific injury to it, but her arm went from bad to worse. Although [rehabilitation consultants] staff noted they observed normal use of the arm when not on the gym floor, the Appellant maintained that she could not drive normally or use that arm to open or close car or fridge doors.

The Appellant was asked about notes in her file where she had indicated that [physiatrist #2] had told her that she should use a cane and how she could reconcile this with the fact that he had not found anything physically wrong with her.

She said that was not something she had wanted to or expected to hear and told [physiatrist #2] that she didn't want to do that and wanted to work on it and go forwards.

Psychological factors

The Appellant was asked about her assessment with [neuropsychologist], which did not lead to any psychological treatment provided by MPIC. She said that she enjoyed working in the [text deleted] and agreed that there was nothing psychological preventing her from returning to work there. She enjoyed her job and would welcome the opportunity to work in any area there as long as she got back to work.

Current Status

The Appellant explained that after she retired, she helped her son, who was doing some [work]. She would help with preparing meals and feeding [text deleted], and things like that. This was restricted by the Covid pandemic.

<u>Re-Examination</u>

On re-examination the Appellant explained that the symptoms which she found to be most disabling were her lower back, neck, arm and left elbow. She said that her hips hurt too because she compensates by walking differently and that using her right arm more tends to irritate her neck and back. She is also bothered by her right knee when walking.

Testimony of [OT]

Following the *voir dire* noted above, the OT was qualified by the Commission as an expert witness in the areas of occupational therapy and workplace capacity evaluation.

Direct examination

The OT was referred to her PDA assessment and her report regarding the Appellant's functional ability to perform the duties of a [text deleted], for comment. She was asked about the use of certain kinds of tests in assessment, such a ROM and end feel testing. These and other diagnostic tools used by some practitioners and others were discussed. [OT] pointed out that in her review of the [rehabilitation consultants] reports, she noted that [rehabilitation specialist] had never provided a diagnosis of the problem with the Appellant's shoulder. In her opinion, it was important to have a specific diagnosis of such a joint problem when prescribing a work hardening program, in order to see if the joint needs special treatment and to avoid exercises which could potentially exacerbate the problem and interfere with recovery.

She questioned [rehabilitation specialist]'s conclusion that although [physiatrist #2] made findings of tenderness in the shoulder, he had made no diagnosis in that regard, simply citing widespread pain of soft tissue origin. In her view, this was a possible injured area, with some inflammation process and overuse of the muscles where the tendon and forearm insert. It would be important to determine safe limits for work in these areas during the program.

She indicated that it would also be important in a work hardening rehabilitation program to determine work tolerance levels within the bounds of muscle fatigue. The best practice would be to repeat such tests several times, but as far as she could tell, [rehabilitation consultants] had not repeated them, and performed them only once. To determine tolerance to work a fulltime shift in a light or higher strength demand, one would want to make sure that the individual has sufficient

endurance, so it is wise to assess more than once in order to be confident in the opinion and see if there is consistent effort.

[OT] also questioned some of [rehabilitation consultants]' conclusions, such as doubt the Appellant did not have the ability to squat when she could climb stairs, based on her assessment of the differing flexion leg strength, endurance and balance requirements for these movements.

[OT] questioned [rehabilitation conultants]' conclusions that the Appellant was malingering, adding that it is important to rely on several different tests in this regard in order to draw a conclusion. During her review of the medical information on file, she did not review material which would lead her to have concerns that the Appellant was feigning symptoms at that time. Rather, the restricted physical movement findings supported functional limitations. Restricted ROM in conjunction with palpable feel or end feel assessment of muscle tightness would make it hard to feign active ROM limitations.

Following an overall review of the [rehabilitation consultants] reports and the methods which were used there, [OT] was not satisfied that the Appellant had the ability to perform full time light work or could meet the criteria to work beyond the sedentary level. While there may have been some improvements shown in the data, some showed no change and there were frequent reports of pain. Although [rehabilitation specialist] seems to have treated the Appellant's job as sedentary, [OT] believed that the job required a medium demand strength level and was of the view that the Appellant did not have the physical tolerance level to perform this job on a full time basis.

<u>Cross-Examination</u>

Counsel for MPIC questioned [OT] about [rehabilitation consultants]' findings that the Appellant's reduced testing for grip and pinch values and other metrics resulted from her reduce motivation and reluctance to participate at full capacity. She agreed that she did not notice anything in the report which confirmed that the Appellant had put in a full effort.

She was asked about the discrepancies in the Appellant's behavior (and particularly the use of her arms to carry things, open doors, drive etc.) when she was on the clinic gym floor and when she was observed outside of this setting. She acknowledged that while there could be many explanations for this, one of them could be that the Appellant was feigning behavior in the clinic setting. She agreed that if an individual does not give their full effort it could have an impact upon the assessment of their ability to meet the strength demands and levels required to do a job. If full effort is not given it could raise questions as to how much more they could have done.

[OT] was asked about the assumption in the beginning of this claim that the Appellant's neck and back would be expected to be healing within 6-8 weeks. She indicated that there are individual variations and the guidelines are not the same for everyone. For chronic soft tissue injuries, she felt that healing could take 6 months or more.

The witness was asked about conclusions in her report that the Appellant was not able to work more than 2 hours at a time, even in a situation where she could combine sitting and standing postures with walking. She emphasized the importance of the need to be productive and that she did not just look at movement in isolation. She agreed that accommodations which an employer might be able to make, such as gradual return to work, shorter hours, and varying tasks, could be important. The Appellant's ability to drive from [text deleted] to [text deleted] could indicate some ability to sit and work at a computer.

[OT] was asked about [rehabilitation specialist]'s opinion that the Appellant had sufficient function to return to her pre-MVA job and [physiatrist #2]'s finding of no MVA-related impairment. She indicated that they had failed to arrive at a diagnosis of the Appellant's condition. When asked about [physiatrist]'s evaluation that the Appellant could return to work, [OT] indicated that she just had a different opinion, and that her own opinion was based upon the Appellant's participation in the program and objective measurable elements.

Re-Examination

On re-examination, the witness was asked to explain the reasons why a patient might not fully participate during a rehabilitation program. She said that if that is referring to not trying hard enough, there can be a multitude of reasons for not participating. There may be other factors such as physical weakness, decreased use of some areas, tolerance issues and pain.

The OT confirmed that she tried to focus as much as possible on the objective data and clinical observations noted on the file, in order to assess the conclusions which had been drawn.

Evidence for MPIC

Testimony of [Rehabilitation Specialist]

The parties agreed that [rehabilitation specialist] would be qualified as an expert in physical medicine, rehabilitation and disability evaluation.

The doctor indicated that he also had some experience in treating or managing patients who experienced pain, but he was not qualified a pain specialist in pain or expert in chronic pain.

1996 MVA

[Rehabilitation specialist] testified that he had first seen the Appellant when he worked with [university] at [hospital], following her 1996 MVA. She had symptoms of neck and back pain. He diagnosed soft tissue injuries, mild in nature. She received physiotherapy and a GRTW program. There were no neurological findings when seen by [neurologist #2]. Her condition was not crippling and she was expected to progress to return to function. Some rehabilitation to address chronic pain issues in order to help her restore her life was recommended. He expected that she would return to work. Most people with a WAD II muscle sprain or strain return to work within 1 or 2 months and very few people go beyond that. But after 8 months, she had entered a chronic phase.

She began to experience headache flare-ups. A GRTW plan was agreed to with her family doctor but the Appellant complained of headaches exacerbated by her physiotherapy treatments. She seemed doubtful concerning the rehabilitation program and did not seem to believe that it would help with her musculoskeletal pain.

A multi-disciplinary problem was identified. Needle injections were tried in order to alleviate the pain, as well as physiotherapy and exercise. The chronicity of her problems made for a poor prognosis, as there did not seem to be severity in her problems, but the Appellant was not receptive or cooperative in implementing the program.

Working with a vocational therapist and rehabilitation coordinator, the employer was very accommodating and allowed her to reduce her hours and duties in order to get back into the workplace.

Some flare ups continued and some problems with a previously unproblematic right shoulder arose. Some workplace incidents caused complaints or injuries, and she was absent from the workplace for periods of time, however, she was provided with opportunities to return to work and did so.

2010 MVA

[Rehabilitation specialist] did not see the patient again until after her 2010 MVA. At that time, he would have expected her injuries from the 1996 MVA to have healed. His team preformed a multi-disciplinary assessment resulting in a diagnosis of whiplash. There was also pain in her hip and leg. He explained the examination and assessment process. He noted that a big indicator of the level of the problem was her lengthy work absence (from November to April) raising concern that she might have chronic pain. No psychologist was consulted in regard to this observation at that time, however, as [rehabilitation specialist] indicated that by his review of the file, he did not feel this was necessary.

[Rehabilitation specialist] described the rehabilitation program at [rehabilitation consultant], including the level of staff supervision, hours involved and reporting techniques used, such as exercise prescriptions, rehab diaries and logs. [Rehabilitation specialist] would see her at least twice during the program and then in the last week, before completion of the program, when the possibility of returning to work may be discussed. Although he found the Appellant to be pain focused and self-limiting with perplexing and confusing reporting of symptoms, and he had hoped to see more participation and progression with higher activity levels, he concluded and reported that her symptoms were benign. There were no physical limitations on her returning to work. When her family doctor did not support the idea of her returning to work he suggested a

team meeting to discuss the situation, which is sometimes helpful in a chronic pain rehabilitation situation, but her doctor chose not to participate.

[Rehabilitation specialist] reviewed some of the results of his assessment of the Appellant following the 7 weeks of rehabilitation, including her widespread symptom complaints and measurements of her functional abilities. Her functional status had declined. In particular she seemed unable to use her left arm, which he described as a "head scratcher", since she only had mild soft tissue injuries and nothing had shown up on her normal x-ray. He described this as self-limitation, as he believed they should have seen at least some effort and such deterioration would not normally be expected. At the same time, he described some of her activities which had been observed and reported by staff when she was outside of the gym. These abilities were inconsistent with her lack of ability and her performance in the gym during exercises and testing. [Rehabilitation specialist] also commented upon [OT]'s conclusions in her report that the Appellant was not even able to meet the designation for sedentary work. He explained why the clinic does not do the end range testing that [OT] had noted, as it can be potentially injurious to patients to push them into a painful range. It was not relevant and lacked therapeutic benefit. The Appellant's diagnosis of whiplash associated disorder and soft tissue injury to her lower back had already been established. Following her extensive rehabilitation, it was his view that she could be discharged from the program fully capable of returning to work, notwithstanding her substantial symptom complaints.

<u>Cross-examination of [Rehabilitation Specialist]</u>

[Rehabilitation specialist] confirmed that he had put his hands on the Appellant to examine her during the initial multi-disciplinary assessment. He did not however, examine her when she began to complain of left neck and arm pain, as the therapists on the gym floor had the

opportunity to observe and evaluate those issues and had not communicated any level of concern to him in that regard. His notes at the end of the program reflected her complaints about pain, including her arm, but did not show that he examined her at that point.

[Rehabilitation specialist] confirmed that he did not use the end feel test to diagnose a shoulder problem. While [physiatrist #2] made note of a shoulder impingement in his report, [physiatrist] and [rehabilitation specialist] had not noted this. He did not agree that either a shoulder impingement or ulnar problem in the left elbow would cause the Appellant to be unable to do things like hold a steering wheel or take her socks off.

When asked if soft tissue injuries always heal within a few weeks, [rehabilitation specialist] indicated that no, that is not always the case and that sometimes it becomes a chronic problem. It can persist for years and can manifest with ongoing symptoms and complaints. He was asked about treatments for chronic myofascial pain syndrome and provided examples such as hot packs, acupuncture or injections with local anaesthetic.

When asked about the Appellant's deterioration and his recommendation that she could return to work notwithstanding, he indicated that they could not find anything wrong with her. Without a major diagnosis he did not see why she could not return to work and he believed that a graduated return to work was recommended. The overall impression and consensus of the medical specialists, he indicated, was that she did not have a condition that would prohibit return to work and that patients are not precluded from going back to work due to muscle achiness that is myofascial pain. He did not know whether MPIC had worked with her employer to determine and confirm return to work duties with restrictions. He was of the view that she certainly could do light or sedentary duties.

[Rehabilitation specialist] was asked if the Appellant saw any staff with psychological expertise during her time at [rehabilitation consultants]. He could not recall specifically, but indicated that if he had been of the impression that she would have benefitted from that based on her behavior and past history, he would have suggested something like cognitive behavioral therapy.

Submissions

Submission for the Appellant

Counsel for the Appellant addressed two aspects regarding her entitlement to further IRI benefits. The first was her fitness to return to her full duties as a [text deleted] and the second was whether injuries preventing her from returning to employment are a consequence -direct or indirect- of the MVA.

Ability to Return to Employment

Counsel submitted that not a single medical professional provided an opinion that the Appellant was fit to return to her full pre-MVA duties. Her family doctor consistently stated she was not fit to return to these duties and [pain specialist #2] and [pain specialist] both provided reports stating that the Appellant could not perform her pre-MVA duties.

Neither [neurologist] nor [physiatrist #2] provided an opinion that she was able to return to work and [physiatrist] declined to provide such an opinion in her first report (as she had not been asked to). [Physiatrist]'s second report deferred such a determination to the physiotherapist, advising that she would have recommended a graduated return to work with numerous restrictions, but because of the Appellant's deterioration did not know what was still possible, as she did not know what was causing the Appellant's symptoms.

The [rehabilitation consultants] discharge report recognized that the Appellant could not perform work at a medium level, as required in her job as a [text deleted]. The PDA confirmed that frequent demands of the job were medium, while [rehabilitation consultants]' testing showed that the Appellant was capable only of sedentary to light duties. In his testimony, [rehabilitation specialist] agreed that the Appellant could not perform at a medium level, although he speculated that she might have been able to do so if she had participated more fully in the rehabilitation exercises. Counsel further noted that [rehabilitation specialist] had failed to properly examine the Appellant's shoulder or elbow and the evidence did not establish that any other staff at [rehabilitation consultants] did so either.

Counsel noted [OT]'s testimony regarding the importance of discovering the cause of pain symptoms in order to provide proper therapy and avoid further damage. She described how the end feel test should be used to determine the problems with joints and assess whether the Appellant was providing honest effort. [Rehabilitation specialist] stated that doctors do not use these passive range of motion or end feel tasks because they could result in further injury, even though [pain specialist] and [physiatrist] did appear to use some passive range of motion tests.

Counsel relied upon [OT]'s review of the medical information on file and her comparison of it with the PDA. She concluded that the Appellant could return to work with a number of restrictions but could not perform significant aspects of her pre-MVA duties. She pointed out several deficiencies in the [rehabilitation consultants] reports which undermined their conclusion that the Appellant could work at a light level. The testing demonstrated she was only qualified for the sedentary category of work. Since several aspects of the Appellant's job required her to perform at a medium level, the OT's conclusion was that she could not return to her job.

Counsel submitted that [rehabilitation consultants] had concentrated on the Appellant's duties in the [text deleted] and failed to take into account potential duties such as intervening in confrontational situations between [text deleted] or numerous tasks required on the night shift, which the Appellant was incapable of performing.

He submitted that [OT]'s report was not invalidated by the fact that she did not perform a personal assessment of the Appellant prior to writing her report, since the final request for an assessment came in 2018 and no personal assessment at that point could shed light on the Appellant's condition several years earlier.

Counsel also criticized [rehabilitation specialist]'s speculation that the Appellant would have been capable of performing medium level work had she participated more fully in the rehab exercises, adding that he failed to take into account the many recognized reasons (such as pain, psycho-social reasons, or fear of re-injury) why someone might not participate fully in a program. [Rehabilitation specialist] interpreted the data in a prejudicial manner and his "impressions" were given more prominence than the actual evidence.

Counsel submitted that given the recommendations of a graduated return to work with restrictions, MPIC should have contacted the employer to determine if modified or alternative work duties were available. But there is no evidence on the file that such an effort was made by MPIC, who instead decided to terminate the Appellant's IRI benefits on the basis that her injuries were no longer the result of the MVA.

All of the evidence before the panel, including the [rehabilitation consultants] reports, indicate that the Appellant was not fit to return to her full pre-MVA duties.

Causation

Counsel took the position that the Appellant had pre-existing neck and low back problems that were consequence of previous MVA's and aggravated by workplace injuries, but she was able to perform her duties as a [text deleted] following recovery. She described some residual pain symptoms in her neck and low back, but these did not prevent her from performing all of the duties of her job.

Since the 2010 MVA she has not been able to return to her pre-MVA job.

MPIC accepted that her neck and low back problems were causally related to this MVA for approximately a year and a half, and her symptoms during that period and subsequent to it have been consistent. In addition, she developed a left shoulder impingement and left elbow neuropathy during the third week of the [rehabilitation consultants] program. It is reasonable to conclude that these additional problems were consequences of the exercises that [rehabilitation consultants] had her performing. Yet [rehabilitation specialist] made no effort at the time to determine a diagnosis, simply concluding that her MVA-related injuries had resolved. MPIC declared that her complaints were no longer related to the MVA, with no rationale offered to support that position.

Counsel for the Appellant reviewed some of the medical evidence on file, pointing out that [physiatrist] had not provided an opinion that the Appellant's symptoms were not related to the MVA. She simply noted that the degenerative disc disease in her cervical and lumbar spine (which were not the source of her pain symptoms) were not MVA-related.

[Physiatrist #2], while asserting that her symptoms were not a consequence of the MVA by referring to some pre-existing pain in the lower in the neck and lower back, ignored the evidence that these problems were consequences of the 1996 and 1997 MVAs.

In fact, earlier reports from 1997 showed that the Appellant had previously been diagnosed with regional myofascial irritability or a chronic myofascial pain syndrome. After that, while there were workplace injury incidents, following rehabilitation and alternate duties, she recovered and returned to work.

Following the 2010 MVA, the Appellant was diagnosed with whiplash muscle strain and musculoskeletal neck and lower back strain. By 2011, reports showed flare-ups of neck and back pain plus sciatica with possible radiculopathy and reduced ROM. Her family doctor and physiotherapist said that she would not be able to perform her pre-MVA duties.

Initially, [physiatrist], while diagnosing myofascial pain in the cervical muscles, opined that the Appellant could not perform the heavier duties of her job, leaving any decision on a graduated return to work to the physiotherapist. However, in her second report, [physiatrist] for some reason changed her mind, with no explanation for doing so. She stated that she did not know what was causing the Appellant's increased pain symptoms, finding that her myofascial pain syndrome had resolved.

Later however, [physiatrist #2] discovered a left shoulder impingement and an ulnar neuropathy in the left elbow was diagnosed. Both could explain the Appellant's left arm problems.

[pain specialist] and [pain specialist #2] reported that myofascial pain was still a problem in 2013. This was also found by [doctor] in 2015. Counsel suggested that chronic myofascial pain syndrome/chronic whiplash disorder/chronic cervical/lumbar dysfunction (all of which have been diagnosed) do not disappear and then reappear over the course of a few months, especially in the absence of specific treatment for the disorders.

Counsel relied upon the reports of [OT] and her systematic critique of the problems with the [rehabilitation consultants] reports. He submitted that [rehabilitation consultants] failed to report that the Appellant's condition actually deteriorated during the course of the rehab program, especially in regard to her left neck, shoulder and arm. Yet [rehabilitation consultants], according to [rehabilitation specialist], made no effort to uncover the cause of that deterioration, admitting that he made no physical examinations of her neck and shoulder during that time. Both the shoulder impingement and ulnar neuropathy were dismissed by [rehabilitation consultants], [physiatrist #2] and MPIC.

Yet [family doctor] continued to report decreased neck movement associated with tenderness as well as restrictions in the left elbow.

[Pain specialist #2] diagnosed chronic WAD II, chronic mechanical back pain syndrome and fibromyalgia, recommending trigger point treatment which MPIC refused to fund.

[Doctor] documented examination findings and diagnosed chronic myofascial pain and dysfunction in the presence of general deconditioning, with the work hardening program having proved more injurious than therapeutic. He disagreed with [physiatrist #2] who had described her

condition as pre-existing fibromyalgia. On the balance of probabilities, he found her condition to be a continuation of the effects of the 2010 MVA.

Counsel also addressed MPIC's position that the Appellant was feigning her injuries in order to avoid returning to work. [OT] noted (and this was agreed to by [rehabilitation specialist]) that inconsistent effort in an exercise program could have many explanations, only one of which is feigning. Further, it would be dangerous to rely on the statement or innuendos of the [rehabilitation consultants] reported observations of the Appellant using her left arm outside of the exercise program, as they are not supported by specific data and don't necessarily show above the shoulder activities. This should be contrasted with [OT]'s evidence that she did not find any evidence of feigning in her analysis of the [rehabilitation consultants] data.

Therefore, it was submitted that the panel should find that the Appellant's ongoing condition and inability to work were causally related to the MVA and that the Commission should overturn MPIC's decision to end the Appellant's entitlement to IRI benefits.

Submission for MPIC

Counsel for MPIC submitted that the medical reports on the Appellant's file tell a story. That story for this Appellant, shows that as work nears, symptoms appear. It is a pattern we see time and again when reviewing her file.

It can be seen in her complaints following the 1996 MVA, when she suffered soft tissue injuries to her neck and back, with bruising, and then developed additional complaints of headache relapse when it was time to go back to work. She then remained off work until August 1997 in spite of efforts to get her back to work by [rehabilitation specialist] and a rehabilitation

counsellor from an organizational rehabilitation group. She stopped attending physiotherapy and seemed to have no real enthusiasm for the gradual return to work program suggested or for her case manager's discussion about getting back to work, even though her family doctor found she was ready to work and [rehabilitation specialist] had confirmed that she could return to work with no restrictions in July.

She then reported incidents at work, one where a towel was placed around her neck and one while lifting laundry soap. As her WCB benefits ended and returns to work approached after these workplace incident, she did not want to go back to work on the night shift, even at modified duties, and called in sick.

The same pattern emerged as the return to work neared following her 2010 MVA. The MVA caused soft tissue injuries to her neck and lower back. By spring of 2011 she had completed a 4 week rehabilitation program at [rehabilitation consultants] and was to start a graduated return to work program. This program was frustrated when she told her family doctor that the rehab program had made her worse and he said she could not work. The case manager deferred to [family doctor] and the rehab program was extended. The progress which had been made was paused and the Appellant continued to collect full IRI benefits.

After another 4 week program, new symptoms appeared. The Appellant remained off work for another year. Even after attending for IMEs with specialists who did not find MVA-related conditions preventing her from working, she did not return to work and continued to collect IRI benefits until terminated by MPIC.

Counsel submitted that the most important documents to consider are the ones from the time of the MVA. These show a diagnosis of musculoskeletal neck and low back strain. Normal healing for that kind of injury is 4-6 weeks or maybe 1-2 months. But after the first few weeks, the Appellant's injuries became a moving target for her doctors. The Appellant added headache, numbness on the side of her head, buttock pain, tingling in her leg, pain in her leg and back, sore hips, numbness in her elbows and right side of her head and face and knee pain. By July 2011, 8 months after the MVA, she was reporting pain everywhere in her body.

Along with her parade of symptoms, he submitted, the Appellant claimed that [physiatrist #2] told her she needed a cane to walk (when he says in his report that she is able bodied) and that her neck was broken when the MVA happened. She was inconsistent in her reports of whether she injured her shoulder at work, and made inconsistent reports in her WCB file after she lifted the laundry soap.

Counsel submitted that caution should be used in relying on the later reports on file from [doctor], [pain specialist] and [pain specialist #2]. They saw the Appellant much later, years after the MVA and did not fully consider her past history of WCB and MVA-related complaints.
More weight should be placed, he submitted, upon reports from [physiatrist] and [physiatrist #2], who saw her closer in time to the 2010 MVA. They took into consideration her clinical presentation and widespread symptom complaints, which neither could relate to the MVA.

Counsel also submitted that even if the Appellant did suffer from these pain symptoms, according to [rehabilitation specialist] she was able to return to her job in a graduated manner. Her employer was prepared to accommodate her. The question of whether she could do medium, sedentary or light work does not matter, because the Appellant was not willing to try.

[Rehabilitation specialist] and his staff saw her over two consecutive rehab programs and confirmed that she did not give her full effort. Then she would not want to attend for a graduated return to work.

Nothing in the [rehabilitation consultant] materials corroborated the Appellant's claim on cross-examination that she had injured her arm on one of the [rehabilitation consultants] exercise machines, and this claim was in direct contrast to her evidence on direct examination (and the evidence of [rehabilitation specialist]) that there were no trauma to her arm sustained in the facility. [Physiatrist #2] noted some shoulder impingement on examination but made no mention or conclusion in regard to it in the report. [Physiatrist #2]'s report and lack of findings of any MVA-related condition led MPIC to reconsider the Appellant's IRI benefits.

Counsel submitted that by then the Appellant's soft tissue, compensable injuries had long since healed. She may have suffered from some subjective pain identified much later by [pain specialist] and [pain specialist #2], which could come and go, but their opinion that this was caused by the MVA should be given less weight than the opinions of [physiatrist #2] and [rehabilitation specialist].

Finally, counsel submitted that the panel should be aware of the Appellant's pattern of continuing to complain of symptoms even after her injuries have healed, through her other MVA and WCB claims and in this case, and should consider the secondary motivation for such behavior which the important IRI benefits provided.

<u>Appellant's Reply</u>

Counsel for MPIC submitted that the Appellant's history did not show a pattern of not wanting to return to work. Rather, while she may have had some discrepancies with her case manager or WCB in the past, over issues such as hours of work or obtaining benefits in a timely manner, she had always returned to work.

Her condition should not be described as a parade of symptoms as counsel for MPIC had implied. While various symptoms did arise after the MVA, this is not unusual. These things do happen and do not negate the fact that she consistently had neck and low back problems following the MVA and until now. Injuries and symptoms that arose as a consequence of rehabilitation exercises following the MVA are still related to the MVA. Her MVA injuries and the chronic pain from which she suffers did not get better with time, in spite of MPIC's expectation that they would. She saw [pain specialist] and [pain specialist #2] only 2 years after the MVA and they attributed her condition to the MVA.

Discussion

The MPIC Act provides:

> **Definitions**
>
> 70(1) In this Part,
>
> > **"bodily injury caused by an automobile"** means any bodily injury caused by an automobile, by the use of an automobile, or by a load, including bodily injury caused by a trailer used with an automobile…..
>
> **Entitlement to I.R.I.**
>
> 81(1) A full-time earner is entitled to an income replacement indemnity if any of the following occurs as a result of the accident:
>
> > (a) he or she is unable to continue the full-time employment;

> (b) the full-time earner is unable to continue any other employment that he or she held, in addition to the full-time regular employment, at the time of the accident;
>
> (c) the full-time earner is deprived of a benefit under the *Employment Insurance Act* (Canada) to which he or she was entitled at the time of the accident

The onus is on the Appellant to show, on a balance of probabilities, that the IRO erred in concluding that she did not suffer from ongoing complaints related to the MVA which prevented her from working. While the Appellant did submit evidence from her family doctor, and [pain specialist], [pain specialist #2] and [doctor] which supported her position, the panel, on consideration of the totality of the evidence before us, has placed greater weight upon the evidence of [physiatrist], [rehabilitation specialist] and [physiatrist #2].

Counsel for MPIC submitted that the answer to whether the Appellant's condition on May 11, 2012 was related to the November 21, 2010 MVA could be found in the IME report of [physiatrist #2] dated February 10, 2012.

[Physiatrist #2]'s examination found widespread symptomatic complaints without a physical or patho-anatomic diagnosis to explain them. He related the Appellant's complaints to her pre-existing history of widespread symptomatic complaints (fibromyalgia syndrome) prior lower back pain and likely prior ulnar neuropathy, with related deconditioning. These may have acted to contribute to her current symptoms as a manifestation of the pre-existing conditions, and also to delay recovery.

> … There does not appear to be any relevancy/ relationship of the current symptoms to the MVA in question.

In reviewing this report, the panel found that [physiatrist #2] did not include a detailed analysis of the lack of connection, in his view, between the current symptoms and the MVA.

The panel therefore turned to [physiatrist #2]'s addendum report of July 31, 2015, which reviewed additional medical evidence regarding her pre-MVA history and documentation regarding myofascial pain and fibromyalgia. With this background, he noted the persistent pre-existing subjective symptoms which the Appellant had experienced and which did not really change after the MVA. He noted that there were only minimal symptoms reported and no major objective findings following the MVA. Her minor soft tissue injuries would have been expected to resolve quickly. Her persisting symptoms were noted still to be present immediately prior to the MVA of 2010. He concluded that a significant contribution to her more recent symptoms by the MVA was not supported by the available medical evidence of the file.

The panel also carefully considered the reports provided by [physiatrist]. The Appellant was referred to [physiatrist] by her family physician. Her first report dated March 7, 2011, was based upon her examination of the Appellant on January 20, 2011 and diagnosed myofascial pain in the cervical muscles and some spondylosis, secondary to degenerative disc disease. She did not assess the Appellant's capability to return to work at that time, but recommended continued stretching and strengthening.

Upon reviewing the file again in June 2011, [physiatrist] was "perplexed" that instead of the Appellant improving from her myofascial pain syndrome in the cervical and upper back area, she was now having additional symptoms. A report from [rehabilitation specialist] dated May 30, 2011 noted that the Appellant had described pain all over her body and pain in her upper left limb, which had not been a problem when [physiatrist] initially saw her in January 2011.

[Physiatrist]'s second report dated July 7, 2011 was based on an examination of the Appellant on June 29, 2011. She described some of her examination results as surprising. The original consultation found tightness of the muscles around the neck and trapezius, right more than left, with no real findings in the shoulders or lower spine. Following review of x-rays, [physiatrist] had concluded that most of the Appellant's problems were of soft tissue origin involving her neck and upper back area.

[Physiatrist] described the results of her examination of the patient on June 29, 2011, which had surprised her.

> When I examined her, surprisingly the tightness of the trapezius muscle was not a major issue and there were no active trigger points to be found. Examination of the posterior cervical, scalene, sternomastoid, and trapezius did not reveal any trigger points. She had fairly good mobility of her neck in flexion and extension but rotation was limited. This seemed to be self-restricted and when I asked her to do lateral flexion, she hardly moved her neck.
>
> The most surprising finding was the left shoulder. In January, she did not have any trigger points or any other findings and this time around, she is very protective of the left upper limb and told me that she could not move the shoulder at all which seems more functional rather than organic because when she was trying to get her socks and shoes off she did use the left upper limb functionally.
>
> Because she felt that she could not raise her arm at all, I did internal and external rotation from the waist level which is pure external and internal rotation and these were full.
>
> I was unable to do the strength because she complained that she was in a lot of pain. During the entire examination, she had significant pain behaviors.

[Physiatrist] concluded that the myofascial pain syndrome had resolved and was replaced by a "diffuse pain disorder of unknown etiology". She diagnosed a "chronic pain disorder and pain focused behavior" with no recommendation for treatment other than continuation of sleep correction and pain control medication. She indicated that she was not sure what was causing the Appellant's chronic pain and pain focused behavior, but that perhaps, as for her worsening,

psychological involvement for cognitive behavioral therapy might assist her to become aware that pain does not mean harm and to increase her function and activity level.

She also recommended a graduated return to work, working only the day and evening shift with no night shift and then set out restrictions on some of the duties and movements the Appellant could do.

The panel has observed that comments such as those made by [physiatrist] regarding the Appellant's pain focused behavior can be seen at a variety of points and in a variety of reports on the file from different medical professionals. This behavior seems to have appeared mostly in the offices of doctors who cared for or assessed her, and at [rehabilitation consultants]. While the Appellant testified that she could no longer do sports and sometimes needed help cleaning her house, she did not provide reliable or specific evidence that showed her to be so affected by pain that her overall activities, including activities of daily living, were significantly impaired. She described being able to do some activities around the house, and to drive to [text deleted] from [text deleted] on several occasions. The evidence showed she used minimal medication for pain control. The panel did not hear evidence from friends, family or co-workers regarding her condition or impairments.

Most importantly for the panel, [physiatrist], by the time of her second report, was no longer attributing the Appellant's pain to the MVA.

This led the panel to consider the opinions of other doctors. Some, like [rehabilitation specialist], [neurologist] and [text deleted] reported around the same time in 2010 and 2011. Others, such as

[pain specialist], [doctor] and [pain specialist #2], did not become involved until some years later (2013-2015). [Family doctor] reported consistently across both periods.

[Rehabilitation specialist] provided a discharge report (from the Appellant's first [rehabilitation consultants] program) dated May 9, 2011. He concluded that although the Appellant was pain-focused and self-limiting during her time in program, and failed to complete tasks as assigned, she had demonstrated the physical ability to start a gradual return to work process at the light to sedentary physical level.

[Rehabilitation specialist] had further discussion with the Appellant to address ongoing symptoms, described in his report dated May 30, 2011.

> [The Appellant] completed a pain diagram today, which indicates pain in all body areas, with no focus of symptoms on her left arm. She affirmed that since the accident there is pain all over, but left arm is now dominant since the MVA. …

He noted that no medication had been prescribed or increased to deal with that pain, his examination of her left shoulder showed almost full ROM, and her left elbow, wrist and hand were normal.

> … There is no outward appearance of any abnormalities to the left elbow, wrist or hand area.

[Rehabilitation specialist] concluded:

> … I remain concerned that her increased symptoms remain enigmatic and that there is no medical pathology evident to explain the symptoms and no medical explanation as to why her symptoms would have worsened in rehab...

This was followed by completion of another 4 week rehabilitation program, with discharge report dated June 24, 2011 recommending gradual return to work, noting no objective findings for the current symptom increases in her left arm and anticipating her further meeting with [physiatrist] on June 29, 2011 (reviewed above).

[Neurologist] examined the patient on July 14, 2011 and reviewed her MRI. He noted the MVAs in which she had been involved. He found moderately restricted cervical range of motion, some shallow disc protrusion with no obvious impingement/distortion and no obvious clinical or radiological signs of a radiculopathy or myelopathy. The discomfort she was experiencing was very probably musculoskeletal. He did not discuss causation.

[Pain specialist] reported on March 18, 2013, diagnosing fibromyalgia and myofascial pain syndrome with taut bands that he recommended for treatment with trigger point injections by [pain specialist #2]. He did not address the issue of causation in this report. In a later report dated May 7, 2015 he opined that the Appellant's presenting signs and symptoms were causally related to the MVA of November 1, 2010 and May 2, 1996, that she suffered from fibromyalgia which was post-traumatic in nature related to the MVAs, and that she was not able to return to work in May 2012 due to MVA-related symptoms.

[Pain specialist #2] reported on March 21, 2013. He reviewed what the Appellant had told him about her MVAs and her pain, diagnosing chronic whiplash syndrome, chronic mechanical low back pain syndrome and fibromyalgia. He recommended a trial of local injections and manual therapy. [Pain specialist #2] did not undertake detailed analysis regarding causation of her condition, but did attribute it to the MVA. He seemed to rely upon the patient's reporting to him of her symptoms and their origin.

Some years later, on February 4, 2015, [doctor] provided a report noting chronic myofascial pain and dysfunction in addition to general deconditioning. He attributed the Appellant's worsening condition not to her pre-existing fibromyalgia or her WCB related injury, but rather to the effects of her MVAs and the vicious cycle of MVA injuries which were not well managed or treated.

> The clinical picture is one of extensive chronic myofascial pain and dysfunction in the presence of general de-conditioning from low levels of exercise and lack of treatment for more than four years duration: the 2011 [rehabilitation consultants] work hardening was more injurious than it was therapeutic, according to her experience. She had some remedial massage in the late 1990's. The distribution of symptomatic muscle groups has close relation to the injury sites from her early motor vehicle accidents: left shoulder, neck and low back. She has had scant treatment or remedial attention and she has resorted to a living pattern that avoids activities that aggravate and provoke her symptoms. In the absence of treatment and coaching on gradual progression and reconditioning, the prognosis is one further gradual decline.

He did not agree with [physiatrist #2]'s diagnosis of pre-existing fibromyalgia and stated that on a balance of probabilities her present condition was a continuation of the effects of the 2010 MVA which caused a significant worsening of the limitations that arose from the prior 1996 MVA.

Although [doctor] reviewed reports from [family doctor], [rehabilitation specialist], [physiatrist #2] and [physiatrist], he also relied upon the Appellant's subjective report to him. For example, he stated that

> [The Appellant] estimates that 90% of her functional impairments in daily living she experiences now were a result of the 2010 MVA. She highlights how post 2010 impairments restrict her lifting and reaching forward at head level and above, particularly with her right arm, weights greater than a few pounds and holding her arms outreached for any length of time. Arm use such as this frequently triggers flare ups of neck stiffness with loss of neck rotation, upper shoulder and posterior neck pain and associated headaches. She complains of a constant presence of stiffness in the neck and shoulders with a tight, burning, tearing discomfort in her posterior left shoulder much worse than prior to her 2010 MVA. She has tingling in the fingertips of both hands in a 50/50 distribution. She finds home activities washing dishes and wiping surfaces to aggravate elbow pain in a bilateral pattern as well as her shoulders and neck.

> Low back symptoms and functional impairments also increased significantly following the 2010 MVA. Her low back pain is near constantly extending into her upper hips and laterally into her upper thighs restricting her tolerance for sitting and standing. She resorts to rocking side to side to ease the discomfort and walks cautiously. The left, lower extremity is more impacted than the right with anterior knee pain, 80%, left side 20%, associated with rising from a seated position and walking up stairs. She relies on her stronger right leg.

As noted, [family doctor] provided consistent care for the Appellant and multiple reports from him were reviewed. Throughout these multiple visits with the patient and reports, he was consistently of the view that the Appellant could not return to work due to her MVA injuries. He referred her to numerous specialists in attempts to address the possible source of her pain. On June 13, 2013, he wrote a narrative report that set out her complaints post-MVA, opining that her neck and back pain related to the MVA and that she was not able to return to work on May 11, 2012 for reasons relating to the MVA.

> … My impression is that following the MVA of November 21, 2010, [the Appellant] has been suffering from headache, pain in the neck, back, upper limbs, hips and knees of musculoskeletal in origin and sciatica with possible radiculopathy as well as mild focal ulnar neuropathy. I am unable to comment on prognosis at this time. [Pain specialist] and [pain specialist #2] made recommendations in connection with further management (see below).
>
> I would say that on a balance of probabilities, [the Appellant]'s ongoing neck and back pain complaints are related to the MVA of November 21, 2010 as she had these complaints since the time of the accident and she continues to have them till now. Also for approximately 17 months, prior to the accident, she had not complained of pain to me.
>
> [the Appellant] was not able to return to work as a [text deleted] on May 11, 2012 for reasons related to the MVA of November 21, 2010, as she complained and continues to complain of neck and back pain and has had decreased/restricted range of movements of her neck and back (spine), associated with tenderness, and the straight leg raises were restricted, associated with tenderness. Also she reported that sitting, standing or walking for longer than five to ten minutes, would increase her pain and that she would not be able to concentrate and focus.

The Commission tends to place a good deal of weight upon the reports of such primary caregivers, who often have the opportunity to see their patient both before and after the MVA and who follow their care and treatment. But in this case, we must also place sufficient weight upon the conclusions of specialist physiatrists such as [text deleted] and [physiatrist #2], and especially [physiatrist], who received the referral to see the Appellant from [family doctor] himself. These specialists did not find evidence of a serious injury following from the MVA, aside from some degenerative changes and the Appellant's subjective reports of pain. [Family doctor] continued to describe the Appellant's pain as she reported it to him, but did not really provide a thorough analysis as to how it continued to be connected to the MVA, regardless of how many years had passed and how few objective findings the specialists' assessments and investigations confirmed.

MPIC's Health Care Services medical consultant noted the significant differences in the Appellant's file on the issue of causation, and in a report dated September 26, 2013, he reviewed the newer information from [neurologist], [text deleted], [pain specialist] and [pain specialist #2].

The consultant was still unable to find a correlation between her diagnosis and ongoing pain.

[Rehabilitation specialist] reviewed [doctor]'s comments on April 13, 2015 and found [doctor]'s report to be incomplete, with erroneous conclusions and incorrect assumptions based largely upon subjective reporting.

The consultant also reviewed [doctor]'s report, on March 12, 2015. He accepted that [doctor] had arrived at different conclusions from the physiatrist reports on file, but noted that this was only one opinion. He could not account for how [doctor]'s diagnosis would be more valid than those

of the other doctors, when he had not explained his differences of opinion from the other doctors' reports on the file.

According to the Appellant, however, the rehabilitation at [rehabilitation consultants] caused her to further injure or damage her arm and her counsel pointed to an examination finding by [physiatrist #2] of some impingement in her shoulder. But [physiatrist #2], beyond noting this finding on physical examination, made no mention of it in the final commentary of his report, and did not put forward any diagnosis in connection with it or relate it to the MVA.

Further, the panel finds the evidence of the Appellant on this point, as expressed to her caregivers and in testimony at the hearing, to be inconsistent and therefore unreliable.

Her reports to caregivers regarding her arms and shoulders were sometimes contradictory, complaining of pain in one arm, then the other, while failing to mark the region on a pain diagram. She complained of arm pain that would prevent her from performing even modified work duties restricted to lifting under 25 pounds and no contact with [text deleted].

In a file note dated May 26, 2011, she told her case manager that her left arm was injured in the MVA. When asked if she had discussed this with her family physician, she said she had, but that he provided no diagnosis and told her to explain her concerns to [rehabilitation specialist]. She testified that she complained about it to a therapist on the floor at [rehabilitation consultants], who told her to consult her family doctor.

The panel did not hear evidence of a specific trauma or injury to her arm, although this was asserted by counsel for the Appellant. Physical examination by [rehabilitation specialist] as well

as x-ray and nerve conduction studies, found her arm and elbow to be normal, but her subjective pain complaints continued.

[Doctor]'s report of October 31, 2012 reviewed the ulnar electrodiagnostic and motor nerve conduction studies and indicated that "the electrodiagnostic studies do not support any evidence of neuropathy to explain her symptoms".

Yet at [rehabilitation consultants] the Appellant said that her arm was more and more sore and that she didn't want to become "armless". The arm pain appears to have coincided with her complaint that everything hurt, with pain all over her body, near the end of her rehabilitation program and the return to work.

The panel also found the evidence of the Appellant regarding her overall condition to be less than consistent or reliable. Her evidence that she is always in pain all over her body contrasted with her demeanor and an absence of impacts described by her. She did not provide cogent evidence of an inability to sit and drive long distances or carry out other activities, with the exception of participating in sports. She testified that she was disabled by her pain and could not perform her housework or job duties, but this was not corroborated by any other witnesses, aside from the opinion of [OT] that she could perform only part-time sedentary employment. But [OT] did not know the Appellant at the time of her termination of benefits and was not able to examine her then. Her evidence was focused on reviewing the Appellant's ability, given her reported symptoms, to perform the job duties of a [text deleted]. Nor was there evidence regarding results of the Appellant's attempts to gradually return to work, since, as will be further reviewed below, she did not fully cooperate in her rehabilitation programs or at all with the graduated return to work programs proposed for her.

Although the Appellant was diagnosed with a pain disorder by the physiatrists, she did not believe that there was anything wrong with her psychologically. She felt that her only problems were physical and was not open to treatment with a psychologist. Unfortunately, in her psychological IME, [neuropsychologist] picked up on this reluctance, opining that psychological treatment was not medically required as a result of the MVA, and it was not approved by the case manager. The Appellant did not challenge this decision.

By this point, the physiatrists who examined her could no longer connect her ongoing pain focused behavior to the MVA or conclude that it prevented her from returning to a gradual return to work program. This was supported by the reports of [rehabilitation specialist], [physiatrist #2] and [physiatrist], who all came to the same conclusions regarding causation, opining that there was no longer anything wrong with the Appellant that was caused by the MVA (or, in the case of [rehabilitation consultant] and [physiatrist], that prevented her from participating in a graduated return to work program.)

Therefore the panel finds that the Appellant has failed to show, on a balance of probabilities, that by May 11, 2012, she was still suffering from a condition caused by the MVA that entitled her to further IRI benefits.

Ability to Return to Work

Although the panel has found that the Appellant's condition on May 11, 2012 was not caused by the MVA, the Commission did hear evidence and submissions from the parties regarding the Appellant's ability to work as a [text deleted]. A large part of the testimony of [rehabilitation specialist] and [OT] centered upon the Appellant's ability to work at a sedentary or light level, and much of the evidence concerning the categorization of her job as a [text deleted] classified

much of the job at a medium level. We also heard and reviewed evidence which indicated that the Appellant's employer had in the past provided lighter duties and accommodated her restrictions, and remained willing to do so in a return to work program. Evidence was not submitted from her employer to indicate that there were tasks within her restrictions which she must perform, that she had attempted a return to any duties and failed, or that accommodations could not be made. Rather, a file note recorded on May 9, 2011 indicated that in a conversation with the case manager the employer explained that they were able to accommodate [rehabilitation specialist]'s return to work plan and her restrictions.

As a result of our findings on the issue of causation, it is not necessary for the Commission to determine the Appellant's ability to work. As an aside, we have noted that much of the medical evidence upon which we relied indicated that there was no condition arising from the MVA which would have prevented the Appellant from returning to a graduated return to work program. In this regard, the panel would have considered her entitlement to further IRI benefits, by way of top-up wages, if the Appellant was not able to work full-time, full duties during the course of a graduated return to work program. However, this was complicated by the Appellant's refusal to participate in such a program after the second [rehabilitation consultants] program, in the same way that she did not provide full cooperation with the [rehabilitation consultants] rehabilitation programs and previous attempts to return her to a graduated work program in May of 2011. The rehabilitation diaries, discharge notes and [rehabilitation consultants] reports showed that, as [rehabilitation specialist] expressed, she was not cooperative or committed to the process. Therefore, the panel has also not found that the Appellant is entitled to IRI top-up benefits to supplement her wages during a graduated return to work program.

In conclusion, the panel determines that the Appellant has failed to show that she is entitled to further IRI benefits as a result of injuries arising out of or caused by the MVA. We find that MPIC did not err in terminating her IRI benefits.

As a result, the IRD dated September 13, 2012 is hereby upheld, and the Appellant's appeal dismissed.

Dated at Winnipeg this 22nd day of February, 2022.

LAURA DIAMOND

JANET FROHLICH

DR. SHARON MACDONALD