Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an appeal by [the Appellant]
AICAC File No.: AC-98-22

PANEL:	**Mr. J. F. Reeh Taylor, Q.C., Chairman** **Mrs. Lila Goodspeed** **Mr. F. Les Cox**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') represented by Ms Joan McKelvey;** **the Appellant, [text deleted], was represented by [Appellant's representative]**
HEARING DATE:	**December 16th, 1998**
ISSUE(S):	**1. Whether personal care assistance benefits properly terminated;** **2. Whether income replacement indemnity benefits properly terminated; and** **3. Whether Appellant entitled to continuing rehabilitative treatment.**
RELEVANT SECTIONS:	**Sections 70, 83, 84, 107, 110(1)(a), 131 and 138 of the MPIC Act ('the Act'), Sections 6 & 8 of Manitoba Regulation #37/94, and Section 2 (plus Schedule A) of Regulation # 40/94**

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

REASONS FOR DECISION

On June 30th, 1994 [the Appellant] was driving north on [text deleted] Keewatin Avenue crossing the intersection of [text deleted] on a green light when a car running the red light struck

his right rear bumper. [The Appellant] testified that the collision caused his car to take a 180-degree spin and end up with its front wheels on the sidewalk. [The Appellant] was able to get himself out of the car and lie down on the boulevard for a few moments, after which he was able to drive his car to a family member's home and report the accident to the police. The driver of the other vehicle had disappeared. [The Appellant's] vehicle, purchased some six months previously for about $900.00, was apparently written off.

[The Appellant] testified that he had hurt his right knee when jamming on his brakes, that his eyeglasses were bent, that his seat belt had tightened up and given his body "a good yank". Shortly after the accident, he said, he had felt a burning in his right leg and soreness in his groin, scrotum and buttocks. He reported to his family physician, [text deleted] on July 4th, 1994 where he was diagnosed with the following injuries. "Neck & back strain & contusion & strain, R (right) knee". (It is perhaps noteworthy that these quoted items continued to be the only complaints and diagnosis recorded by [Appellant's doctor] until December 15th, 1994, when [the Appellant] is reported for the first time to have complained of headaches.) He was treated with heat to the neck, back, and right knee, prescribed Robaxacet and Tylenol 3, and referred for physiotherapy treatment. [Appellant's doctor] determined that he was unable to return to work for the time being.

Post-MVA Medical History

[The Appellant] started physiotherapy treatments on July 11th, 1994. [Appellant's physiotherapist], [the Appellant] and his Adjuster, [text deleted] Mr. Chris Marlatt, reported slow

but steady progress until in early May of 1995, as [the Appellant] puts it he "blew his knee" while exercising. Three hours later, he testified, his knee had swollen so much that he went to see [Appellant's doctor], who advised him to avoid physiotherapy for the following two weeks. Meanwhile, on August 11th, 1994, [the Appellant] was examined by [text deleted], an orthopaedic specialist at the [text deleted] Clinic, on a reference from [Appellant's doctor]. Unfortunately, no report from [Appellant's orthopedic specialist #1], either directly or indirectly through [Appellant's doctor], seems to be available, but [Appellant's orthopedic specialist #1] did arrange for [the Appellant] to be referred to [text deleted], a neurologist, in order to arrange for a myelogram, the results of which proved to be normal. The results of a CT Scan of [the Appellant's] lumbar spine also proved normal.

[The Appellant] started to develop significant bladder dysfunction and erectile dysfunction "some time after" his motor vehicle accident. The evidence as to just when these problems developed is vague. It was primarily because [Appellant's orthopedic specialist #1] had voiced a suspicion that [the Appellant's] knee problem might be related to a 'gouty synovitis' that [the Appellant] was referred to [text deleted], a specialist in urology by [Appellant's doctor and [Appellant's neurologist #1], who felt that [the Appellant's] body might be retaining an excess of uric acid, having a tendency to collect in the joints and thus, perhaps, causing [the Appellant's] knee problem. It is only in [Appellant's urologist #1's] report of May 24th, 1995, about eleven months after his motor vehicle accident, that we find any professional mention of complaints by [the Appellant] of bladder dysfunction, occasional incontinence and, as well, erectile dysfunction. [Appellant's urologist #1's] report, and a perusal of his clinical notes, both reflect serious doubt on [Appellant's urologist #1's] part that any injuries sustained by [the Appellant]

in his motor vehicle accident could have caused the bladder and erectile problems of which [the Appellant] was complaining. As [Appellant's urologist #1] put it in his report "certainly all investigations to date have proved negative. Nonetheless, further tests are scheduled." Those further tests, in the form of urodynamic studies carried out by [Appellant's urologist #2] on September 1st, resulted in a further report from [Appellant's urologist #1] of September 18th, 1995. That report suggested that there might be an "upper motor neuron injury", that is to say, damage to some of the nerve fibres in the spinal cord. [Appellant's neurologist #1] had apparently told [the Appellant] that he might have a "spinal cord contusion".

In the interim, [the Appellant] had also been referred by [Appellant's doctor] to [Appellant's neurologist #2], another neurologist, whom he apparently saw on December 7th, 1994, but unfortunately we were not provided with any report from [Appellant's neurologist #2].

[Appellant's doctor] then referred [the Appellant] to [text deleted], another orthopaedic specialist, who examined [the Appellant] on the 6th of October 1995. [Appellant's orthopedic specialist #2] reported "musuloligamentous strain of lumbosacral spine; sprained right knee - previous ligamentous surgery; strain of right hand. No specific orthopaedic treatment indicated. Had appointment to see [Appellant's rehab specialist #1] at the [hospital #1] re: other treatments. No invasive treatment indicated". [Appellant's orthopedic specialist #2] added the opinion that [the Appellant] was not capable of resuming his main occupation, that his disability was a result of the automobile accident and that the end of that disability was, at the time, indefinite.

[Appellant's neurologist #1] had referred [the Appellant] to [text deleted], a specialist in rehabilitative medicine, who examined [the Appellant] on the 23rd of November 1995. [Appellant's rehab specialist #1] reports that he had seen [the Appellant] "in the clinic for management of neck pain; pain radiation to medial three fingers of right hand and low back pain". [Appellant's rehab specialist #1] prescribed general neck and back stretching and range of motion exercises and recommended investigations to rule out inflammatory arthritis. The only active treatment recommended by [Appellant's rehab specialist #1] consisted of home exercises. In a later report to [Appellant's neurologist #1], dated February 26th, [Appellant's rehab specialist #1] outlined all of the numerous tests that had been administered to [the Appellant], all of which produced essentially normal results. [Appellant's rehab specialist #1] concluded with his impression that:

> [The Appellant] has mechanical low back pain syndrome, does not have any active trigger points at present. I am wondering that his upper motor neuron signs are due to cortical/brain stem or cord lesion and this should be further investigated. I discussed with [the Appellant] that he should see you for further neurological assessment and investigations like evoked potential and CT Scan of the brain. In the meantime, I encouraged him to do range of motion exercises of the neck and back, followed by gentle stretching and strengthening exercises to improve the mobility and the strength of the paraspinal muscles.

On December 20th, 1995 [the Appellant] was examined by another urologist, [text deleted], to whom he had been referred by [Appellant's urologist #1]. [The Appellant] had complained of urinary frequency, with episodes of sudden incontinence. He had also complained of some

numbness and parasthesia in the penis and scrotum. [Appellant's urologist #2] reported that with one exception, the results of all tests and examinations that he had performed were normal. The only possible exception was that, although [the Appellant's] urinary flow was normal, the filling of the bladder was associated with unstable bladder contractions. [Appellant's urologist #2] therefore placed [the Appellant] on the drug Ditropan which had a dramatic effect; [the Appellant's] voiding frequency had improved and, by February 9th,1996, he was no longer incontinent. [Appellant's urologist #2] offered the opinion that [the Appellant] appeared to have detrusor hyperreflexia on the basis of the motor vehicle accident. [Appellant's urologist #2] added that "this would be consistent with a cord injury, and would suggest that the injury to the cord was above the sacral cord level. He anticipated that this would be a permanent deficit and that [the Appellant] might be dependent on anticholinergic agents for the rest of his life. However, said [Appellant's urologist #2], before committing him to that he suggested that the anticholinergic agents be discontinued in six months to one year, to see whether [the Appellant] was still dependent upon them.

Despite the foregoing report from [Appellant's urologist #2], a report from [Appellant's doctor] dated March 8th,1996 reports that [the Appellant] complained that he had "continued to be disabled from the time of the accident, with there being very little difference in what he could or could not do right up to the present. His mobility has remained about the same. His bladder symptoms, that is, his urinary incontinence and his bladder discomfort and intermittent hematuria have become worse."

On April 10th, 1996 [the Appellant's] Case Management Team at MPIC had decided to refer him to [text deleted], a clinical psychologist, partly because the symptoms of which [the Appellant] was complaining seemed to be out of all proportion to any clinical, physical signs, and partly because [the Appellant] obviously needed help in coping with his pain and controlling his feelings of frustration and anger. Meanwhile, [Appellant's rehab specialist #1] and [Appellant's neurologist #1] were apparently continuing to explore the possibility that [the Appellant] might have sustained some spinal cord injury.

[Appellant's psychologist #1's] report to MPIC of May 21st, 1996, after detailing the symptoms complained of by [the Appellant], both physical and emotional, noted that the "medical reason for a number of the physical complaints described have yet to be determined". [Appellant's psychologist #1] felt that [the Appellant] could benefit from counseling that focused on pain and stress management. In a subsequent discussion on June 13th, 1996 with [the Appellant's] Adjuster, [Appellant's psychologist #1] expressed the view that this was a critical period for [the Appellant] who could be at risk if his volatility continued. "At present he is extremely explosive and is greatly agitated by the lack of progress in his case." [The Appellant] appeared to be continually focused upon his alleged ill-treatment by MPIC at the onset of his claim, said [Appellant's psychologist #1].

In the latter part of June 1996, MPIC retained the services of [vocational rehabilitation consulting company] to assist with the coordination of [the Appellant's] rehabilitation. [Appellant's doctor] agreed with[vocational rehabilitation consulting company] that a functional capacity evaluation and an occupational therapy home assessment would be beneficial in

determining [the Appellant's] physical capabilities and safety in the home environment - tests made somewhat more urgent by the imminent arrival of a new baby in the [Appellant] home. [Appellant's doctor] had also indicated to [vocational rehabilitation consulting company] that [the Appellant's] original diagnosis post-injury was difficult to explain. While [the Appellant] had suffered from a back strain, that diagnosis did not coincide with his symptoms of urinary incontinence, parathesia in his right arm and leg, numbness in his mouth and difficulty initiating and maintaining an erection. Essentially all of the tests administered to [the Appellant] in the interim had proven to be inconclusive for a diagnosis of his claimed symptoms, save only for [Appellant's urologist #2's] belief that [the Appellant] had sustained some spinal cord contusion which, in turn, was the probable source of his bladder problems.

Upon completion of the occupational therapy home assessment, [vocational rehabilitation consulting company] recommended the purchase of some eleven items of equipment for [the Appellant's] home use, along with a referral of [the Appellant] to the [text deleted] Clinic at [hospital #2]. On the 18th of July 1996, [the Appellant] underwent a CT Scan of his spine which showed no abnormal signal nor cord expansion. However, due to an incomplete result ([the Appellant's] shoulders were too broad to enable him to fit into the MIR machine) [the Appellant] was subsequently referred to the [text deleted] Medical Centre (a division of the [text deleted] Clinic) near [text deleted], Minnesota, where the attending physician was [Appellant's urologist #3]. Following a complete MRI of the brain and total spine, [text deleted] Medical Centre reported negative examinations of the brain, thoracic spine and lumbar spine. In the cervical spine there was moderate stenosis of the right C6-7 foramen that could contribute to a right C7 radiculopathy. Confirmation of that finding and further evaluation by CT Scan of the lower

cervical spine was recommended, if intervention was contemplated. The radiologist reported that:

> The cervical spine is normal in alignment, both marrow signal and vertebral body morphology. The cord is normal in morphology. There is no gross cord signal abnormality, although subtle cord lesions could easily be missed on this study. Visualized posterior fossa structures and the region of the foramen magnum are normal. The paraspinal soft tissues are unremarkable.

[Appellant's urologist #3] concluded his assessment with the following statement:

> The patient does have some urgency findings, but has no uninhibited contractions and he voids in a coordinated fashion with an intact bulbocavernosus reflex. My interpretation is that this is consistent with an intact sacral spinal cord, and intact communicating between the pontine spinal cord level and the sacral spinal cord level

Meanwhile, on July 31st, 1996 [the Appellant] had been referred to [text deleted] a physiatrist and specialist in Rehabilitation Medicine in the [text deleted]. That reference was made by [vocational rehabilitation consulting company] at the request of [Appellant's doctor]. [Appellant's rehab specialist #2] was asked to assess [the Appellant's] physical complaints, which [Appellant's neurologist #1] had diagnosed as "severe myofascial pain syndrome" and, more particularly, to assess [the Appellant's] physical status secondary to his injuries sustained in his motor vehicle accident.

On August 8th, 1996 [vocational rehabilitation consulting company] delivered to [the Appellant], at his home, all of the equipment that they had recommended to make his domestic tasks easier. [The Appellant] was seen by [Appellant's rehab specialist #2] on October 10th, 1996. [Appellant's rehab specialist #2], in a very detailed, eight-page report of that date, summarizes his impressions as those of chronic pain syndrome, deconditioning, sleep disturbance, anxiety, urinary incontinence (not yet diagnosed) and an old right knee injury. More specifically,

[Appellant's rehab specialist #2] found no evidence of any upper motor neuron injury as would be expected with either a spinal cord or brain injury. He went on to say, in part:

> I am a little suspicious that the bladder investigations are misleading. I would suggest, for clarification, that he be referred to another centre for urodynamic studies as well as urological consultation. I would also advise getting a proper MRI of the brain and spinal cord…..This should help clarify whether or not there is a brain or cord injury with regards to his "upper motor neuron" symptoms. It is my suspicion that the bladder and difficulties may have another explanation other than upper motor neuron problems. Indeed, [Appellant's neurologist #1] found the same physical findings as I have done today, and it is apparent that he does not believe there is an upper motor neuron aspect of the present problems.

> [Appellant's rehab specialist #2] reports that he had advised [the Appellant] that "much of his stated pain experience is not concordant with the emotional or physical manifestations that I have witnessed today. Specifically, he does not look or behave like a person who is in as much pain and discomfort as he says that he is……Also, based on today's assessment, I am unclear as to why he is wearing a wrist orthosis on the right hand…..He is also wearing one of the high quality knee orthoses, ……The right knee that I have examined today does not look like it would be benefiting much from the present brace.….In my opinion, the use of the right wrist orthosis as well as the right knee orthosis should be discontinued immediately.

[Appellant's rehab specialist #2] concluded his October 10th, 1996 report by saying that the successful rehabilitation of [the Appellant] would require an intensive effort on the part of the coordinating physician.

[Appellant's rehab specialist #2's] report was made prior to [the Appellant's] visit to the Minnesota Clinic, where [Appellant's rehab specialist #2's] recommendations were, indeed,

carried out, and where all results reflected what can only be described as a surprising state of normalcy.

On October 24th, 1996, in a discussion with a rehabilitation consultant from [vocational rehabilitation consulting company], [Appellant's doctor] said that he had permitted [the Appellant] to discontinue the use of the two braces - right knee and right wrist - [the Appellant] continued to use them because, he said, he had fallen without the knee brace and felt his grip strength was improved with the wrist brace. [Appellant's doctor] also voiced his opinion that [the Appellant's] right knee problems were likely related to his motor vehicle accident.

On October 31st, 1996 [vocational rehabilitation consulting company] wrote to [Appellant's orthopedic specialist #2] for clarification and with a series of additional questions, all related to [the Appellant's] right knee. [Appellant's orthopedic specialist #2]'s response may be summarized this way:

(a) on examination, there was no free fluid nor effusion in that knee, although [the Appellant] had a positive anterior drawer sign on the right, indicative of laxity or weakness to his anterior cruciate ligament. He was also mildly tender over the medial and lateral joint lines. Manipulative McMurray test was negative; no redness or swelling about the right knee. Left knee completely normal;

(b) [The Appellant] had an unstable right knee with ongoing irritation. The nature of the surgical procedure some ten years prior was unclear, but [the Appellant] must have had problems with his knee before and [Appellant's orthopedic specialist #2] wondered if there was no some cartilage articular damage prior to the motor vehicle injury;

(c) when examining [the Appellant] on October 6th, 1995, [Appellant's orthopedic specialist #2] had not found any pathology that might suggest further treatment. If [the Appellant] continued symptomatic, he might need new X-rays of his right knee and possible arthroscopic evaluation;

(d) with ongoing knee pain, there was always the possibility of gout. Without substantive evidence of increased uric acids or crystals removed from the knee, he would not accept a diagnosis of gout. The knee pain was probably a combination of trauma-related and perhaps some pre-existing condition that had now become more symptomatic;

(e) from an X-ray report of July 7th, 1994, there appeared to be no significant bone or joint abnormalities, no evidence of fracture and no evidence of degenerative wear in the right knee;

(f) [Appellant's orthopedic specialist #2] did not feel that he could say, with any confidence, whether all of the present knee symptomatology was related to the 1994 accident and, if any was thus related, how much of it.

In a subsequent letter of November 19th to [vocational rehabilitation consulting company], [Appellant's rehab specialist #2] reiterated his earlier opinion that the kind of brace that [the Appellant] had been wearing on his right knee was unnecessary but that, if any bracing were needed at all, it would only be a polypropylene brace with velcro closures above and below the knee. He felt that [the Appellant's] degree of instability was quite manageable with strengthening exercises for the quadriceps and hamstring muscles. The polypropylene sleeve would also add to enhancing [the Appellant's] ability to concentrate on contracting those muscles when walking.

A team meeting was held at the [hospital #1] on January 24th, 1997, involving [Appellant's rehab specialist #2], [Appellant's psychologist #1], [Appellant's doctor], [Appellant's MPIC adjuster], [text deleted] (rehabilitation consultant with [vocational rehabilitation consulting company]) and a secretary. After what appears to have been a lengthy and careful discussion of [the Appellant's] continuing problems, the following steps were decided upon:

1. [Appellant's rehab specialist #2] would refer [the Appellant] to [rehab clinic] for physical reconditioning;
2. [Appellant's psychologist #1] and {appellant's rehab specialist #2] would refer [the Appellant] to [text deleted], a clinical psychologist particularly skilled in helping people to deal with pain;
3. [Appellant's rehab specialist #2] would contact [Appellant's orthopedic specialist #2] with respect to a new orthopaedic assessment of [the Appellant];
4. [Appellant's rehab specialist #2] would arrange for an assessment of [the Appellant] by [text deleted], a neuropsychologist; and
5. [Appellant's rehab consultant] would contact [Appellant's urologist #2] to discuss his assessment and plans for treatment of [the Appellant's] bladder symptoms.

It also seems to have been determined that [Appellant's rehab specialist #2] would continue to act as the medical coordinator, maintaining communication with [Appellant's doctor] - particularly with respect to changes in medication.

On February 17th, 1997 [Appellant's urologist #2] reported that he had no plans to adjust [the Appellant's] therapy. He expressed the opinion that, despite his bladder problem, [the Appellant] was certainly rehabitable with respect to his other problems and that, other things being equal, his bladder dysfunction would not keep him from seeking employment.

On February 19th [Appellant's rehab specialist #2], in one of a series of regular reports to [Appellant's doctor], described a low demand test that he had given [the Appellant], the resultant discomfort claimed by [the Appellant], and [Appellant's rehab specialist #2's] own reaction that "It is hard to imagine that he would have been put into such physical discomfort with a minimal effort test such as he did". [Appellant's rehab specialist #2] set out a plan to initiate [the Appellant] into a walking program to be done every morning in a shopping mall, as a "warmup" toward the work hardening program or functional restoration program in which he would be involved with PAR Services.

On February 24th, 1997 [Appellant's psychologist #1], in a report to [vocational rehabilitation consulting company], noting [the Appellant's] belief that he had been seriously injured and was permanently disabled, pointed out that all test results would appear to rule out any spinal cord injury "and now place your client ([the Appellant]) in the position of being able to actively pursue physical rehabilitation". Since [the Appellant] was now to become involved with [Appellant's rehab specialist #2] and the [rehab clinic] treatment program, [Appellant's psychologist #1] felt that it made more sense to transfer [the Appellant's] care to a psychologist connected with that program.

In a report of March 5th, 1997, [Appellant's orthopedic specialist #2] recommended a new X-ray of [the Appellant's] right knee and tibia, and the need to rule out traumatic chondromalacia lateral femoral condyle. He proposed, also, a right knee arthroscopy and arthroscopic surgery with camera. In a letter to [vocational rehabilitation consulting company] on March 14th, 1997, [Appellant's orthopedic specialist #2] added that [the Appellant's] arthroscopic surgery was slated for April 4th, that he had not examined [the Appellant's] right wrist and no particular complaints had been made in the latter context by [the Appellant]. [Appellant's orthopedic specialist #2] felt it reasonable to persist with a functional restoration program, provided [the Appellant] was not getting more symptomatic in his right knee. He could not state that [the Appellant] was suffering from gout in that knee until a better assessment of crystalline synovitis vs. mechanical derangement had been forthcoming following the arthroscopy.

A report from [text deleted], neuropsychologist, bearing date March 7th, 1997, concludes that [the Appellant] was generally functioning within normal limits, that although there was a possibility that he had sustained a mild brain injury any resultant cognitive symptoms had already resolved, but that he had suffered a loss of self-esteem, intermittent periods of depression and only partially successful pain management. [Appellant's neuropsychologist] recommended that vocational planning be a related component of [the Appellant's] rehabilitation program and that [the Appellant] increase his own sense of control or investment in his occupational and physical therapy, such as consulting with his therapist about recreational and other practical issues. He felt that [the Appellant] appeared to be motivated.

[The Appellant's] caregivers continued to hold regular team meetings, at most of which [the Appellant] himself was also present. Meanwhile, on April 9th, 1997, [the Appellant] was referred at [Appellant's rehab specialist #2's] suggestion to [Appellant's rehab specialist #3], another member of the Rehabilitation Medicine Department at the Rehabilitation Hospital, with a view to either confirming or ruling out the likelihood of spinal cord injury or contusion. Unfortunately, no written report from [Appellant's rehab specialist #3] was made available to us but, it seems clear from other material on the file, [Appellant's rehab specialist #3] had agreed with [Appellant's rehab specialist #2's] diagnosis of myofascial pain syndrome and that [the Appellant's] bladder dysfunction was not a result of any contusion or other injury to [the Appellant's] spinal cord. Both [Appellant's rehab specialist #2] and [Appellant's rehab specialist #3] seemed to agree that myofasical pain of the pelvic muscles might cause bladder irritability, along with pain in the coccyx area and limited sitting tolerance, all of which were matters complained of by [the Appellant].

The Appellant underwent arthroscopy on his right knee on April 4th, 1997. [Appellant's orthopedic specialist #2], who had performed the surgery, reported that there was no intra-articular pathology. Upon being examined by [Appellant's rehab specialist #2] on April 16th, while [the Appellant's] right knee was still moderately swollen from his surgery, no infection was noted, the knee was not warm nor tender, and [Appellant's rehab specialist #2] advised [the Appellant] to continue walking within the tolerances of discomfort and not to slow down. [The Appellant] was advised by [Appellant's rehab specialist #2] to return to physiotherapy and to pursue his rehabilitation program within the following few days. By April 23rd, the knee appeared to be well healed and the swelling almost gone. Reporting on a further examination of

[the Appellant] on May 7th, 1997, [Appellant's rehab specialist #2] indicated that the bladder issues seemed to remain [the Appellant's] main focus; the right knee had become less problematic, although [the Appellant] continued to walk with a slight limp but without using the knee brace. [The Appellant] appeared to be largely pain-free, although with mild tenderness in the lumbar spine and coccyx areas. [The Appellant] had described one incident when his "whole leg" gave way from the inguinal region down to his right foot; [Appellant's rehab specialist #2] felt that, if that had happened, it was more consistent with musculoskeletal deconditioning and/or pain behaviour rather than having any neurologic cause.

Despite [the Appellant's] continued complaints, records of subsequent team meetings make it clear that his caregivers were pleased with the apparent progress of his physical conditioning; the only person who did not believe that he had made substantial improvement was [the Appellant] himself - on June 24th, 1997 he advised his Adjuster that, despite all of his therapies, he was not feeling any better, his right shin become 'real painful' from walking and was tender all the time within pain radiating into his toes, his abdomen was very painful and he had stabbing pains in his right groin area, radiating up to his rib cage; driving his car had also become painful, aggravating his right leg. His Adjuster agreed to set him up with a cab account, to avoid any difficulty getting to therapy. His caregivers found it necessary to discuss issues of his non-compliance with parts of his program, and the possibility that factors other than his rehabilitation might be motivating him, particularly since MPIC was continuing to pay him personal care assistance benefits. By June 30th, [the Appellant] said he had developed severe chest pains while in occupational therapy, with increased pain in the testicles, penis and right shoulder.

Because [the Appellant] was now starting to complain of blurred vision, [Appellant's doctor] then referred him to [text deleted], an ophthalmologist, who saw him on July 8th, 1997. [Appellant's ophthalmologist's] summary reads, simply: "Normal eye examination today. His visual symptoms are cerebral in origin." The latter sentence seems capable of two interpretations: [the Appellant] elects to believe that it points to physical brain damage resulting from his accident, but it must be said that there is no clinical evidence of that.

The following weeks seem to reflect increased tension and discord between [the Appellant], on the one hand, and his caregivers, on the other. The greatest barrier to his improvement, in [Appellant's rehab specialist #2's] view, was [the Appellant's] lack of attendance due to apparently conflicting appointments and a recent illness.

[The Appellant] had written to his Adjuster, [text deleted], on July 2nd and [Appellant's MPIC adjuster], after several unsuccessful attempts to set up a meeting with [the Appellant], wrote to him on July 15th. [Appellant's MPIC adjuster] explained, clearly and capably, that the objective of MPIC and all of [the Appellant's] caregivers was to return him to a level of functional ability consistent with that of his pre-accident physical status. Acknowledging that that goal had not yet been reached, [Appellant's MPIC adjuster] emphasized the need for [the Appellant's] continuing cooperation and effort, so that once his functional capabilities had been restored, an effort could be made to identify realistic options for vocational placement.

It should be noted, at this juncture, that the term position occupied by [the Appellant] at the time of his accident, had come to an end, and the position itself had apparently been terminated.

Also on July 15th, 1997, [vocational rehabilitation consulting company] reported to [Appellant's rehab specialist #2] that [the Appellant] continued to complain of a "giving away" sensation in his right knee, that his left knee was also starting to "give out", with pain radiating from the pelvis down both legs to both knees, that he had experienced dizzy episodes and had almost, but not quite, fallen off the side of a stationary bicycle, that the use of increasing weights in occupational therapy had increased his pelvic/bladder problems, that [Appellant's ophthalmologist] had told him his blurred vision was a result of a brain injury, that he was losing the grip strength of his right hand and that, after leaving occupational therapy the previous week, he had complained of chest pain and felt that he was "dying" although the results of an EKG were quite normal. As will be apparent from all of the foregoing, some of these reported symptoms were brand new, others were of a continuous nature. [The Appellant] was also reporting complete dependence for all household and outdoor activities, and his caregivers were patently starting to conclude that, as a report from [vocational rehabilitation consulting company] of July 15th, 1997 puts it, "[The Appellant] has secondary financial gains to remain dependent on others for assistance with activities of daily living as [text deleted] (his companion) is receiving personal care assistance. For [the Appellant] to be independent, this would mean significant family income loss." He was apparently becoming increasingly non-compliant with his program, leaving [rehab clinic] early allegedly to attend appointments with [Appellant's doctor], when in fact he seldom made scheduled appointments and usually saw [Appellant's doctor] on a walk-in basis.

On July 17th, 1997 [the Appellant] was referred by [vocational rehabilitation consulting company] to [Appellant's rheumatologist], a specialist in rheumatology, who was asked for her clinical impression of [the Appellant's] physical findings and diagnoses for them. [Appellant's rheumatologist] was also asked whether, in her opinion, those findings could be directly related to [the Appellant's] motor vehicle accident injuries from June 30th of 1994.

While awaiting [Appellant's rheumatologist's] report, [the Appellant's] caregivers held a further team meeting on July 23rd, 1997. The notes of that meeting make it clear that the medical team, including [Appellant psychologist #2] and [Appellant's rehab specialist #2], felt that [the Appellant] was exhibiting many behaviours consistent with the medically accepted definition of malingering. [the Appellant's] health care team (consisting, at that point, of [text deleted] (physiatrist), [text deleted] (psychologist), [text deleted] (physiotherapist), [text deleted] (occupational therapist), [text deleted] (rehabilitation consultant) and [text deleted] (MPIC's Case Manager) decided upon the following steps:

1. [The Appellant] would continue to attend [rehab clinic] for physical therapy, but on a much reduced basis both as to time and the effort required of him; his therapy would consist of pool exercises, a walking class and the moderate use of the exercise bicycle;
2. [Appellant's occupational therapist #1] and [Appellant's rehab specialist #2] would work out a schedule to measure [the Appellant's] physical abilities objectively over the course of the following four to six weeks, by way of a functional capacity evaluation, reducing his involvement in occupational therapy thereafter;

3. [Appellant's rehab consultant] would complete a Transferable Skills Analysis to identify suitable employment for him in light of his level of education, physical abilities, aptitude, job availability and experience.

4 MPIC would proceed, in September of 1997, to make a two-year determination pursuant to Section 107 of the MPIC Act

On July 24th, 1997 [Appellant's rehab specialist #2], in reporting to [Appellant's doctor] with respect to his most recent assessment of the Appellant, indicated a largely normal examination and concluded:

> Overall, I am at a loss to explain why he keeps having these reoccurring physical ailments that are difficult to substantiate. There is a mild amount of swelling in the right knee at this time, and it may well be that this represents plicae syndrome. The problem is minor and he can continue on with his functional restoration program with the goal towards returning to work.

At the end of July, 1997, [rehab clinic] seriously considered discharging [the Appellant] from their entire program due to what they termed his "inappropriate behaviour and poor effort. He bad-mouths the therapists and caregivers…." They allege that he was making up stories that he had slipped and fallen by the pool and continued to exhibit malingering behaviour. However, after further consultation with [Appellant's psychologist #2], they agreed to continue with the physiotherapy portion of [the Appellant's] program, including pool classes, walking, exercise bike and stretching and strengthening exercises. They decided to discontinue occupational therapy due to [the Appellant's] strong resistance to it.

[Appellant's rheumatologist's] report, dated September 2nd, 1997, was received by [vocational rehabilitation consulting company] on September 17th. Her detailed report concluded that:

1. as to his right knee pain, the onset of those symptoms did not seem associated with his motor vehicle accident and [Appellant's rheumatologist] was unclear as to how the strain of his reported injury would actually be associated with those repeated episodes, especially in the face of a normal arthroscopy. She felt that his knee pain was likely attributable to gout;
2. as to his more generalized pain, although he had had an extremely severe accident and had been left with certain gait abnormalities and pain which precluded him from sitting down for any prolonged periods, there was a paucity of major findings. She wondered whether an attendance at the [text deleted] Clinic might be helpful. Despite [the Appellant's] perceived generalized pain, she found no evidence of a fibromyalgia process and could see no reason why he should not continue participating in his reconditioning program. He seemed to need gait re-education but problems with his probable gout should not cause any difficulties with his physiotherapy as long as his knee were not actively inflamed during that therapy. She did not think that gouty episodes alone would preclude him from employment.

On September 4th, 1997 [Appellant's rehab specialist #2] and [Appellant's occupational therapist #1] performed a functional capacity assessment of [the Appellant]. [Appellant's rehab specialist #2's] resultant report, bearing that same date, describes in detail the results of numerous tests given to [the Appellant], who was described on this occasion as being very cooperative and appearing to try his best. [Appellant's rehab specialist #2's] conclusions may be summarized this way:

1. according to the Canadian Classification and Dictionary of Occupations, [the Appellant] was able to perform physical demands at the heavy demand level;
2. more conservatively, however, his physical demand level would be classified as "medium";
3. [The Appellant] had reached his pre-injury physical level although he continued to have a multitude of somatic complaints, many of which did not appear to have a clear somatic cause;
4. if he were to return to work in his then present condition, the occupational demands would permit him to become reconditioned at the work site and enjoy a full return to work.

A few days later, [Appellant's psychologist #2] indicated that, although [the Appellant] was resistant to the idea of a return to work, there were no known psychological conditions that would prevent it.

Appellant's Pre-accident Occupation

At the time of his motor vehicle accident, [the Appellant] was a temporary employee, working as [text deleted]. He had worked for four months under a six-months term contract. Following his accident, he had tried to return to work for a day or two but, since he was obviously not well enough, his supervisor had sent him home. In his testimony, he said that his job required walking and climbing to locate [text deleted] parts in [text deleted's] warehouse; although he was not required to move or lift heavy parts himself, the parts had to be moved around on the shelf and then moved by a forklift to wherever they were required. He testified that his duties

consisted primarily of data entry and internal communication - that is to say, finding out from each department manager what parts were going to be needed and making sure that the parts got to their proper destinations. [Text deleted] advised [Appellant's rehab consultant] that [the Appellant's] position involved "80-85% of the shift standing, climbing a ladder to retrieve parts weighing five to ten pounds, and 15-20% of the shift working at the computer terminal". It was the view of [Appellant's rehab specialist #2] and [Appellant's occupational therapist #1] that [the Appellant] could complete the demands of that job without difficulty and that any right knee problems that [the Appellant] might encounter in climbing stairs could not be attributed to the injuries he sustained in his motor vehicle accident on June 30th, 1994 but would stem from gouty arthritis.

[Text deleted], Labour Development Manager at [text deleted], confirmed that [the Appellant's] pre-accident job would have been terminated at the end of his six-months term, regardless of his motor vehicle accident, due to downsizing at [text deleted]. However, had his employment at [text deleted] continued, the employer would have been willing and able to modify his computer work station so that, if he preferred to stand rather than sit at the computer, he would have been able to do so.

Termination of Benefits

On September 12th, 1997, [Appellant's MPIC adjuster] wrote to [the Appellant] to advise him that MPIC was satisfied that he was then capable of performing his pre-accident employment and was also no longer in need of personal assistance domestically. [Appellant's MPIC adjuster's]

letter went on to say that MPIC would extend his personal assistance funding to September 30th and his income replacement indemnity to October 19th of 1997; [Appellant's psychologist #2] would remain available to [the Appellant] for support counseling; [vocational rehabilitation consulting company] would remain available to help him in resume preparation, interview skills, training and assistance in identifying prospective employment; [vocational rehabilitation consulting company] or [rehab clinic] would remain available to instruct him on how to engage in his activities of daily living more effectively. [Appellant's MPIC adjuster] also made it clear to [the Appellant] in subsequent discussions and correspondence that he might well be entitled to some award for permanent impairment due to the possibility, at least, of a micro-lesion affecting the spinal cord of the kind suggested by [Appellant's urologist #2].

[The Appellant] appealed from that decision to MPIC's Internal Review Officer, who confirmed it, and it is from the latter decision that [the Appellant] appealed to this Commission by way of a Notice bearing date March 14th, 1998.

Permanent impairment award.

On June 9th, 1998, [Appellant's MPIC adjuster] wrote to [the Appellant] to tell him that [the Appellant's] bladder dysfunction had been given an impairment rating of 5%, pursuant to paragraph 18(b)(ii) of Division 4 of the Schedule to Manitoba Regulation No. 41/94. Since the maximum impairment entitlement, at the date of [the Appellant's] accident, was $100,000.00, he was paid $5,000.00. [Appellant's rehab specialist #2], who also gave evidence at the hearing of [the Appellant's] appeal, testified that, in his opinion, it was highly unlikely that a motor vehicle accident could cause a micro-lesion of sufficient substance that it would be missed by a magnetic resonance imaging. Since both MIR tests given to [the Appellant] had revealed no such lesion, contusion or other, similar damage, [Appellant's rehab specialist #2] felt that he had to discount

the possibility of [the Appellant's] bladder problem having been caused by a micro-lesion resulting from the motor vehicle accident.

Quality of care.

[The Appellant] is highly critical of what he seems to regard as his mistreatment at the hands of MPIC. While it is true that there was not total unanimity at all times amongst all of the medical and paramedical caregivers as to the etiology of his complaints and their proper treatment - hardly surprising, in light of the number of those caregivers - it seems appropriate to point out that, between the date of his motor vehicle accident on June 30th, 1994 and September 12th, 1997, [the Appellant] had been examined and, in many cases, treated, by the following caregivers at the expense of MPIC:

1. [text deleted], family practitioner
2. [text deleted], orthopaedic surgeon
3. [text deleted], neurologist
4. [text deleted], neurologist
5. [text deleted], physiotherapist, [text deleted]
6. [text deleted], urologist
7. [text deleted], orthopaedic surgeon
8. [text deleted], urologist
9. [text deleted], physiatrist
10. [text deleted], psychologist
11. [text deleted], rehabilitation consultant, [vocational rehabilitation consulting company]
12. [text deleted], occupational therapist, [vocational rehabilitation consulting company]
13. [text deleted], urologist, Minneapolis
14. [text deleted], rheumatologist
15. [text deleted], physiatrist
16. [text deleted], neuropsychologist
17. [text deleted], Clinical Psychologist, occupational therapist
18. [text deleted], occupational therapist, [rehab clinic]
19. [text deleted], physiotherapist, [rehab clinic]
20. [text deleted], physiatrist
21. [text deleted], specialist MRI
22. [text deleted], radiologist
23. [text deleted],, occupational therapist, [rehab clinic]

The Issues

The issues before us are simply stated:

(i) was MPIC justified in terminating [the Appellant's] personal care assistance benefits as of September 30th, 1997?

(ii) was MPIC justified in terminating [the Appellant's] income replacement indemnity, as of October 19th, 1997? and

(iii) is [the Appellant] entitled to continuing, rehabilitative treatments?

The Law

For the purposes of the present appeal, the Manitoba Public Insurance Corporation Act ('the Act') defines a 'victim' as a person who suffers bodily injury caused by an automobile or by the use of an automobile. Dealing, first, with [the Appellant's] claim for continued personal care assistance, Section 131 of the Act provides that:

> **Reimbursement of Personal Assistance Expenses**
>
> Subject to the regulations, the Corporation may reimburse a victim for expenses of not more than $3,000.00 per month relating to personal home assistance where the victim is unable because of the accident to care for himself or herself or to perform the essential activities of every day life without assistance.

Section 2 of Manitoba Regulation 40/94 provides:

> **Reimbursement of Personal Home Assistance under Schedule A**

2. Subject to the maximum amount set under Section 131 of the Act, where a victim incurs an expense for personal home assistance that is not covered under Health Services Insurance Act or any other Act, the Corporation shall reimburse the victim for the expense in accordance with Schedule A.

Schedule A forming part of Regulation 40/94 sets out a form of grid system allocating a certain number of points to each area of daily life that a victim is either wholly or partly incapable of performing by reason of injuries sustained in a motor vehicle accident. The total number of points thus allocated must exceed 4 out of a possible 27 in order for the victim to become entitled to any compensation. A thorough assessment of [the Appellant's] functional abilities and needs conducted by [Appellant's rehab specialist #2], [text deleted] (occupational therapist) and [text deleted] (physiotherapist) on September 9th, 1997 resulted in a grid score of 0. No reliable evidence was adduced before this Commission to indicate that the foregoing assessment was materially in error, and this facet of [the Appellant's] claim must, therefore, be dismissed.

Claim for Reinstatement of Income Replacement Indemnity

Section 110(1)(a) of the Act reads, in part, as follows:

Events that end entitlement to IRI

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;……

Was [the Appellant], at the date of termination of his IRI, able to hold his former employment had it been available to him? We are of the view, upon a careful reading of all of the reports referred to above and consideration of the oral testimony given to us by [the Appellant] and [Appellant's rehab specialist #2] at the hearing of [the Appellant's] appeal, that by October 30th, 1997 (if not sooner) [the Appellant's] physical condition had, in fact, been restored to the point at which he could have returned to his former employment, had it been available for him. Despite [Appellant's urologist #2's] initial suspicion that [the Appellant] might have sustained some upper motor neuron lesion of his spinal cord, all of the available neurological and radiological evidence persuades us, on a strong balance of probabilities, that [the Appellant] did not sustain any spinal cord injury. In any event, we find that his bladder dysfunction, even if caused by his motor vehicle accident (an hypothesis that we find to be doubtful in the extreme), by no means renders him unemployable. That condition seems to have been brought well under control by medication and any place of potential employment for [the Appellant] would need only to have readily available washroom facilities to enable him to cope with any resurgence of his bladder dysfunction.

As to [the Appellant's] problem with his knee, while it may well be that his early symptomatology was indeed related to his motor vehicle accident of June 30th, 1994, numerous and careful examinations of that knee have not disclosed any pathology requiring specific treatment. Neither X-rays taken on March 5th, 1997 nor arthroscopic surgery performed on April 4th, 1997 disclosed any pathology requiring treatment of any kind. [Text deleted], medical specialist in rheumatic diseases, although noting that [the Appellant's] history was consistent

with gout, commented that "the onset of his symptoms in his right knee do not seem associated with his motor vehicle accident and I am unclear as to how the strain of his reported injury would actually be associated with these repeated episodes, especially in the face of a normal arthroscopy." There has been no documentation of crystals in [the Appellant's] right knee joint and the presence of a gouty synovitis therefore remains unproven. Even if it exists, we find that it was not caused by [the Appellant's] motor vehicle accident. Despite that, [the Appellant] has been told by [Appellant's rehab specialist #2] that, if he ever has an acute flareup of swelling of his right knee, he should come to the Clinic at the [hospital #1] where either [Appellant's rehab specialist #2] or [Appellant's rehab specialist #4] would aspirate his knee joint or any other joint that is swollen. [Appellant's rehab specialist #2] expressed the view that the small amount of swelling in [the Appellant's] right knee may well be due to the synovial reaction to his arthroscopy and that the incision sites for the scopes were still a little aggravated and producing more synovial fluid than is normal. [Appellant's rehab specialist #2] emphasized, however, that even in the presence of a diagnosis of gout, [the Appellant's] knee should be able to undertake the full range of normal human activities, including heavy activities that a workplace might demand of him.

The multiplicity of complaints voiced by [the Appellant] from time to time amount, in almost every case, to symptom magnification and, as [Appellant's rehab specialist #2] puts it, "appear to be out of proportion to the actual somatic aberrations". Despite his greatly improved functional capacity, [the Appellant] seems determined to believe that his body is seriously impaired and is beyond rehabilitation. Even as late as September 10th, 1997, he reported to [Appellant's rehab specialist #2] that he was encountering severe pains in his neck, shoulder, low back, coccyx,

knee and arm pains throughout the entirety of both arms. He is reported to have described headaches that felt "as if his eyeballs were coming out of his head" - and this, three years and three months after an accident in which, it must be remembered, his attending physician describes his injuries merely as "neck and back strain and contusion and strain to right knee".

The point was raised on behalf of [the Appellant] that he had lost his job by reason of his accident. There are two responses to that submission: firstly, we find that [the Appellant's] position was a temporary one, on a six-month term, of which he had served four months; there were only two months of that employment term remaining at the time of his accident, and that period had expired long before he was ready to return to work; secondly, it is only a full-time earner or a part-time earner who is entitled to any additional income replacement benefits as a result of having lost his or her employment because of a motor vehicle accident, and [the Appellant] would not, therefore, qualify for those additional benefits in any event. Section 6 of Manitoba Regulation No. 37/94 defines temporary employment this way:

> 6. A person holds a regular employment on a temporary basis where the person
>
> (a) has held the employment for less than one year before the day of the accident;
>
> (b) during the course of the employment, has been employed for not less than 28 hours per week, not including overtime hours;…..

Section 8 of the that same regulation defines the phrase "unable to hold employment" as follows:

> 8. A victim is unable to hold employment when a physical or mental injury that was caused by the accident renders the victim entirely or substantially unable to perform the

essential duties of the employment that were performed by the victim at the time of the accident or that the victim would have performed but for the accident.

Ongoing Benefits

While we have found that MPIC was fully justified in terminating [the Appellant's] personal care assistance benefits and income replacement indemnity when it did, it should be noted that the Corporation has offered vocational placement assistance to [the Appellant] although, to the best of our knowledge, he has not yet taken advantage of that offer. We presume that offer still stands as part of the Corporation's obligations under Section 138 of the Act. Similarly, and despite our finding that his ongoing problems with is right knee were almost undoubtedly not caused by his motor vehicle accident, [Appellant's rehab specialist #2] has invited [the Appellant] to reattend at the Clinic at the [hospital #1] if he encounters any further swelling, in order that the knee may be aspirated to at least establish or disprove the presence of any crystalline matter that might indicate gout. That examination would presumably be covered by Manitoba Health Services.

Despite [the Appellant's] numerous complaints of his ill-treatment at the hands of MPIC, [rehab clinic] and many of his other caregivers, we find it hard to imagine any steps that MPIC could possibly have taken towards his rehabilitation, to lessen any disabilities resulting from his motor vehicle accident and to facilitate his return to a normal life, in addition to those which it has taken or offered to take. He remains eligible for vocational placement assistance - at a team meeting of [the Appellant's] caregivers on July 23rd, 1997 the decision was made that [Appellant's rehab consultant] would complete a Transferable Skills Analysis to identify suitable

employment for [the Appellant], but, so far as we can tell, that does not ever appear to have been done.

[The Appellant] also remains eligible for psychological counseling so that he will become less pain focused and able to get on with his life.

Although it might well be argued that, given [the Appellant's] pattern of conduct in the past and this Commission's findings reflected above, he is entitled to no more assistance from MPIC, we are of the view that one more effort should be made to reintegrate him into the workforce. [The Appellant] should, firstly, be referred for a new Functional Capacity Evaluation; secondly, since [the Appellant] has undoubtedly become deconditioned since last attending at [rehab clinic], the results of that evaluation should be used as a guide for a time-limited functional restoration program combined with the psychological counseling referred to above. Needless to say, if [the Appellant] again proves to be uncooperative or fails in any way to give that restoration program his own, best efforts, MPIC will be justified in terminating the program and any further benefits. During the time when [the Appellant] is genuinely and actively participating in the foregoing program, he will be entitled to receive income replacement indemnity at the rate which prevailed on October 19th, 1997. That entitlement will continue until the completion of the foregoing time-limited functional restoration program or until the insurer has validly terminated that entitlement under Section 160 of the Act, whichever first occurs.

Dated at Winnipeg this 23rd day of February, 1999.

J. F. REEH TAYLOR, Q.C.

LILA GOODSPEED

F. LES COX