Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an appeal by [the Appellant]
AICAC File No.: AC-98-63

PANEL:	**Mr. J. F. Reeh Taylor, Q.C. (Chairperson)** **Mr. Charles T. Birt** **Mrs. Lila Goodspeed**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') represented by Ms Joan McKelvey** **[The Appellant] was represented by [Appellant's representative]**
HEARING DATE:	**June 14, 1999**
ISSUE:	**Whether income replacement indemnity benefits were properly terminated.**
RELEVANT SECTIONS:	**Section 110 (1)(a) and 110 (2)(d) of the 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

THE FACTS:

[The Appellant] was a passenger involved in a motor vehicle accident on December 6, 1994. Their vehicle was struck from behind, spun around and hit again in the front of the vehicle. [The Appellant's] physician, [text deleted], diagnosed her as having sustained a musculoskeletal neck injury with strained trapezius and sternocleidomastoid muscles. He

referred her for physiotherapy treatments. In January 1995 her care was taken over by [Appellant's doctor #2]. He determined that along with persistent stiffness and pain in her neck there was a paresthesia involving her left arm for which she was referred to [text deleted], a neurologist for an examination. The results of the examination were normal except for a slight carpal tunnel syndrome which, [Appellant's neurologist #1] and [the Appellant] agreed, was not a result of the motor vehicle accident.

In February, 1995, [the Appellant] attempted a graduated return to work as a restaurant cashier and server of coffee and donuts, with the expectation that she would be able to build up to her pre-accident level of 34 hours a week by the end of March. Because of the pain on the left side of her neck, radiating into her shoulder and arm, she was not able to continue working.

MPIC referred [the Appellant] to [vocational rehab consulting company #1], to coordinate her rehabilitation. She was referred for a Functional Capacity Evaluation at the [rehab clinic #1] on June 21st and 22nd, 1995. Their report of June 27th concluded that her physical abilities did not match the critical job demands and recommended physiotherapy and programs for management of pain and neck postures as well as for overall flexibility and conditioning. A graduated return to work program was suggested, monitored by a therapist but because her employer was not willing to cooperate the report also recommended that she could do job simulation activities.

A rehabilitation plan was agreed to on July 24, 1995 with the goal of returning [the Appellant] to pre-accident activities. A reconditioning and work hardening program was

initiated at [hospital #1] on August 3rd, 1995 and was expected to progress for 4 to 6 weeks.

[The Appellant] was referred to [Appellant's pain management specialist] for instruction in pain and stress management. He reported on October 11, 1995 that she had myofascial pain syndrome involving her jaw, neck, shoulder and back regions. After treating three specific trigger points with acupuncture, [Appellant's pain management specialist] reported that the swelling, pain and numbness of the left arm had resolved and range of motion ('ROM') of her neck had improved. He was continuing with needling the posterior neck muscles and the left sternocleidomastoids. (By May 15, 1996, he was unable to identify any active myofascial trigger points.)

Once [the Appellant's] paresthesia had resolved and she had full ROM of her cervical spine, she underwent a reconditioning program from August 3rd to September 13th, 1995, followed by a work hardening program at [hospital #1] that started on October 2nd. A graduated return to work program (albeit without pay) was added, starting on October 23rd 1995, whereby her hours of work were increased from 2 per day to 4-5 hours daily. In her report of December 1, 1995 [text deleted], physiotherapist at [hospital #1], indicated that [the Appellant] was progressing and had demonstrated steady gains during the programming. A functional assessment indicated that [the Appellant] had increased tolerance in many areas but had some difficulty with repetitive upper extremity work. [Text deleted], the owner of the [text deleted] where the appellant had been employed, had stated that there was no longer a paid position for [the Appellant] to return to.

[vocational rehab consulting company #1] suggested that a consultant provide assistance in resume preparation.

During this rehabilitation period [the Appellant] was monitored by her family physician, [text deleted], by [Appellant's pain management specialist] for acupuncture treatments and pain management generally, and by her physiotherapist, [text deleted]. On March 25, 1996, [Appellant's physiotherapist #2] reported an increase in the appellant's daily functional activities requiring the use of upper extremities, such as washing windows and mopping floors. [The Appellant] was encouraged to continue her stretches and active muscle-strengthening exercises and to resume shoulder-girdle-strengthening exercises at home. Also, she was instructed to increase her workday hours and advance to an 8-hour day as soon as possible and to continue to increase her activities as tolerated.

As of February 20, 1996, [the Appellant] reported she was relocating to [British Columbia]. [Vocational rehab consulting company #1] then referred [the Appellant] to the [rehab clinic #2] for a Physical Assessment. The goal was to develop a rehabilitation program designed specifically to improve her functional ability levels and restore her abilities to match the physical demands of her pre-accident employment in the retail area. The assessment was undertaken by the [rehab clinic #2] on May 16, 1996 and resulted in a finding of 'mechanical neck pain …(and) thoracic outlet syndrome on the left', and in the following recommendations:

1. that [the Appellant] enter into reconditioning program geared toward educating her in proper body mechanics and that she undergo various lifting tests, in order objectively

to measure the effect on the thoracic outlet syndrome, to be performed by an occupational therapist;
2. that [the Appellant] be given further education in the nature of her injury; and
3. that further assessment may be required when results from the foregoing tests were known.

It was expected that the program would be short-term with visits three times per week, concluding before the June 28, 1996 deadline when [the Appellant], who had been oscillating between Manitoba and British Columbia, was leaving to live in [text deleted], British Columbia permanently.

On August 6, 1996, [the Appellant] was referred by her family physician in [text deleted], B.C., [text deleted], to [text deleted], Neurologist, to determine the source of her continuing left arm pain. He diagnosed her condition as thoracic outlet syndrome and referred her to [text deleted], a vascular surgeon who established that [the Appellant] was suffering from a left thoracic outlet syndrome that might require surgical treatment if it did not resolve itself through her therapy program.

On July 2 and 3,1997, [the Appellant] underwent a Functional Capacity Evaluation at the [rehab clinic #2], in [text deleted], B.C. Their conclusions were in accord with those of [text deleted], MPIC's Medical Consultant, who, upon reviewing [the Appellant's] file, reported on April 17, 1997, that [the Appellant] should be able to re-commence a graduated return to work either as a retail sales clerk or as a retail trade supervisor. The return-to-work program was to be time-limited, structured at a level of 4 hours per day for the first two weeks and increasing by one hour a day every week until she reached her usual hours of work.

Before she could start that program, however, [the Appellant] underwent surgery for left thoracic outlet syndrome on August 14, 1997. Her surgeon, [text deleted], reported in a follow-up examination on October 9th that he was very pleased with her progress, that she now had full range of motion and should be able to carry on her activities of daily living. He noted, however, that [the Appellant] was still complaining of severe neck pain and burning into her scapula, and recommended continuance of physiotherapy and chiropractic in that context.

Meanwhile, [the Appellant] had received a letter from her adjuster dated September 16, 1997. That letter reflected MPIC's conclusion, based upon the functional capacity assessment that had taken place on July 2nd and 3rd, 1997, that she was now able to meet the physical abilities associated with her predetermined occupation of a retail trade supervisor and/or retail sales clerk. Since [the Appellant] had been in receipt of income replacement indemnity ('IRI') for more than two years, she would remain entitled to IRI for a further 12 months, to September 15, 1998, to give her an opportunity to find employment. This extended benefits was provided under Section 110 (2) (d) of the MPIC Act. In that period of time, it was expected that she would be actively seeking employment and would be involved with a vocational professional provided by MPIC to assist her in her job search. As well, it was implicit that continued coverage would be provided for her medication, transportation expenses and any rehabilitation appliances that she required.

In early October 1997, [the Appellant] was referred to [text deleted], Rehabilitation Consultants, by MPIC. [Appellant's vocational rehab consultant] of that firm, arranged some volunteer work for the appellant, 2 hours per day for 3 days per week.

On October 30, 1997, [Appellant's doctor #4], agreed that a volunteer placement was appropriate and concurred in [Appellant's vocational rehab consultant's] suggestion that she begin a two hour placement for three days a week, for a two week period and then gradually increase the hours. Her chiropractor, [text deleted], also agreed to that plan, as a first step toward a graduated return to work. A variety of possible volunteer placements were reviewed, with [the Appellant] expressing her preference to volunteer at the [text deleted]. However, she was not accepted there.

On November 23, 1997, [the Appellant] filed an application for review of her injury claim decision, expressing the concern that, after having surgery in August, 1997, and continuing problems with her neck, upper back, arms and hands she was concerned that her problems would not be resolved by September 15, 1998, the date when her insured benefits were scheduled to cease.

On January 6, 1998, [vocational rehab consulting company #2] reported that [the Appellant] had chosen to take on a paid babysitting position with her neighbor's child, which was for four hours a day, five days a week. In the same report, it was noted that [the Appellant] had received permission from [text deleted], her chiropractor, to do some downhill skiing. The rehabilitation consultant had suggested that [the Appellant] might

wish to consider the safety aspect of skiing with limited range of motion of the neck and the implications of re-injuring herself at that point in her rehabilitation.

The appellant's baby-sitting job did not last long; she started a voluntary job at the [text deleted] on January 16, doing 2 ½ hour shifts, but quit on January 24th on the advice of her chiropractor.

The Internal Review Officer's decision, dated January 21st, 1998, provided a thorough review of [the Appellant's] condition. He concluded that, in light of the significant assistance [the Appellant] was receiving, the one-year of additional I.R.I. benefits to September 15, 1998 was more than adequate for her to re-establish herself in the workforce. [The Appellant] had expressed concern over a possible loss of entitlement to further benefits should she suffer a relapse after obtaining employment: the Internal Review Officer noted that the legislation makes provision for continued IRI benefits after a relapse occurs.

It is from this decision that [the Appellant] now appeals. At the hearing of her appeal, she testified that she has still been unable to return to work.

At the outset of the hearing, Ms Joan McKelvey, Counsel for MPI, stated that MPI recognized that the surgery undertaken by [the Appellant] on August 14, 1997 would have retarded her rehabilitation from injuries sustained in her accident. MPI was

therefore prepared to extend [the Appellant's] IRI benefits from September 16, 1998 until the end of December 1998.

Following the internal review decision, [the Appellant's] progress continued to be documented. On January 23, 1998, [Appellant's chiropractor] advised her to stop working at [text deleted] and (contrary to earlier advice he had given her) to undertake a placement that would avoid use of her arms and shoulders or repetitive tasks.

[The Appellant] was given the opportunity to start a graduated return to work on a voluntary basis at the [text deleted], working Monday, Wednesday and Friday from 11:00 A.M. to 1:00 P.M. commencing March 2, 1998. On March 16, 1998, the manager of [text deleted] reported that [the Appellant] had only shown up for two shifts and that she would only consider accommodating [the Appellant] for another two or three weeks. [The Appellant] told [vocational rehab consulting company #2] that she did work the two shifts but had then quit due to influenza and had not yet returned. She added that any work above waist level caused pain. She testified at her appeal that although she liked the situation and enjoyed meeting with people, she did find it very hard and, on the second day, she was only able to manage one hour of the shift because of the pain.

On March 18, 1998, [vocational rehab consulting company #2] reported that [the Appellant] had asked them to put her file on hold, to give her some time and space for her to deal with the issues of pain, return to the workplace, her marital strain, her avoidance and isolation behaviors and her panic attacks. At that time, the consultant had advised

the client to seek further psychiatric care from [Appellant's psychologist], whom she had consulted first in May of 1997. Meanwhile, [the Appellant] had been referred by her family physician to [text deleted], a neck rehabilitation specialist, who first saw her on February 6, 1998.

[Appellant's neck rehabilitation specialist] reported to [Appellant's doctor #4] on February 13, 1998 that he felt that [the Appellant's] neck, shoulder and arm pain, with the numbness in her left arm and face, was secondary to myofacial pain syndrome. On March 19, 1998 [Appellant's neck rehabilitation specialist] suggested to [Appellant's doctor #4] that [the Appellant] should recommence some physiotherapy and massage; it was his impression that she was still volunteering two hours a day. Trigger point injections had produced noticeable lessening in levels of pain; he intended to continue them. After seeing [the Appellant] again on October 16, 1998 [Appellant's neck rehabilitation specialist] advised [Appellant's doctor #4] of the appellant's subjective reports of exacerbated pain in the left side of the neck, scapula and mid-back, axillary pain and headaches following a seven-day trial of minimally demanding office work. [Appellant's neck rehabilitation specialist] said he had nothing more to offer her, other then advice to keep as active as possible.

A report from [vocational rehab consulting company #2], dated April 20, 1998, had advised MPIC in effect that [the Appellant] had become increasingly uncooperative, failing to keep appointments, failing to contact the consultants after undertaking to do so, and remaining non-committal with respect to her participation in a graduated return to

work program. That report therefore recommended that [vocational rehab consulting company #2] be instructed to close their file related to [the Appellant].

[Appellant's psychologist], in a report to [Appellant's doctor #4] dated May 6, 1998, assessed [the Appellant] as "showing the picture of panic disorder without agoraphobia and pain disorder associated with both general medical conditions and psychological factors." He suggested the continuance of Paxil as the appropriate medication for the appellant's depression and referred the appellant to group cognitive behavioral therapy at [hospital #2].

Conclusion

Following careful consideration of all the evidence adduced at the hearing of [the Appellant's] appeal, we have arrived at the following findings of fact:

(i) [the Appellant's] motor vehicle accident of December 6, 1994, resulted in certain musculoligamentous injuries, which may well have included the thoracic outlet syndrome for which she underwent transaxillary left rib resection, although the operative report casts some doubt upon that etiology;

(ii) her surgery was performed on August 14, 1997. By October 9th, her surgeon, [text deleted], was able to express pleasure in her excellent progress. [The Appellant] had "normalized all of the thoracic outlet maneuvers including the hyperabduction maneuver and Adson's maneuver"; the numbness and tingling

had gone from her hand and she had regained full range of motion of the shoulder;

(iii) [the Appellant] had recovered from her thoracic outlet syndrome and resultant surgery well before September 15, 1998 at least to the point at which, other things being equal, she would have been capable of returning to either of her former occupations;

(iv) other things, however, may not necessarily have been 'equal', since [the Appellant] also sustained soft tissue injury to her neck, from which her full recovery was retarded by the presence of the thoracic outlet syndrome; that neck injury resulted in pain that seems to have become chronic, partly due to deconditioning and partly due to psychological factors largely unrelated to the appellant's motor vehicle accident;

(v) by November of 1997 all of [the Appellant's] caregivers had approved the concept of a volunteer placement that would allow a graduated return to the workplace, in situations that would not place heavy physical demands upon her, although she was by no means symptom-free;

(vi) none of her caregivers - not [Appellant's doctor #4], not [Appellant's neck rehabilitation specialist], not [Appellant's psychologist], not [Appellant's chiropractor] nor any physiotherapist or occupational therapist to whose reports we have been made privy - has been able to point to any objective medical evidence that would prevent [the Appellant] from fulfilling the normal demands of her pre-accident forms of employment. Her psychological difficulties were reported by [Appellant's psychologist] on May 6, 1998, to be well under control,

> and the Functional Capacity Assessment completed over two days in July, 1997 makes it clear that, while not symptom-free, the appellant was physically able to start the reconditioning and rehabilitation required.

Every opportunity was provided for [the Appellant] to become rehabilitated through extensive physical and psychological therapy, work hardening programs, surgery and a personal rehabilitative consultant to work with her closely and provide her with any assistance she required. She was given choices about volunteer and work placements but she chose not to follow through with the initiatives provided. There may well be continuing symptoms, however, without objective verification, there is nothing to support a total absence from the workplace. Everything that has been tried to assist [the Appellant] seems to have met a stumbling block. Her attempts for a gradual return to work were strictly on her terms and it did not appear that she made a real effort beyond a couple of desultory attempts; she was not prepared to work through some of the discomfort in order to find some solutions or override the pain to help herself get back to the workplace. From April 20, 1998, when [vocational rehab consulting company #2's] rehabilitation file was closed up to the time of this hearing of her appeal, [the Appellant] has not, so far as we are aware, made further attempts to return to work.

We are satisfied, in consideration of the type of injury sustained in her motor vehicle accident, that [the Appellant] would have been healed through natural history long before the

date when MPIC terminated her benefits, had she been prepared to work through the short-term discomforts that she undoubtedly felt. As MPIC's medical consultant commented, "…in any situation where an individual has been away from a certain activity for a period of time as a result of a painful condition, symptoms of pain do increase initially when returning to their duties. This is not an indication of further injury but, instead, a normal human phenomenon an individual experiences with increased activities…[the Appellant's] perceived occupational disability is based on her persistent symptoms in the absence of objective findings supporting her perception."

We adopt the position of counsel for MPIC that [the Appellant's] surgery retarded her over-all rehabilitation by approximately 3 months but, short of that, the appellant's claim must fail.

DISPOSITION

Accordingly, the decision of the acting internal review officer is rescinded and MPIC will be required to pay [the Appellant] her IRI benefits from September 16, 1998 to the end of December, 1998, with interest thereon at the statutory rate.

Dated at Winnipeg this 19th day of August 1999.

J. F. REEH TAYLOR, Q.C.

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CHARLES T. BIRT, Q.C.

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LILA GOODSPEED