Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-99-63

PANEL:	**Mr. J. F. Reeh Taylor, Q.C., Chairman** **Ms. Yvonne Tavares** **Mr. Colon C. Settle, Q.C.**
APPEARANCES:	**The Appellant, [text deleted], was represented by [Appellant's counsel];** **Manitoba Public Insurance Corporation ('MPIC') was represented by Ms. Joan McKelvey.**
HEARING DATE:	**December 15 and 18, 2000**
ISSUES:	**(a) Whether Appellant entitled to personal and home care assistance;** **(b) Whether cost of ambulance made necessary by motor vehicle accident ('MVA');** **(c) Whether chiropractic care medically necessary and reimbursable;** **(d) Whether travel expenses attributable to MVA; and** **(e) Whether Appellant entitled to Income Replacement Indemnity ('IRI') after 180 days post-MVA.**
RELEVANT SECTIONS:	**Sections 84, 106, 131, and 136 of the MPIC Act ('the Act') And Sections 2, 5(a) and 26 of Manitoba 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

The accident giving rise to this claim occurred on November 4th, 1994, when [the Appellant] was driving her [text deleted]-year-old son from school to a violin lesson. She testified that she was travelling at about 25 kilometres per hour when another vehicle hit her car on the driver's side, just in front of where she was sitting. The other vehicle apparently was travelling at right angles

to [the Appellant's] line of advance. She added that, being somewhat short in stature, she always sits up close to the steering wheel so that her feet will touch the pedals. She believed that the initial impact threw her forward, into her airbag which deployed concurrently.

The damage to the front end of the [text deleted] vehicle being driven by [the Appellant] was sufficiently extensive that the vehicle was written off.

[The Appellant] and her son were taken to [hospital #1] where, as she puts it, "I complained of pain all over, including my neck, back, knee, the back of my head - everywhere". The relevant portions of the report of the admitting physician at [hospital #1] reflect a "[text deleted]-year-old female, seatbelted, not KO'ed, hit on driver's side, front. Complains of pain in the throat area, right arm, right knee…..also complains of numbness of right hand (apparently had this problem on and off), has had numbness of right arm two years from previous accident but worse now. Past history of chronic back pain. On examination, alert, no appreciable disease, oriented, slight tenderness of neck, especially right side…..Right knee - full range of movement, small bruise just below knee." The initial letters 'MCL' and 'LCL' were marked with a tick which, later testimony from [MPIC's doctor] told us, indicated that the medial and lateral collateral ligaments were found to be normal.

[The Appellant] and her son were discharged from hospital later that same night and she consulted her family physician, [text deleted], three days later on November 7th, 1994. [Appellant's doctor #1] testified that [the Appellant's] injuries were consistent with a Whiplash Associated Disorder, that no bruising was evident, but that he had referred her to [text deleted], neurologist, in light of her complaints of numbness in the fingers of both hands. Nerve

conduction studies completed by [Appellant's neurologist #1] on December 20th, 1994, showed no neurological deficits.

We should note, at this juncture, that [the Appellant] had been the victim of an earlier MVA on January 10th, 1993, for which she had been treated by [Appellant's doctor #2] and by [text deleted], a physiatrist, [text deleted]. [Appellant's physiatrist] had also treated [the Appellant] on several other, earlier occasions, for musculoligamentous problems related to slip-and-fall accidents.

The file contains the opinion of [text deleted], [the Appellant's] former family physician, expressed on April 26th, 1994, that "this lady has a Post-Traumatic Pain Syndrome, exacerbated by her accident of 10th January 1993. She had pre-existent osteoarthritic changes which have prolonged her recovery." We also have the opinion of [text deleted] (orthopedic specialist) of November 19th, 1993, also related to the accident of January 10th, 1993, who says in part "….She told me that her right leg at the back side of her right thigh and leg bothers her, that may radiate down to the plantar aspect of the right foot. She describes her pain as a hammering type of pain, mostly felt when she is walking for 15 to 20 minutes. ….She always seems to have some pain in the area, felt even when she is lying down. She told me that she has been having problem related to her right leg for about three years. She seems to be feeling more discomfort during the last three or four months. … In 1992 this lady was doing volunteer work for about 10 years [text deleted], attending meetings and helping with fundraising. She told me that since November of 1992, after she had the fall, she has not been doing those activities. She has a [text deleted]-year-old child at home. She told me that in November and December of 1992 she was not preparing meals. Her mother helped and her husband had been helping her. The only thing she was doing

was preparing very light meals at home. After the accident in January of 1993…she did not prepare any meals until about August or September, when she resumed light household chores."

A brief analysis of [the Appellant's] lengthy medical history between November 4th, 1994, and December 15th, 2000, (the date when her appeal was heard by this Commission), becomes necessary. She was referred by [Appellant's doctor #1], not only to [Appellant's neurologist #1] but, as well, to the [text deleted] Physiotherapy Clinic, to [Appellant's physiatrist] (who referred her to [rehab clinic] for further physiotherapy), to [text deleted] (orthopedic specialist), to [text deleted], a pain specialist, to [text deleted], an orthopedic surgeon, to [text deleted], a specialist in rheumatology, and to [text deleted], also an orthopedic surgeon. In addition to three separate courses of physiotherapy - one at [rehab clinic] and the other two at [text deleted] Physiotherapy Clinic - [the Appellant] also consulted [text deleted], a chiropractor, who saw her initially on July 29th, 1997, and whom she continued to see until November of this year and perhaps thereafter.

As a result of her 1993 MVA, [Appellant's physiatrist] treated the Appellant for Whiplash Associated Disorder affecting her neck, back and spine. [the Appellant] testified that this earlier claim had been settled and she had substantially recovered from those injuries by late summer or early fall of 1994, and that the only bodily injury from which she was suffering immediately prior to her November 1994 MVA was a chronic right ankle sprain that had apparently persisted from about May 1st, 1994.

Although [Appellant's physiatrist] first saw [the Appellant] on June 13th, 1995, in connection with complaints arising from her MVA of November, 1994, his treatments were concentrated on relieving myofascial pain syndrome with trigger points in multiple muscles of the upper body,

similar to those that she had experienced in the past and for which she had received similar treatments from [Appellant's physiatrist]. In due course, [Appellant's physiatrist] was able to report that the areas he had been treating in her upper body had now, in large measure, been returned to normal. It was not until December 12th, 1997, that [Appellant's physiatrist] appears to have examined [the Appellant] in connection with her right knee.

Meanwhile, [Appellant's doctor #1] had initially referred [the Appellant] to [text deleted], orthopedic surgeon at [text deleted]. [Appellant's orthopedic surgeon #2], who had also examined and treated [the Appellant] in connection with her 1993 accident, reported to [Appellant's doctor #1] on October 26th, 1995, that [the Appellant] had presented to him with pain at the right ankle and right knee. "She still relates giving way of the ankle. This time she states that it is to inversion not to eversion. This is different from her last history, which stated that she gave way to eversion. I'm unsure what to make of this….She still has pain over the anterior aspect of the knee and medial aspect of the knee extending down the medial aspect of the cuff. She relates no pain coming from her hip, groin or buttock and no pain coming from the back….She relates gross swelling of the knee….I see no effusion today but this lady is fairly obese and has large thighs. Range of motion of the knee appears normal. Patella appears to track normally. Palpation: she is tender to patellar grind on the right-hand side, numb tender over medial and lateral retinaculum. She is tender over the lateral joint line today and over the medial joint line. …Ligament testing appears stable." [Appellant's orthopedic surgeon #2] felt that [the Appellant's] pain was secondary to dashboard knee-type of injury, mainly patello-femoral. He recommended a magnetic resonance imaging (MRI) to rule out any ligament damage or meniscal tears. The MRI results, while otherwise normal, did raise the possibility of a medial meniscal tear. A cortisone injection administered by [Appellant's orthopedic surgeon #2] did not seem to help very much.

[The Appellant] was then referred to [text deleted] for a second opinion. His initial report of April 28th, 1996, speaks of "diffuse peripatellar and articular tenderness in the right knee with no ligamentous instability". Because [the Appellant] had told him of her persistent anterior right knee pain and because the MRI had at least raised the possibility of a meniscal tear, [Appellant's orthopedic surgeon #3] performed a right knee arthroscopy for her on June 14th, 1996. That procedure disclosed no tearing of the meniscus but did reveal tibial chondromalacia, particularly in the lateral compartment and, to a lesser extent, in the medial compartment. [Appellant's orthopedic surgeon #3] performed an extensive chondroplasty of the lateral tibial compartment and a similar, but less extensive, procedure medially. [Appellant's orthopedic surgeon #3] advised [Appellant's doctor #1] that "one may consider a varus customized brace some time next year". Because [the Appellant] still complained of pain and tenderness in the right posterior thigh, radiating up into the buttock and low back, and another pain radiating distally from the knee down the medial leg and the top of the foot, [Appellant's orthopedic surgeon #3] suggested a referral by [Appellant's doctor #1] to a consultant in rheumatology rehabilitation medicine. In a later report, addressed to MPIC on January 23rd, 1997, [Appellant's orthopedic surgeon #3] expressed the view that "one would not expect to see primarily tibial chondromalacia changes as a result of a direct blow to the front of the knee in a motor vehicle accident". He was of the view that [the Appellant's] pain complaints arose outside the knee joint itself.

[Appellant's doctor #1] then referred [the Appellant] to [Appellant's pain specialist] of the [text deleted], who provided her with acupuncture. She had complained of the fingers on both hands becoming numb through most of the day, although worse when she was sitting; right knee pain as a "constant, burning pain which crisscrossed the anterior kneecap and ankle"; back pain and right hip pain and pain in both shoulders radiating to the hands. [Appellant's pain specialist]

noted his understanding that [the Appellant] had sustained two or three previous motor vehicle accidents for which she had received treatments for several years thereafter, including trigger-point needling by [Appellant's physiatrist]. [The Appellant] testified that only one of those incidents was motor vehicle related. [Appellant's pain specialist's] examination of the Appellant disclosed no physical abnormality. In particular, there was full range of motion of the knee, with no swelling, redness or heat, no ligamentous debility nor cartilaginous signs of the knee. [Appellant's pain specialist] noted that [the Appellant] walked with an ataxic gait and, in general, a little gingerly. She was wearing both knee and ankle braces - the knee brace on the advice, she said, of [Appellant's orthopedic surgeon #3], and the ankle brace because she felt that her ankle turned over. [Appellant's pain specialist] recommended a course of trigger-point acupuncture although, interestingly enough, he had not been able to identify any trigger points.

[The Appellant] then consulted [text deleted], chiropractor, who first saw her on July 29th, 1997. Much of [Appellant's chiropractor's] initial health care report and his treatment plan report is illegible, but it seems clear that he expected to treat her with chiropractic adjustments at a frequency of twice weekly for three months, then once per week for the next four to six weeks, reducing to once a month and discharging her from care in February or March of 1998. [Appellant's chiropractor] found no dermatomal deficit, no myotomal weakness, no reflex changes and a normal neurologic examination. He felt that the two factors likely to delay [the Appellant's] recovery in the context of her low back and upper torso pain and numbness of the fingers were the multiplicity of her care-givers and her unresolved right knee condition. By March 23rd, 1998, [Appellant's chiropractor] was reporting that [the Appellant's] main complaints pertained to her low back, hips, knees and ankles, with the right knee problem causing her to compensate by putting additional stress on her low back, hip, left knee and left ankle. It is noteworthy that, contrary to the report of [Appellant's orthopedic surgeon #1] from

November of 1993, [the Appellant] told [Appellant's chiropractor] that she had had no prior history of knee problems.

[Appellant's pain specialist] noted [the Appellant's] "self-limited pain behaviours and, in general, a pain-focussed outlook". [Appellant's doctor #1] agreed, in a discussion with MPIC's adjuster on February 21st, 1997, that despite her injuries, [the Appellant] was quite capable of engaging in employment as a typist or in related office work, if that was the occupation for which she had been trained. In fact, she had not been gainfully employed since the mid-1970s. In the belief that there were psychological overtones to this claim, [Appellant's doctor #1] undertook to refer [the Appellant] to a clinical psychologist, but [the Appellant] declined that option.

A report to MPIC of December 15th, 1997, from [text deleted] Physiotherapy Clinic shows that, when first referred there by [Appellant's doctor #1] on November 7th, 1994, [the Appellant's] main complaints were of pain on both sides of her neck, between her shoulder blades, pain down the entire arm, wrist and all fingers, parasthesia, numbness and decreased power in the right arm which she felt unable to use, right low back and buttock pain radiating down the right thigh and knee, and constant headaches primarily in the right frontal area. The physiotherapist noticed some bruising in [the Appellant's] right upper arm and in the area of the right knee. There was slight swelling at the right ankle and she had reported a history of chronic myofascial problems which the therapist thought might be a contributing factor to the severity of her muscular signs. On examination, her right knee showed no significant swelling and had good range of motion. Ligament testing and patellar mobility were unremarkable and straight leg raise was full at about 75º.

On November 23rd, 1994, [the Appellant] had complained of increased right leg swelling, with similar complaints on November 28th and December 5th. After December 14th, 1994, the Appellant had cancelled further physiotherapy, apparently upon the advice of her physician. On April 5th, 1995, on referral this time from [Appellant's physiatrist], [the Appellant] commenced a new series of physiotherapy treatments at the [text deleted] Physiotherapy Clinic, which continued until May 19th of that year. This course of treatments was directed primarily to the neck and shoulder area, although part of the therapy included treadmill walking. On May 3rd the therapist noticed increasing knee signs which he defined as a "mild patello-femoral arthralgia".

Later in May 1995, [the Appellant] appears to have been complaining more of problems with her right ankle, but her physiotherapist could find no acute inflammatory condition, range of motion was essentially full and all ligament testing was stable, with minimal thickness along the lateral malleolus. He felt that her right ankle and lower leg discomfort was primarily due to weakness and that her active movements were limited primarily by subjective complaints of pain.

In August of 1995, [the Appellant] again started a program of physiotherapy at [rehab clinic]. She complained of bilateral neck and upper limb pain, with the right side being worse than the left, as well as frequent headaches over the posterior scalp and the forehead, with occasional dizziness when she would "pass out" and fall. She also indicated paresthesia in both hands in no particular pattern. Although, when completing a pain diagram, she had not noted any knee trouble, she did report that her walking tolerance was "good" at first but that, after some time, her knee and ankle began to hurt. Her attendance at physiotherapy treatments appears to have been sporadic and, her physiotherapist noted, "she required repeated instruction and constant supervision to perform and complete her exercises. One has to question her compliance with the home exercise program as she could not demonstrate her exercises. She did not attend the

recommended pool class due to other self-reported medical problems…..On October 16th, 1995, she stated that she preferred to do her exercises at home, as she did not have time to come to physiotherapy treatments. She did not know her exercises, did not perform them well, and required instruction again." After missing several appointments she advised [rehab clinic] that she had no time to come in for physiotherapy and she was therefore discharged on October 30th, 1995.

[The Appellant] was again referred for physiotherapy, this time by [Appellant's rheumatologist] on September 9th, 1996, with a diagnosis of mechanical low back pain, right trocanteric bursitis and gluteal pain, with right knee pain secondary to meniscal injury. [The Appellant] told her physiotherapist that she had received a cortisone injection in her right knee with no perceived benefit and that [Appellant's orthopedic surgeon #3's] arthroscopy had discovered some degenerative changes. She complained of increasing pain, especially on the right side, when walking, the site of her pain being mainly across her lumbosacral area. Her therapist said that, objectively, [the Appellant] had full knee range of motion with minimal patello-femoral or ligamentous dysfunction, that there was no clear sign where the knee tenderness was but that this might be explained by her degenerative changes. The Appellant had reported using a cane as well as an aircast on her ankle and a brace on her right knee. She was "still quite focussed on pain management as opposed to exercise and improved function". This latter course of physiotherapy seems to have concluded on October 24th, 1996, and it was not until March 5th, 1997, that [the Appellant] was again referred to the [text deleted] Clinic, this time by [Appellant's pain specialist]. She told her therapist that, despite injections of Synvex into her right knee and acupuncture treatments from [Appellant's pain specialist] for her back and knee symptoms, she had seen no significant improvement and was still waiting to see [Appellant's physiatrist]. She complained mostly of the pain being in her right buttock, low back, right knee

and right ankle. She was wearing a knee brace and an aircast and was often using a cane. Her right knee range of motion actively was 0-126º with no significant lag; she had good patellar mobility with reports of pain, but no obvious gross crepitus. Her gait was still grossly affected, with a stiff right knee being apparent, and she was walking on the outside of her right foot. She appeared quite dependent on her knee and ankle braces and her own pain scale rating suggested a chronic pain-focused behaviour. Her physiotherapist spoke with [Appellant's pain specialist] on May 7th, 1997, when they agreed to try a twice weekly exercise program in an effort to wean [the Appellant] off her supports. [The Appellant] did not attend for any further scheduled appointments at the [text deleted] Clinic. [Appellant's pain specialist] had, in the meantime, discharged [the Appellant] from his treatments on April 9th, 1997.

On December 12th, 1997, [the Appellant] saw [Appellant's physiatrist] on referral from [Appellant's doctor #1], this time with particular reference to her anterior right knee region. Neither X-rays of her right knee nor a magnetic resonance imaging of that knee showed any abnormality. [Appellant's physiatrist] found that the knee was stable with no evidence of medial or lateral ligament tears. He found no evidence of effusion. He was able to locate a taut band and an acutely tender trigger point in the right vastus medialis which he was able to irritate, causing referral of pain to the anterior knee. Another taut band and tender trigger point was found by [Appellant's physiatrist] in the Appellant's right medial gastrocnemius, of which the irritation caused referral of pain down the calf. [Appellant's physiatrist] noted that these findings were characteristic of myofascial trigger points with local and referred pain symptoms, regardless of any pathology that might be present in [the Appellant's] knee. He carried out needling with 1% Xylocaine injection of the two trigger points referred to above.

On February 27th, 1998, [the Appellant's] case manager at MPIC wrote to her, to advise that:

a) it was the view of MPIC that she had reached maximum therapeutic benefit respecting any injuries directly attributable to her motor vehicle accident of November 4th, 1994;

b) her ongoing knee and ankle complaints were not attributable to that accident;

c) there was no medical evidence to support the existence of psychosocial problems attributable to that accident;

d) chiropractic treatments were primarily supportive in nature, pending resolution of the right knee/leg condition; and that

e) any further expenses related to her ongoing complaints would be [the Appellant's] responsibility.

[The Appellant] appealed from that decision to MPIC's Internal Review Officer who, by the time he conducted his review, had been provided with additional material, consisting principally of the following:

(i) copy of a report from [Appellant's physiatrist] to [Appellant's doctor #1] of April 27th, 1998. He had carried out a further trigger-point needling and stretch procedure which had improved the condition of her right medial collateral ligament; [the Appellant] still had tender trigger points in the right vastus medialis and right medial gastrocnemius; on April 6th [the Appellant] had complained of right anterior thigh pain and pain along the medial knee and leg. On examination, range of motion of the right knee was full in extension with no evidence of deformity; flexion allowed the heel to reach within two inches of the buttock; [Appellant's physiatrist] could not locate acutely tender trigger points in the right vastus medialis or the right medial collateral ligament. Acute tenderness was present in the right vastus intermedius at mid-thigh level. [Appellant's physiatrist] had last seen [the Appellant] on April 14th, 1998, when he had again performed some trigger-point needling. She continued to have definite myofascial trigger points as described on each of her previous visits. The tenderness over the medial

collateral ligament had resolved, but she continued to complain of pain in the region of the right knee and continued to wear the knee brace out of fear that her knee would give way. "The myofascial trigger points may be secondary to internal knee degenerative changes as documented by [Appellant's orthopedic surgeon #3] during arthroscopy".

(ii) A letter from [Appellant's doctor #1] of May 6th, 1998, which notes [the Appellant's] continuing symptoms and complaints despite multiple medical and paramedical interventions. He comments that [Appellant's physiatrist], [Appellant's pain specialist] and [Appellant's rheumatologist] had all identified [the Appellant's] right knee problem as regional myofascial pain, and remarks that similar complaints of pain and discomfort had been noted to affect other regional areas of [the Appellant's] body, some of which had been similarly assessed and treated with good outcome. [Appellant's doctor #1] concluded that [the Appellant] needed continued coverage for medications and for physiotherapy specifically geared towards fibromyalgia which, in his oral testimony, [Appellant's doctor #1] equated with myofascial pain syndrome.

(iii) A further letter from [Appellant's physiatrist] to [Appellant's doctor #1] of June 30th, 1998, to the effect that [the Appellant] no longer had pain along the right lateral thigh, nor anywhere in the right leg below the knee, but still had anterior knee pain. [Appellant's physiatrist's] report respecting [the Appellant's] right knee, from his examination of June 10th, 1998, was closely akin to that contained in his report of April 27th. By June 30th, 1998, [Appellant's physiatrist] felt that "many of her trigger points have been eradicated along with decrease in overall pain symptoms". He also commented that a new X-ray of [the Appellant's] right knee had been normal and there did not appear to be any internal derangement of that knee.

(iv) Letter from [Appellant's doctor #1] addressed to MPIC's Internal Review Office on September 18th, 1998, indicating that further examinations of [the Appellant's] condition were pending and asking MPIC to re-establish her benefits.

(v) Brief letter from [Appellant's chiropractor] of March 23rd, 1998, to the effect that [the Appellant's] main complaints pertained to her low back, hips, knees and ankles, with the right knee causing her to compensate by putting extra stress on her low back, hip and left knee and ankle. [Appellant's chiropractor] concluded that, since [the Appellant] did not relate any prior history of knee problems, he could only conclude that the injuries of which she complained were due to her MVA of November 4th, 1994.

(vi) A further letter from [Appellant's orthopedic surgeon #3] to MPIC of October 5th, 1998, agreeing that no further treatment nor any medication were required on account of [the Appellant's] injuries from her MVA of 1994. "I have not found enough definite objective abnormalities continuing, that can be attributed to the old accident. It was my impression also that her continued symptoms would not likely respond to further therapy or surgical intervention, whether or not these complaints were accident related."

(vii) A letter of January 14th, 1999, to MPIC from [Appellant's chiropractor], outlining the problems of which [the Appellant] had complained and for which he was treating her. [Appellant's chiropractor] did not appear to be treating [the Appellant's] right knee but he did comment that she would not be free of the "biomechanical deficits in her hip and low back" (for which he was treating her) until her right knee symptoms had been completely resolved.

(viii) Letter from [Appellant's physiatrist] of January 18th, 1999, to MPIC's Internal Review Officer. This letter, in part, summarizes [Appellant's physiatrist's] earlier reports referred to above. In referring to the fact that right knee pain and bruising were noted when [the Appellant] attended at the emergency department of [hospital #1] on

November 4th, 1994, [Appellant's physiatrist] says "the bruising was more localized to the medial aspect of the knee rather than the anterior aspect that would be expected with a straight-on dashboard knee injury". We have to conclude that [Appellant's physiatrist] learned that from [the Appellant] herself, since the hospital report does not say so, but simply refers to "small bruise just below knee". [Appellant's physiatrist] says that, as of January 18th, 1999, [the Appellant] had two definite diagnoses relating to her right knee: she had definite myofascial pain syndrome with muscle trigger points as described in his earlier reports, many of which he had been able to eradicate by needling of those trigger points; she also had chondromalacia of the right knee, as diagnosed by [Appellant's orthopedic surgeon #3] on June 11th, 1996. [Appellant's physiatrist] expressed the firm view that both of those diagnoses were contributors to [the Appellant's] chronic knee pain complaints. He felt that the chronic myofascial pain syndrome began at the time of the November 4th, 1994, MVA but that her treatments prior to his involvement had failed to eradicate the trigger points. [The Appellant] had told him that her knee had struck the dashboard of her car but, [Appellant's physiatrist] felt, it was just as likely that her knee had struck some other surface of the car than the dashboard, or had struck the front of the car anteriorly rather than medially. He could see no evidence to exclude the fact that trauma to [the Appellant's] right knee on November 4th, 1994, could have been the initiating cause of her subsequent chondromalacia. "Although dashboard knee injuries usually cause pathology related to the patello-femoral surface of the knee joint it is not certain that she had a typical dashboard injury. Finally, myofascial pain syndrome can remain for many years despite effective treatment if there are underlying perpetuating factors."

Finally, [Appellant's physiatrist] noted that [the Appellant] "had residual pain complaints in the neck, shoulder girdle and back prior to the MVA of November 4, 1994. She likely had exacerbation of some of those pain complaints but I feel that these symptoms settled down and ongoing symptoms in regions other than the knee cannot be blamed on the MVA of November 4, 1994. Likewise, she sprained her right ankle prior to the MVA of November 4, 1994."

(ix) Lengthy report from [Appellant's rheumatologist], [text deleted], dated February 1st, 1999. Significant portions of [Appellant's rheumatologist's] report may be summarized this way: [the Appellant] had told him that, in the course of her MVA in November 1994, her right knee hit the dashboard quite hard and she had also injured her right ankle at the same time; she had problems with ambulation and, since mid-June of 1996, had used a cane in the right hand for walking; range of motion at the hips and knees was normal and there was no evidence of ligamentous laxity; [Appellant's rheumatologist] was of the view that [the Appellant's] persistent knee discomfort was secondary to her chondromalacia; "By this point, I would have expected the ill effects from the accident to have completely resolved. Her persistent problem was secondary to persistent patello-femoral pain secondary to documented chondromalacia….Her widespread musculoskeletal symptoms were, based upon a balance of probabilities, not related to her MVA of November 1994."

(x) Letter from [Appellant's orthopedic surgeon #3] of April 21st, 1999, addressed to the Internal Review Officer. [Appellant's orthopedic surgeon #3] comments that "the symptoms in November 1994 were partially an aggravation of a previous accident in 1993, with symptoms in the neck, shoulder and left upper extremity. It appears it is only the 1994 accident which contributed to her right knee and right leg problems as far as the medial ankle. Then there was a subsequent injury to the right ankle in 1995, not related

directly to the motor vehicle accident". He could find no evidence that [the Appellant] would benefit from further physiotherapy or rehabilitation. There was no objective evidence of a progressive degenerative or post-traumatic condition developing as a consequence of the MVA and [Appellant's orthopedic surgeon #3] therefore concluded that healing of any injuries sustained in that accident would have occurred by the date of his letter; continued symptoms were not a direct consequence of that accident.

(xi) Letter from [Appellant's orthopedic surgeon #4], [text deleted], of April 30th, 1999, addressed to the Internal Review Officer. [Appellant's orthopedic surgeon #4] notes that [the Appellant] "still complains of right knee pain as well as some giving way". He reports that she was wearing a "Don-joy" brace prescribed by another physician but, since he found no evidence of ligamentous insufficiency either clinically or on MRI, [Appellant's orthopedic surgeon #4] was uncertain as to the reason for the brace. [The Appellant] was bothered predominantly by low back and radicular leg complaints, for which she was seeing [Appellant's physiatrist]. There were no present plans for any future knee-related investigations or treatment.

Based upon the foregoing, as well as the earlier material on file and an opinion of MPIC's in-house medical team, the Internal Review Officer confirmed the decision of the case manager and dismissed [the Appellant's] review application. From that decision, [the Appellant] appealed to this Commission on July 7th, 1999.

Unfortunately, the final hearing of [the Appellant's] appeal was delayed since, half-way through the hearing, her original attorney was obliged to withdraw from the case for reasons that are not material here. After her Notice of Appeal had been filed but before the final re-hearing of that appeal, this Commission was provided with additional evidence in the forms of:

i) Letter from [Appellant's doctor #1] to [the Appellant's] lawyer, undated but apparently sent on November 29th, 1999. This letter reports that on July 13th, 1999, while bending to put on her shoes, [the Appellant] had fallen down some stairs at her home. She could not recall the circumstances of her fall but remembered experiencing lower back pain and her right leg giving out suddenly. No neurological deficits had been discovered, nor had a CT scan established any specific pathology in the lower back.

ii) Letter from [Appellant's physiatrist] to a lawyer who had acted for [the Appellant] respecting her January 10th, 1993 accident. [Appellant's physiatrist's] letter bears date December 15th, 1994, but makes no mention of [the Appellant's] MVA in November of that year. He does say that she was not disabled in regards to activities of daily living, based upon his last examination on August 31st, 1994.

iii) Sundry reports from [Appellant's doctor #3] relating to the Appellant's 1993 accident and not relevant to the present enquiry.

iv) A memorandum from [MPIC's doctor] of January 4th, 2000, reviewing documents received since September 9th, 1998, and concluding that

> The mechanism by which [the Appellant] potentially injured her knee and the clinically [*sic*] findings identified on the [hospital #1] report form would suggest that a direct blow occurred to the lower part of her knee. This would not expose the tibial plateaus to significant force which, in turn, would result in chrondromalacic changes. In other words, the changes noted in arthroscopy likely developed from time itself and not a result of a single traumatic event that might have occurred in the motor vehicle collision in question. Based on the information obtained from the reports of [Appellant's orthopedic surgeon #3] and [Appellant's rheumatologist], it appears that [the Appellant's] right knee condition is not a result of the motor vehicle collision in question.

v) The letter from [Appellant's physiatrist] to [Appellant's doctor #1] of January 19th, 2000. [Appellant's physiatrist] reported that, on July 13th, 1999, [the Appellant] was bending to put on her shoes and her right knee became painful and gave way, causing her to fall down three steps and to land on the landing of the garage connected to her home. She

had been taken by ambulance to [hospital #2] Emergency where she received analgesics and was sent home. At the time of [Appellant's physiatrist's] letter, [the Appellant] was taking five different drugs (MS Contin, Zoloft, Amitriptyline, Clonazepam and Diclofenac). She had been referred to [Appellant's neurologist #1] who had found no neurologic deficits. She had been referred back for further physiotherapy and [Appellant's physiatrist] was carrying out more trigger-point needling. There is no other reference in this report to [the Appellant's] right knee problem.

vi) A letter from MPIC's claims supervisor to [the Appellant] of February 9th, 2000, denying her claims for personal assistance expenses (Section 131 of the Act) and for a 180-day determination with regard to any possible Income Replacement Indemnity entitlement, under Sections 85 and 86 of the Act.

vii) Letter from the Internal Review Officer to [the Appellant] of March 15th, 2000, confirming the decisions of the claims supervisor. Each of those latter decisions has also been the subject of an appeal to this Commission.

The setting of a date for the hearing of [the Appellant's] appeal was again delayed by the twin facts that [the Appellant] had now found new counsel and that he had encountered difficulty in obtaining updated medical reports.

Evidence of [the Appellant]

Much of [the Appellant's] oral testimony amounted to confirmation of many of the facts already outlined earlier in these Reasons. She noted that [Appellant's physiatrist] had not treated her knee initially because he was not an orthopedic specialist and others were dealing with that region. She testified that [Appellant's physiatrist's] injections were not in the knee itself, but elsewhere - sometimes in the buttock, sometimes in the thigh or elsewhere, but each such

injection would trigger pain in the knee. His treatments had relieved her pain to a great extent and she was to see him twice more in January 2001 for further needling respecting her right knee.

[The Appellant] also testified that, when she had her fall in July of 1999, she had lifted her right foot to put on her runners and, when she put her foot back down on the ground, her right leg gave way. She had fallen down three steps and been taken by ambulance to the hospital. She had paid the ambulance bill of $250. [The Appellant] also testified that prior to her 1994 accident, she could perform all her normal household activities; she used to bowl, dance, enjoyed parties and do almost anything. Since then, she said, she had been seriously limited, could no longer dance, could not drive very much and needed help from her family with simple household chores. [Appellant's husband] or their son have to drive her 75% of the time when she goes for medical appointments. She had not been gainfully employed for some years before her accident. [Appellant's husband] helps when he can, but sometimes the house does not get vacuumed for five consecutive months. She still has back problems due to her knee pains, although her neck and shoulders are now free from trouble. [Appellant's chiropractor] treats her for everything except her knee. [The Appellant] further said that, at the time of her accident in 1994, she was still wearing an ankle splint - she still does, in fact, although not while she is at home where she has "walls to hang on to".

She had slipped on ice in 1990, 1991 and 1992 for which [Appellant's physiatrist] had treated her. She had been diagnosed with myofascial pain syndrome prior to the 1994 accident. She had last been gainfully employed in 1978/9 working in the Accounts Receivable and Accounts Payable departments of a national moving and storage company. She still does home exercises,

10 to 15 minutes daily, although the exercises that she does seem largely limited to exercises for her low back.

While her husband, son, mother and neighbours help her out with her household tasks, she has never had to hire someone outside the family to do so.

[The Appellant's] evidence was that her husband gets food from the freezer and brings it to her, since she cannot go up and down stairs between the basement and the main floor of her home. "I have difficulty even making myself a sandwich. My husband makes the coffee and puts the bread in the toaster." She describes herself as being unable to bend in her kitchen to pick up pots and pans, since the pain in her knee radiates all the way up to her hip. She cannot stand for very long, even with the use of her cane, "but when I take my MS Contin (*a morphine derivative*) I have no pain and I can do anything I want". [The Appellant] acknowledged that there had also been times prior to her accident when she had been unable to do anything at home and unable to do any shopping, particularly after her 1993 accident.

Evidence of [Appellant's husband]

[Appellant's husband] confirmed most of the Appellant's evidence, although he did indicate that the majority of the damage to their vehicle had been at the left front portion of the van, further towards the front than [the Appellant] seemed to recall. He testified that, during the last six years, his wife's knee was the one part of her body that was not getting any better. "Sometimes, her whole lower leg (from the knee down) swells up."

Evidence of [Appellant's doctor #1]

[Appellant's doctor #1], as noted earlier, is [the Appellant's] family physician and has been so since the fall of 1992. He first saw [the Appellant], in the context of the accident now under review, on November 7th, 1994, three days after the accident. Her injuries, he said, were consistent with a Whiplash Associated Disorder. No bruising was evident but, in light of the nature of her complaints, he had referred her to [Appellant's neurologist #1] and to [Appellant's orthopedic surgeon #2] for neurologic and orthopedic assessment respectively. He had written to [the Appellant's] attorney on May 24th, 1995, and had recommended a Functional Capacity Evaluation although, it would appear, no such assessment was ever actually made. [Appellant's doctor #1] noted that, initially, the Appellant had complained of pain at the anterior as well as the outer and inner aspects of her knee. By the date of the hearing of her appeal, [the Appellant's] symptomotology seemed to have settled at the inner side of her right knee, said [Appellant's doctor #1].

By June of 1995, [the Appellant] had been recovering slowly but steadily in all areas other than her right knee. [Appellant's doctor #1] interpreted [Appellant's physiatrist's] reports to mean that, while he could find no actual injury to the knee itself, [Appellant's physiatrist] could create the pain of which [the Appellant] complains at the front of her right knee by needling the right vastus medialis. Contrary to the views expressed by [Appellant's orthopedic surgeon #3], [Appellant's physiatrist], [Appellant's orthopedic surgeon #4] and [Appellant's rheumatologist], [Appellant's doctor #1] felt that another MRI should be performed, to see whether a meniscal tear had, perhaps, now developed; he could not suggest any other reason for the continued symptoms of which [the Appellant] complains. As he put it, "my guess is we're dealing with two pathologies: the one [Appellant's physiatrist] has been treating - soft tissue, trigger points;

the other may be some occult pathology occurring within the knee which, if present, should show up on a new, updated MRI".

[Appellant's doctor #1] also said he had seen [the Appellant] shortly after her fall in July of 1999. She had told him there had been a sudden giving way of her right leg. She felt that it was her knee that had given way but, as [Appellant's doctor #1] puts it, "one can't be sure of these things". [Appellant's doctor #1] also testified that, although he had noted [the Appellant's] claim that her injuries were limiting her household duties, he himself had never performed an assessment in that context. He was also unaware, at the time of the 1994 accident, that [the Appellant] had had a history of chronic myofascial pain syndrome.

[Appellant's doctor #1] agreed that [Appellant's physiatrist] had opined that the Appellant's knee was now stable although, he added, one cannot tell that merely from an X-ray. [Appellant's doctor #1] also agreed that a brace can create a dependency and can also cause a wasting of the muscle and a stiffening of the joint if worn for too long. While agreeing that exercise is a vital part of rehabilitation, [Appellant's doctor #1] commented that "we sometimes place too much faith in physiotherapists who can be too aggressive".

[Appellant's doctor #1] recalled that [the Appellant] had told him there had been several incidents, prior to her actual fall in her garage, when she had felt her knee or leg might be about to give way, but the anticipated event had not actually taken place. While the majority of the Appellant's pain seemed to be localized at the medial point of her knee, [Appellant's doctor #1] felt that her problems were more generalized than that.

Evidence of [MPIC's doctor]

[MPIC's doctor], who practises primarily in the field of physical medicine and, in particular, sports medicine, is a member of the medical services team of MPIC. He has never examined the Appellant but has reviewed the entire file.

[MPIC's doctor] noted that [Appellant's orthopedic surgeon #3] had identified what is essentially a degenerative type of disease which would take place over a period of years. [Appellant's orthopedic surgeon #3] had recommended a lateral knee brace, whereas what she had been given was a medial brace - just the opposite from what she needed. [MPIC's doctor] added that a brace is sometimes called for to take some of the stress off the load-bearing area of a knee, but prolonged use can promote joint stiffness, dependency and weakening or wasting of the supportive muscle. Exercise is a vital part of treatment. He was of the view that some of the major factors causing the continuance of [the Appellant's] knee pain were the poor motivation that was reflected at several points throughout the file, her chronic right ankle sprain that had occurred at least six months prior to the 1994 accident, the pre-existing myofascial pain syndrome and the Appellant's obesity. The poor motivation had led to self-imposed inactivity which, in turn, will necessarily lead to the worsening of the patient's symptoms. Activity was vital, including weight-bearing activities. [MPIC's doctor] noted that [the Appellant] had been given two aircasts and high-top runners. He said that he often prescribes an aircast when the patient is involved in high-demand activities and where there is any sign of instability, but [the Appellant] had no such signs nor any such activities.

[MPIC's doctor] defined fibromyalgia as the presence of 11 or more out of 18 tender points, where pain, interrupted sleep and depression exist for six months or more, in the absence of pathophysiological signs. Myofascial pain syndrome, on the other hand, describes a bundle of

symptoms based on the existence of certain trigger points which, when properly manipulated, can create pain in other, predetermined areas of the body. It can also be localized, as in [the Appellant's] case.

[MPIC's doctor] agreed with [Appellant's orthopedic surgeon #3] and [Appellant's rheumatologist] that any problems remaining by October 5th, 1998, were no longer related to [the Appellant's] motor vehicle accident. While [Appellant's orthopedic surgeon #3], [Appellant's rheumatologist] and [Appellant's orthopedic surgeon #4] all seemed to feel that the ongoing problems [the Appellant] was experiencing with her knee were not MVA related, [Appellant's physiatrist's] opinion to the contrary seemed to be based largely on the absence of evidence that excludes the causal relationship between the MVA and the ongoing pain. [MPIC's doctor], for his part, would have encouraged [the Appellant] to participate in all domestic activities, even if initially painful.

[MPIC's doctor] agreed that [Appellant's physiatrist] had had the maximum exposure to [the Appellant] in the context of her myofascial symptoms. [Appellant's physiatrist] made clear, said [MPIC's doctor], that the Appellant had sustained an exacerbation of her myofascial symptoms and that those symptoms had largely dissipated quite some time ago, leaving only the knee pain to be dealt with.

[MPIC's doctor] testified that he had initially been of the view that [the Appellant] had struck her leg, just below the knee, on the dashboard. He said that if she had struck the medial aspect of her knee on the steering column, as was now being suggested, there would be even less likelihood of patello-femoral injury; her foot would have been on the accelerator, her leg would have been

extended and there would have been less muscular contraction. The hospital report shows both medial and lateral collateral ligaments as normal.

[MPIC's doctor] added

> Simply put, this person banged her knee. I'm not aware that anyone who has banged their knee would have these continuing symptoms four years later. There is insufficient evidence to indicate that there was more than mild or, at the most, moderate trauma to the knee.

[MPIC's doctor] preferred to rely upon the opinions of [Appellant's orthopedic surgeon #3] and [Appellant's rheumatologist] to the effect that [the Appellant's] condition was not MVA related. As he said, "they have greater expertise in joint pathology".

Emphasizing that the Appellant had no instability of her knee, [MPIC's doctor] gave his opinion that, when she had fallen in July of 1999, she may have felt pain from the chondromalacia when she shoved her foot into her shoe; that, in turn, might have caused a sudden reflexive withdrawal of the foot and a resultant loss of control. It could not, by any stretch of the imagination, be related to her motor vehicle injury.

[MPIC's doctor] further testified that chondromalacia can lead to joint irritation and some swelling, with decreased range of motion (although the Commission notes that there is little, if any, documentation of reduced range of motion of the Appellant's knee). That could limit some activities, such as bowling and dancing. Activities that one can control are easier - for example, housework can be done, tying one's shoe can be done.

[MPIC's doctor] said that he would not have had much confidence in the outcome of a Functional Capacity Evaluation, which would probably not have been a true reflection of [the Appellant's] real capabilities, in view of her pain-focussed, self-limiting behaviour.

[Appellant's orthopedic surgeon #3] had recommended a lateral-hinged brace, but [Appellant's doctor #1] had prescribed a medial-hinged brace. Pain in the knee could have arisen from the pressure from the brace, or even from the Appellant's gait, favouring her right ankle. [MPIC's doctor] also felt that [the Appellant] had, at least in some measure, caused the continuance of her symptoms by her failure to follow the recommendations of her therapists that she exercise and remain active.

Submissions by Counsel for the Appellant

The salient points of [Appellant's counsel's] submissions on behalf of [the Appellant] may be summarized this way:

1. Despite her 1993 accident in which [the Appellant's] vehicle had been rear-ended, she had been treated successfully by [Appellant's physiatrist] and had substantially recovered by the late summer or early fall of 1994. Only her chronic ankle sprain remained as a problem of any consequence prior to her 1994 MVA.
2. The impact of her 1994 MVA was so severe that, while sitting close up to the steering wheel, she was thrown forward; the airbag deployed and the Appellant does not know what, if anything, her knee hit. It may have been the steering column, bringing the inner knee in contact with it.
3. [Appellant's doctor #1] and [Appellant's physiatrist] both emphasize the absence of prior knee problems. Although several specialists have theorized that there was a pre-existing condition, there are no documented symptoms prior to the 1994 MVA.

4. If [the Appellant] were as non-compliant and self-limiting as some of her care-givers suggest, she would not have put herself through all of the therapies, the needling, the MRIs and so on.

5. She had not seen [Appellant's rheumatologist] since 1998, nor [Appellant's orthopedic surgeon #3] since 1996. Although they all opine that no further surgical intervention is called for, [Appellant's physiatrist] continues to treat her, as does [Appellant's chiropractor].

6. The Appellant testified that she exercises for 15 to 20 minutes per day, which is all that she can apparently manage to accomplish.

7. [The Appellant] had apparently resumed most of her normal activities after her 1993 MVA, despite her continuing ankle problem. She had testified that she had been able to bowl, dance, drive, et cetera.

8. Six months after her 1994 MVA, although largely recovered in the upper body, she was unable to function due to her right knee problem.

9. She had her fall in July of 1999, which she attributes to her 1994 MVA and the fact that her knee gave way. Her consequent injuries were also, therefore, MVA related.

10. She should be referred back for another magnetic resonance imaging that would show, at least, what her present condition is.

11. [Appellant's physiatrist's] report of January 18th, 1999 (the last report from [Appellant's physiatrist] respecting [the Appellant's] knee), emphasized that [Appellant's physiatrist] knew of no evidence of right knee pain complaints prior to the 1994 MVA. He had last seen her on June 30th, 1998, when she reported that, following his trigger-point needling and stretching procedures in the quadriceps and calf muscles, the Appellant's diffuse knee pain and her pain along the medial aspect of her calf had decreased. However, she still had persistent pain along the medial and anterior aspects of the knee.

12. [Appellant's counsel] emphasized the temporal relationship between the 1994 MVA and the onset of [the Appellant's] knee pain. Even if the chondromalacia were a pre-existing problem, the Appellant had been asymptomatic until immediately after the accident which, on a strong balance of probabilities, must therefore be assumed to have caused the subsequent, ongoing pain and related problems.

[The Appellant] therefore seeks the reinstatement of benefits from the date (February 27th, 1998) when MPIC ceased paying for her therapies; she seeks payment of $3,470.36, being reimbursement for the cost of numerous medications; she seeks $627 of chiropractic expenses incurred with [Appellant's chiropractor]; she seeks reimbursement for 4,750 kilometres of travel to and from medical and paramedical appointments; she seeks reimbursement of $250, being the cost of the ambulance required to take her to hospital following her fall on July 13th, 1999; she seeks payment for all of the personal care assistance that had to be provided to her by other members of her family; finally, she seeks Income Replacement Indemnity for the period from the 180th day immediately following her accident, up to the present time and until she has been fully restored to pre-accident status.

Submissions by Counsel for MPIC

Ms. McKelvey, for the insurer, made the following submissions, *inter alia*:

1. By [the Appellant's] own testimony, her leg was extended and her foot was on the accelerator at the time of the collision, a position that would tend to obviate a patello-femoral contact with the dashboard.

2. [Appellant's doctor #1], who correctly speaks of a chronically unstable right ankle, can offer no explanation for any possible injury to the knee in light of the airbag deployment. Indeed, [Appellant's doctor #1] is reported to have said, in a telephone discussion with

MPIC's case manager of February 23rd, 1998, that [the Appellant's] knee problem was "likely not related (to her MVA) but after such a long time issues become blurred" and it was "hard to define what's what". (It must be added that [Appellant's doctor #1], on cross-examination, testified that he had no recollection of that discussion.)

3. [The Appellant] is reported by [Appellant's physiatrist] to have been wearing a below-the-knee splint or brace as early as August 31st, 1994, and a careful reading of [Appellant's physiatrist's] last report before the 1994 MVA is significant, in that it is far from clear that [the Appellant] was then capable of resuming all of her former activities, particularly when read in light of the reports from [Appellant's doctor #2] and [Appellant's orthopedic surgeon #1]. At that juncture, [Appellant's physiatrist] had last seen the Appellant on August 31st, 1994, when she continued to complain of numbness, especially with repetitive use of the right upper limb in such activities as typing, and with physical exertion related to household duties such as vacuuming. She complained of intermittent pain in the posterior neck and interscapular region. [Appellant's physiatrist] reports that, on August 31st, 1994, there was still some restriction in the Appellant's lateral bending; there were a few taut bands and tender points in the right and left infraspinatus muscles. In that same report, [Appellant's physiatrist] had concluded that

> if she does develop any increase in acute symptoms, I would expect improvement with a short course of further treatment. She is not disabled in regards to activities of daily living based on my last examination of August 31st, 1994. The effect of more strenuous physical activities cannot be assessed on physical examination alone and would require Functional Capacity Evaluation carried out by a skilled occupational therapist if there is a goal of seeking employment or if there is any question in regards to her ability to carry out housework or activities related to her volunteer duties."

4. There is patent non-compliance with any exercise regimen prescribed by [the Appellant's] care-givers and this, combined with prolonged over-use of her knee brace

and her self-imposed inactivity, is the most probable cause of [the Appellant's] continued knee pain.

5. The Appellant's claim for reimbursement for chiropractic treatments is unwarranted; [Appellant's physiatrist] had already reported major progress in the areas apparently being treated by [Appellant's chiropractor]. [Appellant's chiropractor], himself, noted that his treatments were likely to accomplish very little until the knee problem was cleared up.

6. [Appellant's physiatrist], in his report of April 27th, 1998, to [Appellant's doctor #1], agrees that the myofascial trigger points he had been treating "may be secondary to internal knee degenerative changes as documented by [Appellant's orthopedic surgeon #3] during arthroscopy".

7. The report of [hospital #1] immediately following the 1994 MVA reports only a "small bruise below right knee" - hardly the outward sign of major internal damage likely to last more than four years.

8. [Appellant's doctor #1] only made one reference to the Appellant's housekeeping activities (on May 24th, 1995) and only then because, as [Appellant's doctor #1] put it, "she claims her injuries are preventing her from performing normal household chores….." In that same letter, it might be noted that [Appellant's doctor #1] added "there are some concerns about a psychogenic component which had been raised". In any event, with respect to the claim for home care assistance, this claim was never originally raised with MPIC and no grid assessment has ever been completed pursuant to Section 131 of the Act and Schedule A of Manitoba Regulation 40/94. Further, there was no evidence that any monies had, in fact, been paid to any third party for home care or personal assistance and there was nothing, therefore, to be reimbursed.

9. The fall in July of 1999 was obviously not MVA related and no expenses flowing from that fall were, therefore, compensable.

10. As to the claim for Income Replacement Indemnity after 180 days, there is no evidence to suggest that [the Appellant] was incapable of performing the office types of duties that she had fullfilled in the past and, since this was the occupation that was, or would have been, determined for her, she would have had no entitlement under Section 85(1) of the Act.

Discussion

A part of our concern relates to the question of causation. The actual mechanics of [the Appellant's] MVA are still unclear. She, herself, has no real recall and this is not surprising since the entire incident took place suddenly and unexpectedly; an exploding airbag moves at a rate of about 300 kilometres per hour. [The Appellant] initially told several care-givers that she had hit her knee on the dashboard of her vehicle. More recently, and apparently at [Appellant's physiatrist's] suggestion, she has started to believe that it was the inner, or medial, side of her knee that collided with the steering column. Yet [Appellant's physiatrist], on April 27th, 1998, reports that "tenderness over the medial collateral ligament has resolved", and this was following an examination of April 14th of that year.

In any event, the unanimous conclusion of all [the Appellant's] care-givers seems to be that any direct damage caused to her right knee by her MVA was minimal, and that any continuing problems do not originate in the knee itself but, rather, stem from her widespread myofascial pain syndrome. Despite the temporal factor, there is no compelling evidence that either this or the chondromalacia were caused by her collision - indeed, the bulk of the evidence leads us to the contrary conclusion.

With respect to [the Appellant's] claim for home care assistance, we agree with the submissions of counsel for MPIC. We might add that, although there is no doubt that [the Appellant] did receive help from her immediately family and, perhaps, occasionally from neighbours or friends, her descriptions of her domestic incapacity were fraught with hyperbole. If she was as incapable as she described, we have to assume that this was due more to a self-limiting approach to the world around her than from any real, physical limitations.

With respect to [the Appellant's] claim for the $250 ambulance fee incurred following her fall in July of 1999, we cannot find that that fall was in any way related to her motor vehicle accident of 1994. She has given two or three different versions of that incident but, whichever version we adopt, to relate it to her MVA of November 1994 would stretch credulity. In this context, we might note that [the Appellant] had been referred to [Appellant's neurologist #2], a neurological specialist, in November of 1998. This referral was made because [the Appellant] had complained of an incident when she had fallen against a wall, hitting her right arm on the wall, resulting in pain at the right shoulder, radiating down to the hand, along with paresthesia. An EMG and nerve conduction studies were done in November of 1998, followed by a CT scan of the cervical spine in December of that year. Those tests disclosed no evidence of knee abnormalities nor of any significant spinal stenosis nor of nerve root compression. [Appellant's rheumatologist], whose report is referred to above, concludes that the Appellant's widespread musculoskeletal symptoms were unrelated to injuries sustained in the 1994 MVA.

Turning, now, to [the Appellant's] claim for reimbursement for her chiropractic treatments, we note that [Appellant's chiropractor], who first saw [the Appellant] in July of 1997, was not treating her knee. It seems to be generally acknowledged by all of her care-givers that, (setting

aside for the moment the problems directly affecting [the Appellant's] right knee) any physical sequelae of her 1994 MVA had been resolved by February 27th, 1998, at the latest. [The Appellant] has been reimbursed for all chiropractic treatments up to February 27th, 1998, and [Appellant's chiropractor] himself has acknowledged that any further treatments from him were likely to be ineffectual until the knee problem had been resolved. We are therefore unable to find that continued chiropractic treatments after that date were medically necessary.

[The Appellant] is claiming reimbursement for travel expenses involving 4,750 kilometres from March 9th, 1998, until December of 2000, primarily for visits to [Appellant's doctor #1], [Appellant's chiropractor] and [Appellant's physiatrist], but also to [Appellant's rheumatologist], [Appellant's orthopedic surgeon #1], [Appellant's orthopedic surgeon #4] and [Appellant's neurologist #2]. While we make no comment about the frequency of [the Appellant's] visits - 67 to [Appellant's doctor #1], 42 to [Appellant's chiropractor] and 41 other, assorted medical and paramedical visits - we find that any aggravation of [the Appellant's] prior condition that may have resulted from her 1994 MVA had been resolved by February 27th, 1998. We base that conclusion in large measure upon the opinions of [Appellant's orthopedic surgeon #3] and [Appellant's rheumatologist] who, it must be remembered, were not specialists selected by MPIC but were, rather, experts to whom [the Appellant] had been referred by her own general practitioner. It follows, therefore, that in our opinion, based upon a reasonable balance of probabilities, any treatments received by [the Appellant] after that date, whether physical, medicinal or otherwise, were not made necessary by her 1994 accident.

Finally, we must deal with the question whether [the Appellant] was entitled to start receiving Income Replacement Indemnity as at the 181st day following her 1994 accident. [The Appellant] was a "non-earner" within the meaning of the MPIC Act at the time of her accident. Section

86(1) of the Act requires the Corporation to determine an employment for a non-earner as at the 181st day after an accident and, if the non-earner is, because of injuries sustained in that accident, unable to hold the employment thus determined for her, MPIC is required to pay Income Replacement Indemnity ('IRI') for as long as that disability prevails, calculating the amount of the IRI in the manner set out in Section 86(2) of the Act. MPIC determined an employment for [the Appellant] as an entry-level office worker - entry level, presumably, because she had last been gainfully employed in 1978 or 1979 and would have required substantial retraining in modern office technologies in order to attain her former seniority. We find, from the evidence, that [the Appellant] was capable of performing that kind of work by the 181st day following her accident, and does not therefore qualify for IRI under Sections 85 and 86 of the Act.

Conclusion

In light of the foregoing, we are obliged to dismiss each facet of [the Appellant's] appeal.

Dated at Winnipeg this 2nd day of January, 2001.

J. F. REEH TAYLOR, Q.C.

YVONNE TAVARES

COLON C. SETTLE, Q.C.