Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-05-128

PANEL:	**Ms Yvonne Tavares, Chairperson** **Ms Diane Beresford** **Mr. Paul Johnston**
APPEARANCES:	**The Appellant, [text deleted] was represented by [text deleted];** **Manitoba Public Insurance Corporation ('MPIC') was represented by Ms Kathy Kalinowsky.**
HEARING DATE:	**March 5, 2008**
ISSUE(S):	**Entitlement to Income Replacement Indemnity benefits beyond October 15, 2004**
RELEVANT SECTIONS:	**Section 81(1) of *The Manitoba Public Insurance Corporation Act* ('MPIC Act')**

AICAC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE PERSONAL HEALTH INFORMATION OF INDIVIDUALS BY REMOVING PERSONAL IDENTIFIERS AND OTHER IDENTIFYING INFORMATION.

Reasons For Decision

The Appellant, [text deleted], was involved in a motor vehicle accident on September 11, 2002. As a result of the motor vehicle accident, the Appellant sustained fractures to his right 7th, 8th and 9th ribs with hemothorax and lung contusion. Due to the bodily injuries which the Appellant sustained in this accident, he became entitled to Personal Injury Protection Plan ('PIPP') benefits pursuant to Part 2 of the MPIC Act.

At the time of the motor vehicle accident, the Appellant was employed as a [text deleted] truck driver with [Text deleted]. Due to the injuries which the Appellant sustained in the motor vehicle accident, he was unable to do any heavy lifting, shoveling or riding in a [text deleted] truck and therefore, he was unable to return to his full-time employment. As a result, the Appellant became entitled to Income Replacement Indemnity ('IRI') benefits based upon his position as a [text deleted] truck driver.

In order to assist with the Appellant's rehabilitation, a reconditioning program at [Rehabilitation (Rehab) Clinic] was undertaken in March of 2003. However, the program was limited due to the Appellant's right flank complaints and shortness of breath with physical activity.

The Appellant's right chest wall pain persisted and he was referred to a respiratory specialist [Appellant's Respirologist], for assessment. In his report dated April 13, 2004, [Appellant's Respirologist] advised that:

> In assessment, severe obstructive lung disease. The cause of this is not entirely certain at this time although COPD from smoking may well be a major factor. However, additional therapy to attempt reversing his airway obstruction is under way.
>
> His chest wall injury with multiple rib fractures may certainly have aggravated his condition adding to his sense of dyspnea.
>
> I am uncertain as to all of his duties required with regards to his employment as a [text deleted] truck driver. I would predict that he would be capable of only mild exertion.

Based upon the foregoing report, the case manager subsequently attempted to confirm with [Appellant's Respirologist] that the Appellant's inability to return to his pre-accident employment was due to the chronic obstructive pulmonary disease ('COPD'). By letter dated May 17, 2004 the case manager asked [Appellant's Respirologist] whether aside from the Appellant's COPD, had he recovered from his motor vehicle accident-related injuries and

whether the Appellant would be capable of returning to his employment as a [text deleted] truck driver. In a faxed reply dated July 2, 2004, [Appellant's Respirologist] responded by indicating that the Appellant could not return to work. As for the reason for the inability to return to work, [Appellant's Respirologist] noted "severe COPD".

The file was then reviewed by [MPIC's Doctor] of MPIC's Health Care Services Team. In an Inter-Departmental Memorandum dated July 19, 2004, [MPIC's Doctor] advised that:

> MEMORANDUM
> As per the fax from [Appellant's Respirologist] (dated July 2, 2004), the reason the claimant cannot return to work is due to "severe COPD" (Chronic Obstructive Pulmonary Disease). This condition was not caused by the motor vehicle accident.

The case manager then wrote to the Appellant's family physician, [Appellant's Doctor], to confirm whether or not the Appellant had recovered from his motor vehicle accident-related injuries. By letter dated September 30, 2004, [Appellant's Doctor] replied that:

> [The Appellant] is not capable of returning to work. Indeed he suffers from COPD (Chronic Obstructive Lung Disease). His other problems include delayed union with exuberant caluses of fractured (R) Ribs 7, 8, 9; History of lung contusion and hemothorax. His main medical reason for non return to work is likely COPD, but patient continues to c/o ® chest wall pain and splinting on deep breathing. The results of the MVA of Sept 11/2002 likely has aggravated his lung condition.

The file was once again referred to MPIC's Health Care Services Team for review. [MPIC's Doctor] analyzed [Appellant's Doctor's] report and in an Inter-Departmental Memorandum dated October 8, 2004, [MPIC's Doctor] concluded that:

> This file was discussed with the case manager this morning. It is noted that a prior Health Care Services' memorandum of July 19, 2004 identified that the attending respirologist, [Appellant's Respirologist], had provided a correspondence on July 2, 2004 indicating that the reason the claimant could not return to work was due to "severe COPD" (Chronic Obstructive Pulmonary Disease). This condition was not caused by the motor vehicle accident.

> Subsequent to this prior review, a correspondence has been received from the claimant's family physician, [Appellant's Doctor], dated September 30, 2004. In this report, [Appellant's Doctor] indicates that the claimant is not capable of returning to work. He provides comment that the main medical reason for inability to return to work is likely COPD, but noted the claimant continued to report right chest wall pain and splinting with deep breathing. Other listed medical problems included delayed union of fractured ribs (right 7th, 8th and 9th) and history of lung contusion/hemothorax occurring at the time of the motor vehicle accident.
>
> The additional information supports that the co-existing condition of COPD (Chronic Obstructive Pulmonary Disease) presents as the medical reason for inability to return to work at this time. Although the claimant reports the presence of right chest wall pain, the limiting factor with respect to return to work is the co-existing/underlying respiratory condition, which is unrelated to the motor vehicle accident.

In a letter dated October 25, 2004, MPIC's case manager wrote to the Appellant to advise that:

> As we discussed in our telephone conversation of October 14, 2004, a review of all medical information has been completed by our Health Care Services department. The purpose of this review was to determine if your inability to return to work at this time is related to your initial injury from the motor vehicle accident.
>
> Based on this review, it has been determined that the medical reason for your inability to return to work at this time is due to a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and not the injuries from your accident.
>
> I have enclosed a copy of our Health Care Service's review for your information. Also enclosed is a copy of [Appellant's Respirologist's] report dated April 13, 2004 and [Appellant's Doctor's] report of September 30, 2004. These reports also confirm that your inability to work is due to the diagnosis of COPD.
>
> Based on the above we are unable to consider any further Income Replacement Indemnity benefits beyond October 15, 2004.

The Appellant sought an Internal Review of that decision. In support of his Application for an Internal Review, the Appellant submitted a further report from [Appellant's Doctor] dated January 3, 2005. In that report [Appellant's Doctor] indicates that:

> [The Appellant] continues to have sudden episodes of chest wall pain (sharp) requiring analgesics. He has continued to splint especially on deep breathing. He has also continued to be short of breath. He was referred to [Appellant's Respirologist]. [Appellant's Respirologist], in addition to the diagnosis of MVA: Lung contusion,

> Hemothorax, Fractured right ribs, added the diagnosis of COPD. The diagnosis of the latter was also confirmed by pulmonary function tests.
>
> Prior to the motor vehicle accident patient did not give any history of shortness of breath, chest wall pain, or splinting on deep breath. His shortness of breath has progressively worsened. He is on bronchodilators and other respiratory medications. He continues to use pain medication for recurrent sharp chest wall pain.
>
> [The Appellant] continues to have episodes of sharp chest pains, which are due to pleural irritation secondary to exuberant callosity of the fractured right ribs 7, 8 and 9. Lung contusions would have triggered or aggravated the Chronic Obstructive Lung Disease (COPD). Return to any form of work is unlikely.

A further analysis by [MPIC's Doctor] addressed [Appellant's Doctor's] report of January 3, 2005. In an Inter-Departmental Memorandum dated February 28, 2005, [MPIC's Doctor] indicates that splinting cannot be restricted in isolation from severe COPD. She notes that the typical natural history of COPD is a progression of shortness of breath, while a lung contusion is a temporary condition (as shown on the x-ray), and callus formations remodel to a smaller size over time. Further, [MPIC's Doctor] noted that:

> It is not unusual to visualize considerable callus formation about a healing rib fracture at the four month post-fracture point in time. Typically, these types of fractures take many months for the fracture line to disappear and the visible callus to remodel. On the balance of probability, the amount of callus present at the four month point does not represent the completed evolution of healing. It would be expected that over the subsequent year or two, the callus would likely remodel down to a smaller size. Although an updated x-ray would clarify the size of the callosity, it is unclear as to the mechanism by which [Appellant's Doctor] has proposed that the callus formation (a normal process of fracture healing) would result in pleural irritation (irritation of the lining of the lung) and affect the COPD condition. The Internal Review Officer may wish to request that [Appellant's Doctor] clarify the basis upon which this opinion was provided.

In a decision dated June 20, 2005, the Internal Review Officer confirmed the case manager's decision and dismissed the Appellant's Application for Review. In his decision, the Internal Review Officer determined that:

[The Appellant] contends that he had no problems whatever with breathing prior to the accident. Notwithstanding that, I cannot accept that his accident-related injuries caused the COPD. That is inconsistent with the medical evidence, and I accept [MPIC's Doctor] opinion as expressed in her short opinion of July 19, 2004 on this point. Although there is no real need for more comment on this point, clearly, [the Appellant's] [text deleted] history of smoking up to February 2001 is relevant here.

On the other hand, [the Appellant] did suffer right-sided rib fractures and a lung contusion in the accident. Accordingly, your suggestion that the motor vehicle accident injuries aggravated the underlying COPD deserves serious consideration.

At the hearing, you argued that [the Appellant] had suffered a "punctured lung" in the accident and that this permanently damaged his ability to breath (sic). I take it you were relying on the point made shortly after the hearing in the last paragraph of [Appellant's Doctor's] report of January 3, 2005 to the effect that [the Appellant's] "lung contusions would have triggered or aggravated the chronic obstructive lung disease (COPD)." (And this seems to be confirmed by your letter of February 21, 2005.) There is some question as to whether a contused lung is a "punctured" lung, but that may be merely a semantic issue. The important question has to do with whether [the Appellant's] injury permanently damaged his ability to breathe. On this issue, I accept the assessment that appears in paragraph #3 of [MPIC's Doctor's] February 28, 2005 report. On the evidence, the sort of "lung contusion" [the Appellant] suffered was "a temporary condition, not one that would result in permanent functional alteration." [MPIC's Doctor] indicates that this view of things is confirmed by [the Appellant's] January 24, 2003 chest x-ray (four months post-accident). The report of that x-ray indicates "the lungs are clear."

Furthermore, according to [MPIC's Doctor], "the typical natural history of COPD is one of progression with respect to shortness of breath." Although asked to do so, [Appellant's Doctor] has not provided any medical support for the view that the progression of [the Appellant's] shortness of breath derives from his rib fractures or from the temporary intercostal trauma sustained in the September 2002 accident. [Appellant's Doctor's] response boils down to a repetition of the point that [the Appellant] gives no history of shortness of breath until after the automobile accident. Since it is clear that the accident did not cause the COPD, and that COPD is progressive, this is probably not even a relevant one. It certainly provides no basis for believing that [the Appellant's] inability to work can be attributed to the car accident. What is disabling him is the COPD, not the car accident.

[Appellant's Doctor] also comments on "pleural irritation secondary to exuberant callosity of the fractured right ribs 7, 8, and 9." The most recent evidence supporting that "exuberant callosity" are x-rays taken on March 14, 2003, only six months post-accident. As [MPIC's Doctor] notes in paragraph #4 of her February 28, 2005 report, "the amount of callus present at the four month point does not represent the completed evolution of healing. It would be expected that over the subsequent year or two, the callus would likely remodel down to a smaller size." My letter of April 5, 2005 to [Appellant's Doctor] asked for current evidence supporting the exuberant callosity". [Appellant's Doctor] has provided none. As things stand, therefore, there is no evidence at all that [the Appellant] presently has excessive callus formation at the sites of his rib fractures.

> Perhaps more significant, there is no evidence of any mechanism by which such excessive callus formation, if it in fact exists, could bring about the "pleural irritation" referred to by [Appellant's Doctor]. My letter of April 5, 2005 to [Appellant's Doctor] also requested an explanation of the mechanism by which the hypothetical excessive callus formation could result in the pleural irritation [Appellant's Doctor] says exists. His most recent report fails to provide the explanation.
>
> On the evidence available, there is no basis whatever for any interference with the decision under Review.

The Appellant has now appealed from that decision to this Commission. The issue which requires determination in this appeal is whether [the Appellant] is entitled to IRI benefits beyond October 15, 2004. In particular, the issue requires determination of whether his chronic obstructive pulmonary disease was caused, aggravated or exacerbated by the motor vehicle accident of September 11, 2002.

Submissions of the Appellant

Counsel for the Appellant submits that the Appellant is unable to return to his employment as a [text deleted] truck driver due to the injuries which he sustained in the motor vehicle accident of September 11, 2002. Additionally, he contends that either the motor vehicle accident triggered the Appellant's COPD or the motor vehicle accident exacerbated or aggravated the Appellant's COPD to cause his current condition. In support of his position, counsel for the Appellant relies on the medical opinions of the Appellant's caregivers, as follows:

- [Appellant's Respirologist's] report of April 13, 2004 wherein, [Appellant's Respirologist] notes that:

  > In assessment, severe obstructive lung disease. The cause of this is not entirely certain at this time although COPD from smoking may well be a major factor.

However, additional therapy to attempt reversing his airway obstruction is under way.

His chest wall injury with multiple rib fracture may certainly have aggravated his condition adding to his sense of dyspnea.

I am uncertain as to all of his duties required with regards to his employment as a [text deleted] truck driver. I would predict that he would be capable of only mild exertion.

- [Appellant's Doctor's] report of January 3, 2005 wherein he indicates that:

  [The Appellant] continues to have sudden episodes of chest wall pain (sharp) requiring analgesics. He has continued to splint especially on deep breathing. He has also continued to be short of breath. He was referred to respirologist [Appellant's Respirologist]. [Appellant's Respirologist], in addition to the diagnosis of MVA: Lung contusion, Hemothorax, Fractured right ribs, added the diagnosis of COPD. The diagnosis of the latter was also confirmed by pulmonary function tests.

  Prior to the motor vehicle accident patient did not give any history of shortness of breath, chest wall pain, or splinting on deep breath. His shortness of breath has progressively worsened. He is on bronchodilators and other respiratory medications. He continues to use pain medication for recurrent sharp chest wall pain.

  [The Appellant] continues to have episodes of sharp chest pains, which are due to pleural irritation secondary to exuberant callosity of the fractured right ribs 7, 8 and 9. Lung contusions would have triggered or aggravated the Chronic Obstructive Lung Disease (COPD). Return to any form of work is unlikely.

- [Appellant's Doctor's] report of March 7, 2007 wherein he notes that:

  Subsequent to that he had developed chronic chest wall pain and shortness of breath. He has had episodes of splinting and severe pleuritic pain. The above symptoms caused his inability to work. He has since been disabled and will very likely continue to be so. Patient was diagnosed with C.O.P.D. subsequent to the accident. Even when C.O.P.D. has been under control, the episodes of pleuritic pains, splinting and subsequent shortness of breath persisted.

  The patient was last assessed on March 6, 2007. He continues to give the same history: splinting, sharp right-sided pleuritic pain radiating to right and left and subsequent respiratory distress (shortness of breath).

  As time goes on it appears that the causes of his inability to work (disability) are the symptoms directly related to the accident of September 11, 2002.

Based upon these medical opinions, counsel for the Appellant submits that the Appellant is unable to return to his employment as a [text deleted] truck driver as a result of the injuries which he sustained in the motor vehicle accident. Accordingly, counsel for the Appellant maintains that the Appellant's IRI benefits should be reinstated effective October 15, 2004.

Submissions of MPIC

Counsel for MPIC submits that the Appellant's COPD was not caused by the motor vehicle accident and it is the COPD which causes the Appellant's inability to work. Further, she maintains that although the COPD may have been temporarily aggravated by the motor vehicle accident, the natural progression of the disease has now overtaken the effects of the motor vehicle accident and accounts for the Appellant's inability to return to work. Additionally, counsel for MPIC submits that there is no biological plausibility that the trauma sustained by the Appellant could cause or exacerbate the COPD. In this regard, she relies on the reports of [MPIC's Doctor] and particularly [MPIC's Doctor's] report dated June 14, 2005, wherein [MPIC's Doctor] opines that:

> **[Appellant's Doctor] was to clarify the mechanism by which the callus formation would result in pleural irritation and affect the COPD (Chronic Obstructive Pulmonary Disease) condition.**
>
> > In response to this inquiry as to the explanation of the mechanism by which callus formation would result in pleural irritation, [Appellant's Doctor's] response was that the claimant's respiratory and chest wall conditions included chest injury as a result of the multiple rib fractures, lung contusion and hemothorax. He stated that "the pleural irritation due to fractured ribs per se can cause shortness of breath or aggravate the shortness of breath cause by COPD".
>
> **COMMENTS**
> [Appellant's Doctor's] responses to the Internal Review Officer's inquiries have been reviewed and considered. Although callus formation is present at the site of the right-sided rib fractures, [Appellant's Doctor] has not provided a mechanism by which callus formation causes pleural irritation. Having reviewed [Appellant's Doctor's] response, a

> mechanism relating the healed rib fractures (with callus formation) to pleural irritation has not been provided.

Accordingly, counsel for MPIC submits that it is not medically probable that the Appellant's COPD was either caused, exacerbated or aggravated by the motor vehicle accident of September 11, 2002. She therefore submits that the Appellant's appeal should be dismissed and the Internal Review decision of June 20, 2005 confirmed.

Discussion

Upon a careful review of all of the medical, paramedical and other reports and documentary and oral evidence filed in connection with this appeal, and after hearing the submissions of counsel for the Appellant and of counsel for MPIC, the Commission finds that either:

1. the Appellant's COPD was exacerbated or aggravated by the motor vehicle accident of September 11, 2002; or
2. his ongoing continuing pain, splinting and shortness of breath prevent him from returning to work, independent of the COPD.

As a result, we find that the Appellant's inability to work as a [text deleted] truck driver beyond October 15, 2004 continued to be related to the motor vehicle accident of September 11, 2002 and therefore his IRI benefits should be reinstated effective October 15, 2004.

Section 81(1)(a) of the MPIC Act provides as follows:

> **Entitlement to I.R.I.**
> **81(1)** A full-time earner is entitled to an income replacement indemnity if any of the following occurs as a result of the accident:
> (a) he or she is unable to continue the full-time employment.

In determining that the Appellant's inability to continue his full-time employment as a [text deleted] truck driver resulted from the motor vehicle accident of September 11, 2002, we rely upon the following:

- [Appellant's Respirologist's] opinion stated in his report of April 13, 2004 that the Appellant's chest wall injury with multiple rib fractures may certainly have aggravated his condition adding to his sense of dyspnea.
- [Appellant's Doctor's] opinion, expressed in several reports, that the Appellant's motor vehicle accident-related injuries would have triggered or aggravated the COPD and that the episodes of splinting and severe pleuritic pain, independent of the COPD, prevent him from returning to work.
- The faxed response from [Appellant's Respirologist] indicating that the reason that the Appellant could not return to work was due to severe COPD was an inadequate basis upon which to terminate the Appellant's IRI benefits. Further explanation as to the cause of the COPD and the effect of the Appellant's other motor vehicle accident- related injuries on his ability to work should have been sought from [Appellant's Respirologist].
- [MPIC's Doctor's] determination that the COPD was the reason for the Appellant's inability to return to work was flawed. Based upon [Appellant's Respirologist's] inadequate response, she found that the limiting factor with respect to the Appellant's return to work was the co-existing/underlying respiratory condition, i.e. the COPD. She discounted the Appellant's sharp chest wall pain as a contributing factor to his inability to return to work. However, based upon [Appellant's Doctor's] opinion, the Appellant's continued complaints of sharp chest wall pain, episodes of splinting and severe pleuritic pain also

prevented the Appellant from returning to work (in addition to the COPD). Despite the fact that [Appellant's Doctor] was unable to adequately explain how these symptoms could cause pleural irritation, the fact remains that the Appellant has continued to report these symptoms since the motor vehicle accident and they contribute to his inability to work. [MPIC's Doctor] failed to give sufficient consideration to these symptoms and their contribution to the Appellant's inability to return to work.

Accordingly, for the foregoing reasons, the Commission determines that:

A. MPIC incorrectly terminated the Appellant's IRI benefits as of October 15, 2004; and

B. [The Appellant's] IRI benefits shall be reinstated as at October 15, 2004. Interest shall be added to the amount due and owing to [the Appellant] in accordance with Section 163 of the MPIC Act.

As a result, the Appellant's appeal is allowed and the Internal Review decision dated June 20, 2005 is therefore rescinded.

Dated at Winnipeg this 2nd day of July, 2008.

YVONNE TAVARES

DIANE BERESFORD

PAUL JOHNSTON