Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File Nos.: AC-11-010, AC-11-077, AC-15-011

PANEL:	**Mr. Mel Myers, Q.C., Chairperson** **Ms Jacqueline Freedman** **Ms Janet Frohlich**
APPEARANCES:	**The Appellant, [text deleted], appeared on her own behalf; Manitoba Public Insurance Corporation ('MPIC') was represented by Ms Danielle Robinson.**
HEARING DATE:	**April 14, 2015**
ISSUE(S):	**1. Whether the Appellant is entitled to a further permanent impairment award for her concussion;** **2. Whether the Appellant is entitled to a permanent impairment award for fine hand motor coordination, nystagmus, benign paroxysmal positional vertigo, torticollis or tinnitus; and** **3. Whether the Appellant is entitled to a permanent impairment award for a visual impairment.**
RELEVANT SECTIONS:	**Subsection 127(1) of The Manitoba Public Insurance Corporation Act ('MPIC Act') and Divisions 1, 2, 4 and 12 of Schedule A to Manitoba Regulation 41/94.**

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

Background:

On April 13, 2008, the Appellant, [text deleted], was involved in a multi-vehicle collision in which the car she was driving was rear-ended and pushed into the vehicle in front of her. She

suffered various injuries as a result of the motor vehicle accident ("MVA"). By a decision letter from the case manager dated December 7, 2010, MPIC confirmed that the Appellant was entitled to a permanent impairment ("PI") benefit of 0.5% relating to the concussion suffered by her in the MVA. The Appellant filed an Application for Review of this decision. The case manager's decision was confirmed by an Internal Review Officer by letter dated January 25, 2011, which provided, in part, as follows:

> "The only issue on this review is whether the permanent impairment of concussion – 0.5% as outlined in the decision of December 7, 2010, was correctly assessed and calculated. Based on my review of the file, the Permanent Impairment entitlement for concussion was correctly assessed. I am, therefore, confirming the decision of the case manager and dismissing the Application for Review.
>
> With respect to your request for permanent impairments outlined in your Application for Review, the case manager will have to review this issue and issue a subsequent decision regarding whether or not you are entitled to further permanent impairments. ..."

The Appellant disagreed with this Internal Review decision and filed an appeal with the Commission.

In addition, the Appellant sought PI benefits for further physical deficits from which she was suffering. As noted above, in the Internal Review Officer's letter dated January 25, 2011, the Officer had asked the case manager to consider whether further PI benefits may be awarded. The case manager advised the Appellant by decision letter dated March 31, 2011 as follows:

> "On February 14, 2011, we wrote to your physician, [Appellant's doctor #1], and will address entitlements to further permanent impairments for physical deficits that may be rateable under the regulations upon hearing from him.
>
> Currently, there is insufficient information on file to indicate that you are having difficulties with fine hand motor coordination, nystagmus, benign paroxysmal positional vertigo, torticollis, and tinnitus to a point that it would be rateable as impairment. ..."

The Appellant filed an Application for Review of this decision dated April 8, 2011, in which she requested PI awards in respect of all of the above conditions, as well as post concussion

syndrome. The Internal Review Officer confirmed the decision of the case manager and by letter dated June 7, 2011, advised the Appellant as follows:

> "On March 31, 2011, you were sent a letter (decision) by your case manager advising that he had written to [Appellant's doctor #1], and would address entitlements to further permanent impairments (which may be rateable under the regulations) upon hearing from him. He again noted that there was insufficient information on file at this point to substantiate an entitlement to further Permanent Impairment awards. ...
>
> I am, therefore, at this time confirming the case manager's decision and dismissing your Application for Review. There is insufficient evidence on file to support your request for Permanent Impairment awards outlined in your Application for Review of April 8, 2011."

The Appellant appealed this decision to the Commission.

The Appellant also sought PI benefits with respect to visual impairment. By letter dated December 22, 2014, the case manager advised the Appellant that she was not entitled to any further PI benefits. The Internal Review Officer confirmed this by letter dated January 8, 2015, which states as follows:

> "The case manager's decision is correct. The medical information does not support that you developed a permanent impairment that is causally related to the accident with respect to your vision."

The Appellant also appealed that decision to the Commission.

Accordingly, there are several issues which require determination on this appeal, specifically, whether the Appellant is entitled to PI benefits with respect to the following:

1. concussion and related symptoms;
2. fine hand motor coordination;
3. nystagmus and benign paroxysmal positional vertigo;
4. torticollis;
5. tinnitus; and

6. visual impairment.

Decision:

For the reasons set out below, the panel finds as follows:

1. The Appellant has established, on a balance of probabilities, that she is entitled to a further PI benefit with respect to her concussion and related symptoms, specifically cognitive impairment;
2. The Appellant has not met the onus to establish, on a balance of probabilities, that she is entitled to a PI benefit with respect to fine hand motor coordination;
3. The Appellant has established, on a balance of probabilities, that she is entitled to a PI benefit with respect to vestibular issues, including nystagmus and benign paroxysmal positional vertigo;
4. The Appellant has not met the onus to establish, on a balance of probabilities, that she is entitled to a PI benefit with respect to torticollis;
5. The Appellant has established, on a balance of probabilities, that she is entitled to a PI benefit with respect to tinnitus; and
6. The Appellant has not met the onus to establish, on a balance of probabilities, that she is entitled to a PI benefit with respect to visual impairment.

Preliminary and Procedural Matters:

At the outset of the hearing, the conduct of the hearing and the order of the proceedings were reviewed. The parties determined that apart from the Appellant, no witnesses would be called. Both parties would rely upon the documentary evidence found in the indexed file, consisting of 289 documents, together with one additional document tendered at the hearing by the Appellant and marked as "Exhibit 1". Accordingly, the Appellant was sworn and provided testimony and

submissions in support of her position. Counsel for MPIC provided submissions in support of MPIC's position.

Evidence and Submission for the Appellant:

The Appellant described the MVA of April 13, 2008. She indicated that her vehicle was rear-ended by a pickup truck in a high speed crash, which caused her to be tossed back and forth twice. She was diagnosed with whiplash and a concussion. In addition, she had dental injuries and post-concussion symptoms, including headaches, dizziness, fatigue, and difficulties with balance. The Appellant noted that the Commission, in an earlier decision dealing with her entitlement to income replacement indemnity ("IRI") dated August 27, 2010, found that the Appellant's post-concussion symptoms are related to the MVA.

The Appellant submitted that since the time of her accident and throughout the last several years, she has been consistent in her complaints that she has been suffering from post-concussion syndrome and that there has been a vestibular component to her complaints. She has had difficulty working since the time of the accident. At the time of the accident, the Appellant was employed as [text deleted]. She was unable to return to her employment after the MVA due to the accident-related injuries. A return to work was eventually attempted but was unsuccessful. Alternate employment was attempted but was also unsuccessful.

The Appellant argued that MPIC did not properly appreciate the nature of her injuries and did not treat them appropriately. Eventually she was referred to a neuropsychologist, [Appellant's neuropsychologist #1]. His report, dated February 23, 2010, states as follows:

> "Neuropsychological conditions: Yes, [the Appellant] does have evidence of cognitive difficulties. These were in nonverbal or visual forms of attention/concentration, and memory, as well as a few of her visual spatial skills. (In addition she had a mild difficulty in one form of auditory attention and mild slowness in her right hand's fine motor coordination). In contrast, she had been functional in verbal types of skills, such as verbal intellect, verbal reasoning, etc.
>
> In response to your question on the relationship to the MVA, yes [the Appellant's] current difficulties are felt to have their origin in her MVA. ..."

The Appellant referred the panel as well to [Appellant's neuropsychologist #1's] report of February 18, 2010, in which he stated as follows:

> "Thus I feel that there is likely an interaction between [the Appellant's] cognitive symptoms that are visual in nature, and the fact that she still might be having some dizziness and nausea that could be triggered by complex visual information and/or by postural changes. Her records do indicate that she had been referred for vestibular physiotherapy at [text deleted], and she had a detailed assessment there on June 5, 2008, which had found problems with her balance, dynamic gait, etc. They had recommended to MPI that she receive vestibular physiotherapy. As far as [the Appellant] could recall, she had simply completed one session, and she was not certain what had happened with this.
>
> Thus my primary suggestion to [the Appellant] at the end of our testing was to have medical followup (sic) over what might still be some vestibular symptoms. I do feel she has had a concussion, but I can't diagnose or treat a vestibular condition. ..."

The Appellant noted that she was referred to a vestibular physiotherapist, [Appellant's vestibular physiotherapist #1], at the Physiotherapy department of [hospital]. She did complete several treatments with [Appellant's vestibular physiotherapist #1]. However, she noted that although she made some progress through physiotherapy with [Appellant's vestibular physiotherapist #1], she continues to have difficulty.

The Appellant stated that she still suffers from all of the cognitive difficulties identified by [Appellant's neuropsychologist #1] in his report of February 23, 2010. In addition to vestibular difficulties, she has attention and concentration problems, difficulty multi-tasking, difficulty with visual and spatial skills and with memory. The Appellant stated that these difficulties began

immediately after the MVA and continue to date. The Appellant submitted that at this point, given the elapsed time since the accident, which occurred in 2008, these conditions have become chronic and therefore permanent. She also noted that she has been trying to get better, and pointed to the comments of [Appellant's neuropsychologist #1], in his report of February 23, 2010, who stated "Her difficulties are not from a lack of effort, since [the Appellant] has put forth good effort based on validity testing and observations."

The Appellant also referred the panel to another report, from [Appellant's neurologist], a neurologist, dated May 24, 2013. In that report, [Appellant's neurologist] stated as follows:

> "After seeing [the Appellant] again as requested and after reviewing all of the documents submitted including all records Manitoba Public Insurance has on file, my conclusions are the following:
>
> - I believe her complaints are consistent with a posttraumatic syndrome following her injury in a motor vehicle accident where she sustained trauma to her neck. As part of that injury there was head movement of some kind which resulted in brain injury resulting in the symptoms she continues to experience. ..."

[Appellant's neurologist] went on to discuss the Appellant's vestibular issues as follows:

> "[The Appellant] has complained throughout of problems with dizziness and balance associated with some visual distortion. There is a debate throughout the record whether these symptoms are due to peripheral (vestibular) or central (vestibular or cerebellar) causes. Dizziness including vertiginous sensations sometimes occur with neck muscle tightness causing restricted head motion. There is some difference of opinion about this. [Appellant's neuro-opthalmologist], neuro-opthalmologist, might be regarded as the person most expert in this disorder believes that she had peripheral vestibular problems (with a contribution from head motion restriction). This is largely an academic matter as either are the result of her accident and result in a fairly similar symptoms. The problem has been that the methods to treat the vestibular complaints have not worked to date. The problem is compounded by the fact that there is no medication or physical therapy that is uniformly effective to manage this symptom in any patient apart from those who have typical (often self-limited) benign positional vertigo or who have self-limited, inflammatory or other peripheral vestibular disorders. Some argue that the lack of evidence of brain injury documented by MR scans argues against a central (brain) cause. I think this is unfair as we expect minor abnormalities of vestibular connections to the peripheral vestibular apparatus, brainstem and cerebellum caused by trauma or any other pathology to not necessarily be large enough be seen on

> MRI – just as the presumed axonal injuries that result in the post-traumatic syndrome are not associated with abnormalities on brain MRI in the majority of cases presenting with the symptoms described by [the Appellant]. In addition, the detection of some subtle eye movement abnormalities associated with vestibular disease is not a skill many have – myself included. We have to make the diagnosis by history. For example, [Appellant's neuro-opthalmologist] and the vestibular therapist detected downbeat nystagmus as an indicator of specific vestibular involvement. Others did not (or could not). Furthermore, physical signs of this type may vary from one time to the next."

The Appellant referred the panel to several reports from [Appellant's chiropractic neurologist], a chiropractic neurologist whom she saw on several occasions. In his report of November 7, 2013, [Appellant's chiropractic neurologist] indicated:

> "My objective findings on examination are that [the Appellant] has a wider than normal based gait with diminished bilateral arm swing and a right head tilt. Occulo-motor testing shows difficulty in gaze stabilization at 20° to the right horizontally, and right pursuit tracking. Optokinetic testing shows diminished right horizontal response.
>
> Balance testing in Rhomberg's position showed a moderate left anterior centre of balance. Left vestiulo (sic) occuler (sic) reflex testing showed a diminished gain.
>
> [The Appellant] had been assessed by Videonystagmography (VNG). Her assessment showed loss of gaze stabilization centrally, in the vertical and horizontal planes. She exhibited downbeat nystagmus with posterior canal placement.
>
> These findings conclude the diagnosis of a centrally maintained vestibulopathy consequent to her mild traumatic brain injury. This means that the symptoms she continues to exhibit are cause (sic) by the damage to in (sic) the central nervous system with regards to vestibular information."

[Appellant's chiropractic neurologist] treated the Appellant in order to try to improve her symptoms. The Appellant referred the panel to a progress report from [Appellant's chiropractic neurologist] dated May 6, 2014, in which he stated as follows:

> "To put it in layperson's terms – if I work [the Appellant's] brain too much, she experiences debilitating migraines that can last up to a few days. There is no benefit to pursuing treatment when this is the result, as it is counter-productive. When she has such an event, I necessarily impose a period of rest and we resume treatments when she is physically able to do so.
>
> [The Appellant] continues to show disability from her head injury when (sic) with regards to quick head motion and eye movements. She continues to struggle with busy settings where there is a lot of motion and noise. She continues to struggle with light

> sensitivity. I remain optimistic that we will continue improvement in this patient. At the conclusion of our sessions, I will send a final report and make further recommendations as to where [the Appellant] can continue to progress, and where she may have permanency in her traumatic brain injury."

The Appellant noted that although she did improve somewhat as a result of her treatments with [Appellant's chiropractic neurologist], she still remains debilitated due to the vestibular issues that she faces. She can't go for a long walk and then out for dinner like she used to prior to the MVA because she gets overwhelmed by the vestibular issues. She used to run recreationally and she can't do that anymore. She also finds she can't go for a bike ride. She still gets migraines and tension headaches, even seven years later.

[Appellant's chiropractic neurologist] noted in his report of July 6, 2014 as follows:

> "I have seen significant improvement in gaze stabilization in static and dynamic settings. She has improved in horizontal smooth pursuit tracking. There had been no improvement in her downbeat nystagmus, and [she] is maintaining convergence insufficiency.
>
> Unfortunately, her symptoms continue to cause her significant disability despite the improvement. She continues to exhibit objective findings consistent with her injury. At this stage in her treatment, I am of the view that I have exhausted all options available to me at this time, and I recommend that my treatment of this patient discontinue."

The Appellant argued that [Appellant's chiropractic neurologist] thereby confirmed that her condition was permanent.

The Appellant referred to one final report from [Appellant's chiropractic neurologist] dated November 4, 2014. In that report he indicated that he had reviewed various medical reports and conducted a general neurological examination as well as a musculoskeletal examination of the Appellant. As well, he had examined the Appellant using a technology to examine the balance of the inner ear and central functions of the vestibular network. He indicated as follows: "Based

on the objective testing and the reported symptoms, I have concluded that [the Appellant] sustained a trauma to her vestibulocerebellum."

The Appellant also referred to the reports of [Appellant's neuro-opthalmologist], a neuro-opthalmologist. She was referred to [Appellant's neuro-opthalmologist] with respect to her vision and vestibular issues. [Appellant's neuro-opthalmologist] saw her in 2010, approximately 2½ years after the MVA. In her report of December 13, 2010, [Appellant's neuro-opthalmologist] stated:

> "She has downbeat nystagmus which on this examination was almost exclusively positional and fits with anterior (superior) semicircular canal benign paroxysmal positional vertigo (BPPV). ..."

[Appellant's neuro-opthalmologist] provided another report dated October 31, 2011 in which she stated "her headaches were consistent with migraine headaches, likely post-traumatic."

The Appellant was referred to another eye specialist, [Appellant's neuro-developmental optometrist]. He provided a report dated January 26, 2015, in which he stated:

> "[The Appellant] was involved in a car accident in April 2009 (sic). Since this time she suffers from ***Convergence Insufficiency (378.83 IDC-9)*** and ***Ocular Motor Dysfunction (379.58 IDC-9)***. These medical conditions result in headaches while reading. Convergence Insufficiency results in headaches, strain and/or double vision at near. Due to the nature of the car accident, her Convergence Insufficiency is quite severe, but treatable. Her Ocular Motor Dysfunction prohibits her from reading clearly, comfortably and binocularly and is also treatable." (emphasis in original)

The Appellant submitted that based on the reports of [Appellant's neuropsychologist #1] and [Appellant's neuro-developmental optometrist], her post-concussion symptoms entitle her to a PI benefit under Manitoba Regulation 41/94. In addition, she argued that her vestibular issues also fall within the provisions of the Regulation. She noted that Division 12 of the Regulation requires vestibular issues to be compensated over time and to be rated at both 6 and 12 months

after injury and that this was not done in her case. She argued that given the length of time that has elapsed since the injury, it is clear that her vestibular condition has definitely become permanent. She also argued that it is clear that she has a visual impairment, which ought to be compensated by a PI benefit.

The Appellant acknowledged that MPIC's Health Care Consultant disputes the diagnosis of post-concussion syndrome or post-traumatic syndrome. However, she argued that to take the position that she did not suffer from a brain injury ignores the evidence of the mechanism of the MVA itself and her testimony as well as the decision of the Commission dated August 27, 2010, along with the various medical reports to which she referred and which are found in the indexed file.

The Appellant also addressed the report of [Appellant's neuropsychologist #2], a neuropsychologist whose report is relied upon by MPIC. She argued that although [Appellant's neuropsychologist #2] was engaged to provide a neuropsychological assessment, an incomplete version of testing was done by her. The Appellant submitted that [Appellant's neuropsychologist #2] did not spend sufficient time with her and in addition had a pre-existing idea with respect to her impression of the Appellant. The Appellant submitted that [Appellant's neuropsychologist #2] was of the view that post-concussion symptoms should resolve within six weeks and accordingly the Appellant argued that [Appellant's neuropsychologist #2] was predisposed to the view that the Appellant would not provide valid test results. Accordingly, the Appellant submitted that the panel should disregard the opinion of [Appellant's neuropsychologist #2].

The Appellant submitted that she has impairments with her gait, spatial relations and coordination, as well as cognitive difficulties. She submitted that medical support for her vestibular difficulties and her cognitive difficulties can be found in numerous medical reports

and that PI benefits ought to be awarded to her under the legislation. She indicated that while she may have referred to her symptoms over the course of the years as dizziness from time to time rather than vertigo or vestibulopathy, she argued that MPIC cannot put the onus on the Appellant to come up with the correct medical terms.

With respect to tinnitus, the Appellant indicated that she has suffered from tinnitus since the MVA and that she has advised her health care providers of her symptoms. She referred the panel to the report of [Appellant's neuropsychologist #1] dated February 23, 2010, where he notes her report of symptoms. She indicated that the more she exerts herself, the worse her tinnitus gets. She submitted that typically, a diagnosis of tinnitus is based on self-reporting. She feels that her tinnitus is severe and she is asking for the maximum PI benefit.

With respect to her ability to perform activities of daily living and re-entry into the workforce, she indicated that she does not think that she is able to perform any job. She indicated that possibly she may be able to do some work at home on her own time. She noted that she has rights to a particular book and she would like to be supported in that.

Submission for MPIC:

It is MPIC's position that the Appellant is not entitled to any further PI benefits in respect of any of the areas of injury identified.

With respect to concussion, counsel for MPIC argued that the Appellant suffered only a minor concussion, and she has already been awarded PI benefits for a minor concussion under Section 1.1 of Subdivision 1 of Division 2 of Schedule A to Manitoba Regulation 41/94. Under that section, a minor concussion is defined as being one in which there is either post-traumatic

amnesia of less than 30 minutes or a loss of consciousness of less than 5 minutes. Counsel argued that there is nothing in the medical evidence to indicate that the Appellant suffered a loss of consciousness that was greater than five minutes. In fact, counsel argued, it is unclear whether she even suffered a loss of consciousness at all. Counsel also pointed out that the objective medical evidence, namely MRI reports, did not identify any inter-cranial abnormalities. Accordingly, counsel argued that the PI rating with respect to the concussion should not be increased from minor to either moderate or severe.

In addition, counsel for MPIC argued against awarding the Appellant PI benefits with respect to post-concussion syndrome. She referred to the report of [Appellant's neuropsychologist #1] of February 23, 2010, which had been referred to by the Appellant. She noted [Appellant's neuropsychologist #1's] comments at page 14 of the report as follows:

> "However I certainly recognize that [the Appellant] did not have a documented loss of consciousness and that her neuroimaging has been normal. In her particular case I am speculating that her cognitive difficulties might be secondary to the vestibular symptoms that she is describing, particularly in light of her vestibular therapist having noted some problems in visual scanning in her June 2008 report. This is also a possibility since [the Appellant] was reporting nausea in her testing here (although she had felt this was related to fatigue). I wonder if tests that are visually complex had a distracting effect on her. (For this to be happening, it would not matter if her vestibular symptoms are cervicogenic or from a vestibular concussion.) Thus, if [the Appellant's] vestibular symptoms can be improved, it is certainly also possible that her selected cognitive difficulties may improve as well. ...
>
> Prognosis: I do not expect [the Appellant] to be left with any permanent cognitive sequelae. She currently has temporary cognitive sequelae. ..."

Counsel for MPIC referred the panel to a report dated April 6, 2010, from MPIC's Health Care Services' psychological consultant. In that report, the consultant reviewed [Appellant's neuropsychologist #1's] report and noted [Appellant's neuropsychologist #1's] conclusion that the Appellant was having some cognitive difficulties. The consultant stated:

> "Based upon [Appellant's neuropsychologist #1's] neuropsychological assessment report, it is concluded that the claimant may be having some cognitive difficulties within the non verbal areas primarily. The severity of these difficulties is in the mild to moderately below average range and would not, in all probability, impact on her day to day functioning in a significant way, nor should they preclude her from returning to her pre-mva occupational activities. This takes into account that the claimant's cognitive functioning, based upon neuropsychological testing, in all other areas was intact. In particular there were no observed difficulties with cognitive executive functioning, problem solving, or verbal memory."

MPIC's Health Care Services' psychological consultant provided a further report dated October 28, 2010, in which he stated:

> "... It is the opinion of the neuropsychologist that the claimant's cognitive symptoms are unlikely to be permanent in nature and are to be considered temporary. Therefore, a permanent impairment for cognitive disorder is not applicable at this time."

Counsel for MPIC referred the panel to the report of [Appellant's neuropsychologist #2], which is dated November 11, 2013. [Appellant's neuropsychologist #2] stated:

> "The literature on mild traumatic brain injury (i.e. concussion) has consistently demonstrated that injury-related symptoms normally resolve very quickly and there are typically few, if any, symptoms three months post-injury. The literature further shows that residual symptoms (post concussion syndrome) are largely due to comorbidities or non-injury factors. These factors might include symptom expectation and misattribution of symptoms (e.g., I have a brain injury, therefore my headaches are caused by the brain injury), poor coping skills, personality factors, depression and anxiety, and symptom exaggeration. It is highly improbable that her current reported symptoms are linked to her MVA back in April 2008. It is much more likely that there are other explanations for her difficulties."

Counsel for MPIC submitted that the report of [Appellant's neuropsychologist #2] should be taken at face value and she urged the panel to accept its conclusions.

Counsel submitted that the objective evidence on the file indicates that the Appellant does not have a permanent cognitive dysfunction as a result of the concussion that she was found to have sustained in the MVA and accordingly the Appellant should not be entitled to any further PI benefits.

With respect to fine hand motor coordination, counsel for MPIC noted that she could find only one reference in the indexed materials regarding the Appellant's fine hand motor coordination. This is contained in [Appellant's neuropsychologist #1's] report dated February 23, 2010, where he noted that her fine motor coordination was assessed. He found that "she was mildly slow on her right non-dominant hand". Counsel noted that MPIC's Health Care Services' medical consultant reviewed this issue and provided a report dated November 21, 2011. He stated:

> "Based on my previous reviews of [the Appellant's] file, it was determined that she regained full cervical range of motion and was not identified as having a permanent impairment of neurologic function. Based on this, it is not medically probable she would develop permanent torticollis and/or permanent dysfunction involving fine hand motor coordination as a result of the incident in question."

Counsel noted that the Commission had requested the neurologist, [Appellant's neurologist], to assess the Appellant. [Appellant's neurologist] did so and provided a report, dated May 24, 2013, which the Appellant had referred to in her submissions. Counsel for MPIC argued that that report did not contain any objective medical information as [Appellant's neurologist] did not do a "conventional neurological examination" of the Appellant but rather spent much of his time with the Appellant discussing her symptoms. In the report, he did alter his diagnosis somewhat from post-concussion syndrome to post-traumatic syndrome. MPIC's Health Care Services' consultant subsequently reviewed [Appellant's neurologist's] report and provided his own report dated September 23, 2013. The consultant indicated that he was not familiar with the term "post-traumatic syndrome", and he concluded that there was no evidence that the Appellant's fine hand motor coordination, nystagmus, vertigo or tinnitus had been objectively validated. The consultant also determined that there was no evidence that the conditions were related to the MVA, nor that the conditions are permanent. Accordingly, counsel for MPIC submitted that the Appellant is not entitled to any PI benefits with respect to any deficit in fine hand motor coordination.

With respect to nystagmus, counsel for MPIC noted that the Appellant was evaluated initially by the physiotherapist, [Appellant's vestibular physiotherapist #2], during a vestibular assessment on April 13, 2008. In [Appellant's vestibular physiotherapist #2's] report, the degree of nystagmus is noted to be "nil". A further assessment report dated June 5, 2008, noted the degree of nystagmus to be "none".

Counsel also referred to the chart notes of the physiotherapist, [Appellant's vestibular physiotherapist #1]. Counsel acknowledged that [Appellant's vestibular physiotherapist #1's] report from March 2, 2010, identified that the Appellant did have nystagmus. However, an entry from May 27, 2010, notes "absolutely no nystagmus". Counsel also referred to a report from [Appellant's ear, nose and throat specialist], an ear, nose and throat specialist, dated April 6, 2010. In that report, [Appellant's ear, nose and throat specialist] stated: "there is no spontaneous or gaze-evoked nystagmus."

Counsel for MPIC acknowledged the reports from [Appellant's neuro-opthalmologist] dated December 13, 2010 and October 31, 2011, in which [Appellant's neuro-opthalmologist] notes the presences of downbeat nystagmus. However, counsel pointed out that [Appellant's neuro-opthalmologist] gave no opinion as to whether this condition is permanent. Counsel argued that the medical information from shortly after the MVA when the Appellant was specifically assessed for nystagmus indicates that there was no evidence of this condition.

Counsel for MPIC noted that [Appellant's chiropractic neurologist's] report of November 4, 2014 related the Appellant's nystagmus to her MVA. However, counsel pointed out that although [Appellant's chiropractic neurologist] had reviewed certain medical documents, he had not done a complete review of the entire medical file and therefore counsel argued that any

conclusions that [Appellant's chiropractic neurologist] reached regarding causation should not be considered to be valid. Further, even if a causal connection is accepted by the Commission, counsel submitted that [Appellant's chiropractic neurologist] did not indicate in this report that the condition is permanent. It is MPIC's position, therefore, that the nystagmus is not causally related to the accident and that there is no evidence indicating that it is permanent. As a result, no PI benefits should be awarded.

With respect to benign paroxysmal positional vertigo ("BPPV"), counsel argued that there was no indication from the medical evaluations shortly after the MVA that the Appellant was experiencing vertigo. Counsel referred to the vestibular assessment by physiotherapist, [Appellant's vestibular physiotherapist #2], dated April 13, 2008, and noted that it was indicated on that form that there were no complaints of vertigo during the visit. In addition, the diagnostic code for BPPV is not circled on the form. Similarly, on the vestibular assessment from June 5, 2008, the question regarding vertigo is answered "no".

Counsel for MPIC acknowledged the reports of [Appellant's neuro-opthalmologist] in which she noted the presence of downbeat nystagmus and that this is consistent with BPPV. However, counsel pointed out that [Appellant's neuro-opthalmologist] did not give an opinion as to whether this condition is permanent.

Counsel submitted that given that the medical information from the period of time close to the accident indicates that there are no vertigo symptoms, it is MPIC's position that the Appellant has not discharged the onus of proving that this condition is causally related to the accident. Further, there is no indication that this condition is permanent. Counsel referred to the report of

MPIC's Health Care Services' medical consultant dated November 21, 2011. In that report, the consultant stated:

> "Benign paroxysmal positional vertigo is most often a self-limiting disorder that results in symptoms of dizziness (i.e. vertigo). This could contribute to the origin of nystagmus. [Appellant's neuro-opthalmologist] did not provide documentation indicating this has resulted in a permanent impairment of vestibular function."

Counsel for MPIC therefore submitted that the Appellant had not established that the BPPV is causally related to the accident and further has not established that the condition is permanent. Accordingly, counsel submitted that no PI benefits should be awarded.

With respect to torticollis, counsel for MPIC indicated that she could find only one reference to the condition in the indexed file material. She referred the panel to an Emergency Room Report dated February 1, 2009. In that report, the Appellant is diagnosed with torticollis after visiting the emergency room subsequent to a chiropractic neck manipulation two days earlier. Counsel submitted that this seems to be the first and only report of the condition and it is almost a year after the accident. There is no indication that the condition is permanent. Accordingly, counsel for MPIC submitted that the Appellant has not established any causal connection to the MVA, nor has she established any permanence. Accordingly, MPIC argued that no PI benefits ought to be awarded for torticollis.

With respect to tinnitus, counsel for MPIC noted that in [Appellant's doctor #2's] Primary Health Care Report dated April 25, 2008, the Appellant did not indicate that tinnitus was one of her symptoms. Tinnitus is indicated as a symptom in [Appellant's doctor #3's] Primary Health Care Report of August 10, 2009. MPIC argued that given that the condition is not identified until approximately one year after the MVA, the Appellant has not established a causal connection between the condition and the MVA. Further, there is no indication that the

condition is permanent. Accordingly, it is MPIC's position that no PI benefits should be awarded for tinnitus.

With respect to visual impairment, counsel for MPIC submitted that the medical documentation from the period of time soon after the MVA indicates that the Appellant did not report any vision issues. For example, [Appellant's doctor #2's] Primary Health Care Report dated April 25, 2008, does not identify any concerns related to blurred vision or visual field deficit. Similarly, the multi-disciplinary assessment from [rehabilitation clinic] dated August 19, 2008, in its description of the Appellant's history, does not identify any vision issues.

Counsel for MPIC did note that the Appellant reported blurred vision in her initial assessment with [Appellant's athletic therapist], athletic therapist, on August 25, 2008. Counsel also acknowledged that physiotherapist, [Appellant's vestibular physiotherapist #2], had identified difficulties with smooth pursuit in her vestibular assessment of June 5, 2008. However, in the Primary Health Care Report from [Appellant's doctor #3] dated August 10, 2009, there were no difficulties indicated with respect to the symptoms "blurred vision" and "visual field deficit".

Counsel referred the panel to the report of [Appellant's neuro-opthalmologist] dated December 13, 2010, which indicated that visual fields were normal and that there was no change in binocular acuity with vertical or horizontal head-shaking.

Counsel referred to the reports of [Appellant's chiropractic neurologist] dated April 29, 2013 and November 4, 2014 which identified visual difficulties of the Appellant. The issue was sent to Health Care Services' medical consultant. He provided a report dated December 15, 2014 which stated:

> "Based on my review of the documents presently contained in the [text deleted] claim file, it is my opinion the medical evidence does not support the position that [the Appellant] developed a permanent impairment of visual acuity or ocular mobility or a permanent visual field defect secondary to the incident in question (this includes information obtained from [Appellant's chiropractic neurologist's] most recent report). With this in mind, [the Appellant] is not entitled to a permanent impairment benefit as it relates to the visual system. ..."

Counsel for MPIC noted that the Appellant relies on the report of [Appellant's neuro-developmental optometrist] dated January 6, 2015, which identifies that she suffers from convergence insufficiency and ocular motor dysfunction. Counsel noted that [Appellant's neuro-developmental optometrist] indicated that the conditions were treatable. This matter was again referred to MPIC's Health Care Services' medical consultant. He provided a report dated March 26, 2015, in which he indicated:

> "The information obtained from [Appellant's neuro-developmental optometrist's] January 26, 2015 report does not confirm the presence of a medical condition that is causally related to the incident in question or a condition that would result in permanent impairment of the visual system, in accordance to the Revised Schedule of Permanent Impairments. ..."

Counsel for MPIC submitted that the medical evidence does not establish a causal connection between the MVA and the Appellant's development of visual problems. Counsel further submitted that even if the Commission finds that the Appellant sustained a visual impairment as a result of the MVA, the medical evidence does not indicate that any such impairment is permanent. Accordingly, no PI benefits should be awarded for visual impairment.

Reasons for Decision:

The onus is on the Appellant to show, on a balance of probabilities, that she is entitled to a PI benefit under the MPIC Act and Regulations, as a result of the MVA. The MPIC Act provides as follows:

Lump sum indemnity for permanent impairment

127(1) Subject to this Division and the regulations, a victim who suffers permanent physical or mental impairment because of an accident is entitled to a lump sum indemnity of not less than $500. and not more than $100,000. for the permanent impairment.

The Appellant is seeking various PI benefits. They will be dealt with separately below.

After a careful review of all the reports and documentary evidence filed in connection with this appeal (the most pertinent of which are referred to below, as well as in the submissions of the parties) and after hearing the evidence and submissions of the Appellant and the submissions of counsel for MPIC and taking into account the provisions of the relevant legislation, the Commission, having the jurisdiction under paragraph 184(1)(b) of the MPIC Act to make any decision that MPIC could have made, finds as follows:

Concussion and Related Symptoms:

In a previous decision of the Commission, dated August 27, 2010, the Appellant was awarded a PI benefit under Section 1.1, Subdivision 1 of Division 2 of Schedule A to Manitoba Regulation 41/94, which provides as follows:

Subdivision 1: Skull, Brain And Carotid Vessels
1. Alteration of brain tissue

1.1 Cerebral concussion or contusion	
(a) minor (post-traumatic amnesia (PTA) < 30 min or loss of consciousness (LOC) < 5 min)	0.5%
(b) moderate (PTA > 30 min < 24 hrs or LOC > 5 min < 1 hr.)	2%
(c) severe (> 24 hrs of (PTA) or > 1 hr (LOC))	5%
(d) post concussion syndrome: (see sections 4.6, 4.7 and 4.9 of this subdivision)	

The Commission's decision of August 27, 2010, found the Appellant's concussion to be minor and awarded the Appellant a PI benefit of 0.5%. The Appellant submits that she suffers from post concussion syndrome, which is dealt with under paragraph (d) above. Her position is that she falls within Section 4.9 of Subdivision 1 of Division 2 of Schedule A to Manitoba Regulation 41/94, specifically paragraph (e), which provides as follows:

> 4.9 Alterations of the higher cognitive or integrative mental functions (organic cerebral syndrome, dementia and neurologic deficiencies)
> ...
>
> (e) an alteration of the higher cognitive or integrative mental functions, including adverse effects of medication, that impairs the person's ability to perform the activities of daily living but not to such an extent that he or she requires supervision 5%

The issue for determination, then, is whether the MVA has caused the Appellant to have a permanent alteration of her higher cognitive or integrative mental functions, which impairs her ability to perform her activities of daily living to some extent.

The panel accepts the reports of the Appellant's treating health care providers, [Appellant's neuropsychologist #1] and [Appellant's neurologist], the neurologist, who each met with the Appellant on a number of occasions.

[Appellant's neuropsychologist #1] found that the Appellant suffered from cognitive deficits and that these were the result of the MVA, in his report of February 23, 2010:

> "Neuropsychological conditions: Yes, [the Appellant] does have evidence of cognitive difficulties. These were in nonverbal or visual forms of attention/concentration, and memory, as well as a few of her visual spatial skills. (In addition she had a mild difficulty in one form of auditory attention and mild slowness in her right hand's fine motor coordination). In contrast, she had been functional in verbal types of skills, such as verbal intellect, verbal reasoning, etc.
>
> In response to your question on the relationship to the MVA, yes [the Appellant's] current difficulties are felt to have their origin in her MVA. ..."

Although [Appellant's neuropsychologist #1] opined, in 2010, that these cognitive effects may be temporary, he noted that there was likely an interaction between the Appellant's cognitive symptoms and her dizziness and nausea and he stated that the Appellant's cognitive issues would only be resolved if the Appellant's vestibular symptoms were to be resolved: "... Thus, if [the Appellant's] vestibular symptoms can be improved, it is certainly also possible that her selected cognitive difficulties may improve as well." She testified, however, that her vestibular symptoms have not resolved, and neither have her cognitive symptoms.

As will be noted below, the Appellant continues to suffer from dizziness and vestibular symptoms. The Appellant testified that since the time of the MVA, she has had difficulties with attention and concentration, difficulty multi-tasking and difficulty with visual and spatial skills as well as memory problems. She stated that these problems continue to date. The panel found the Appellant to be forthright in her testimony and accepts her evidence. The panel accepts [Appellant's neuropsychologist #1's] assessment in his report of February 23, 2010, that "Her difficulties are not from a lack of effort".

The panel also accepts the report of [Appellant's neurologist], neurologist, dated May 24, 2013, in which he found that her cognitive symptoms are a consequence of the MVA.

> "She continues to identify the persistence of the same symptoms she described when I saw her in 2010. Her major symptoms continue to be daily headache, variable dizziness, problems with neck and jaw pain and variable effects on memory and intellectual function as it relates to multitasking when stressed or when symptoms are most active. ...
>
> After seeing [the Appellant] again as requested and after reviewing all of the documents submitted including all records Manitoba Public Insurance has on file, my conclusions are the following:
>
> - I believe her complaints are consistent with a posttraumatic syndrome following her injury in a motor vehicle accident where she sustained trauma to her neck.

> As part of that injury there was head movement of some kind which resulted in brain injury resulting in the symptoms she continues to experience. ...
>
> To be practical, if she is to return to work, she must choose something she can manage with her symptoms experienced at the present time – without the expectation that she will be able to do more at least for the time being. ..."

The Appellant made several attempts to return to work but was unable to do so successfully. She has testified that given her symptoms, she does not feel she is capable of any re-entry into the work force.

Based on the foregoing, and while recognizing that there is some conflicting evidence, the panel finds that the weight of the evidence establishes that the Appellant has suffered some degree of alteration of her higher cognitive mental functions which is impairing her ability to perform the activities of daily living. Accordingly, the panel finds that she has met the onus to establish, on a balance of probabilities, that she is entitled to a PI award of 5% under paragraph 4.9(e) of Schedule A to Manitoba Regulation 41/94.

Fine Hand Motor Coordination:

The only evidence adduced by the Appellant with respect to any deficit in her fine hand motor coordination is found in the report of [Appellant's neuropsychologist #1] dated February 23, 2010. In that report, he indicated that "she was mildly slow on her right non-dominant hand" with respect to certain tests of her functioning. The Appellant did not adduce any evidence or testify with respect to her functional capabilities currently, nor was any objective evidence introduced to indicate that she had any impairment in her fine hand motor coordination which is permanent. Accordingly, the panel finds that the Appellant has not met the burden of

establishing, on a balance of probabilities, that a PI benefit should be awarded to her with respect to her fine hand motor coordination.

Vestibular Issues:

The Appellant submits that she suffers from vestibular difficulties as a result of the motor vehicle accident, including nystagmus and BPPV. She further submits that these conditions are permanent and accordingly she should be entitled an award of PI benefits, under Class 2 below.

Section 4.2 of Division 12 of Schedule A to Manitoba Regulation 41/94 provides as follows:

> 4.2 Functional criteria of vestibular impairment
>
> | **Class** | **Symptom or condition** | **Impairment Rating** |
> |---|---|---|
> | Class 1 | Peripheral or central vertigo does not affect the capacity to perform activities of daily living (ADL). | 2.5% |
> | Class 2 | Peripheral or central vertigo does not affect the capacity to perform most ADL, but certain activities, such as driving an automobile or riding a bicycle, may endanger the safety of the patient or others. | 7.5% |
> | Class 3 | Peripheral or central vertigo necessitating continuous supervision for the performance of most ADL such as personal hygiene, household chores, or walking. | 30% |
> | Class 4 | Peripheral or central vertigo requiring continuous supervision for the performance of most ADL and requiring confinement of the patient at home or an institution. | 50% |
>
> Vestibular injury may be compensated over time and should be rated at both 6 and 12 months after injury to establish whether it has become static.

The issue for determination, then, is whether the MVA has caused the Appellant to develop a vestibular impairment, in the form of vertigo (benign paroxysmal positional vertigo (BPPV), or dizziness), which impairs her ability to perform certain of her activities of daily living safely,

such a riding a bicycle. This vertigo, in the Appellant's case, was associated with nystagmus, the involuntary movement of the eyes.

There was evidence of concern regarding the Appellant's vestibular function shortly after the MVA. The Appellant was sent to a vestibular physiotherapist, [Appellant's vestibular physiotherapist #2], for an assessment. In [Appellant's vestibular physiotherapist #2's]report dated June 5, 2008, she noted the following:

> "Pt presents with full neck ROM but pain [at] end left side flex/rot.
> - Has mild saccadic eye movement with smooth pursuit (oculomotor test) & some dynamic visual acuity involvement.
> - [Decrease] balance with eyes closed. Gait/Dynamic balance with head movement is [decreased].
> - Positioning error returning from left [side].
> - [Decreased] strength left neck flexors."

In [Appellant's neuropsychologist #1's] report of February 18, 2010, he also noted that the Appellant had vestibular symptoms. [Appellant's neuropsychologist #1] stated as follows:

> "Thus I feel that there is likely an interaction between [the Appellant's] cognitive symptoms that are visual in nature, and the fact that she still might be having some dizziness and nausea that could be triggered by complex visual information and/or by postural changes. Her records do indicate that she had been referred for vestibular physiotherapy at [text deleted], and she had a detailed assessment there on June 5, 2008, which had found problems with her balance, dynamic gait, etc. They had recommended to MPI that she receive vestibular physiotherapy. As far as [the Appellant] could recall, she had simply completed one session, and she was not certain what had happened with this.
>
> Thus my primary suggestion for [the Appellant] at the end of our testing was to have medical followup (sic) over what might still be some vestibular symptoms. I do feel she has had a concussion, but I can't diagnose or treat a vestibular condition. ..."

[Appellant's neuro-opthalmologist], in her report dated December 13, 2010, confirmed that the Appellant had downbeat nystagmus and BPPV, which are both vestibular conditions. In the course of its deliberations, the panel considered writing to [Appellant's neuro-opthalmologist] to seek elaboration from her regarding her reports and the panel therefore sought commentary from

the parties regarding a draft letter to [Appellant's neuro-opthalmologist]. No response was received from MPIC; however, the Appellant strongly objected to the Commission seeking a further report from [Appellant's neuro-opthalmologist]. Accordingly, no further report was sought from [Appellant's neuro-opthalmologist].

[Appellant's neurologist], the neurologist, in his report of May 24, 2013, confirmed that the Appellant suffered from vestibular symptoms that were the result of her accident:

> "[The Appellant] has complained throughout of problems with dizziness and balance associated with some visual distortion. There is a debate throughout the record whether these symptoms are due to peripheral (vestibular) or central (vestibular or cerebellar) causes. Dizziness including vertiginous sensations sometimes occur with neck muscle tightness causing restricted head motion. There is some difference of opinion about this. [The Appellant's neuro-opthalmologist], neuro-opthalmologist, might be regarded as the person most expert in this disorder believes that she had peripheral vestibular problems (with a contribution from head motion restriction). This is largely an academic matter as either are the result of her accident and result in a fairly similar symptoms. ..."

This finding was confirmed by [Appellant's chiropractic neurologist], a chiropractic neurologist, in his report dated November 7, 2013:

> "These findings conclude the diagnosis of a centrally maintained vestibulopathy consequent to her mild traumatic brain injury. This means that the symptoms she continues to exhibit are cause (sic) by the damage to in (sic) the central nervous system with regards to vestibular information."

[Appellant's chiropractic neurologist] explained further in his report of May 6, 2014:

> "... [the Appellant] continues to show disability from her head injury when (sic) with regards to quick head motion and eye movements. She continues to struggle with busy settings where there is a lot of motion and noise. She continues to struggle with light sensitivity. ..."

[Appellant's chiropractic neurologist] noted in his report of July 6, 2014, that:

> "... There had been no improvement in her downbeat nystagmus, and [she] is maintaining convergence insufficiency.
>
> Unfortunately, her symptoms continue to cause her significant disability despite the improvement. She continues to exhibit objective findings consistent with her injury. At this stage in her treatment, I am of the view that I have exhausted all options available to me at this time, and I recommend that my treatment of this patient discontinue."

The panel agrees with the Appellant's submission that [Appellant's chiropractic neurologist] thereby confirmed that her condition was permanent.

While there is some conflicting evidence, it is clear that the Appellant has been consistent in her complaints of headaches, dizziness, fatigue and difficulties with balance since immediately after the accident. Vestibular difficulties have been noted and confirmed by several of her health care providers since shortly after the MVA. The diagnoses of specific difficulties including nystagmus and BPPV were made slightly later on; however, the panel finds that the Appellant has established, on a balance of probabilities, that her vestibular difficulties were caused by the MVA. In addition, the panel finds that these vestibular difficulties persist to date and are therefore to be considered permanent. The Appellant has testified that she has difficulties in going for a bike ride, along with other difficulties in performing various activities of daily living. Therefore, the panel finds that the Appellant has established, on a balance of probabilities, that she is entitled to a PI benefit of 7.5% under Class 2 of section 4.2 of Division 12 of Schedule A to Manitoba Regulation 41/94.

<u>Torticollis:</u>

At the Internal Review stage, the Appellant advanced the position that she was entitled to a PI award for the condition of torticollis, where the neck tends to twist to one side. In her submissions before the Commission, she did not specifically advance an argument that she was

still claiming a PI benefit with respect to that condition. There is one reference in the indexed file in which the Appellant was diagnosed with that condition, specifically an Emergency Room Report, from February 1, 2009. Given that this report is dated almost a year after the MVA, and given that no other evidence was adduced by the Appellant with respect to this condition, the panel finds that the Appellant has not met the burden of establishing, on a balance of probabilities, that she is entitled to a PI award with respect to the condition of torticollis.

Tinnitus:

The Appellant submits that she is entitled to an award of PI benefits for the condition of tinnitus. Tinnitus is dealt with under section 5 of Division 12 of Schedule A to Manitoba Regulation 41/94, which provides as follows:

5. Tinnitus, unilateral or bilateral

Class	**Symptom or condition**	**Impairment Rating**
Class 1 (mild)	Tinnitus is intermittent and noticeable only in quiet environment.	0.5%
Class 2 (moderate)	Tinnitus is constantly present and bothersome in quiet environments, disturbing concentration and sleep.	1.0%
Class 3 (severe)	Tinnitus is constantly present and bothersome in most environments, disturbing concentration, sleep and activities of daily living.	2.0%

The issue for determination, then, is whether the MVA has caused the Appellant to develop tinnitus, and if so, whether that tinnitus is mild, moderate or severe.

[Appellant's doctor #3], in his Primary Health Care Report dated August 10, 2009 (based on an examination of April 19, 2008), identifies tinnitus as one of the Appellant's symptoms. This symptom was thus identified shortly after the MVA. [Appellant's neuropsychologist #1], in his report of February 23, 2010, noted that "She reported a "buzzing" sensation in her ears, and this

has not fully resolved." [Appellant's ear, nose and throat specialist], an ear, nose and throat specialist, in his report of April 6, 2010, states "the patient does suffer from bilateral tinnitus". The Appellant's evidence was that her tinnitus has persisted since the time of the accident and that it is severe. Her evidence was that the more she exerts herself, the worse her tinnitus gets.

It is clear that the Appellant has been consistent in her complaints of tinnitus since immediately after the accident. Reports of tinnitus and "buzzing" in her ears have been noted and confirmed by several of her health care providers since shortly after the MVA, including an ear, nose and throat specialist. The Appellant has testified that she has ongoing difficulties with tinnitus and that it is severe and the panel accepts this evidence. Therefore, the panel finds that the Appellant has established, on a balance of probabilities, that she is entitled to a PI benefit of 2% under Class 3 of section 5 of Division 12 of Schedule A to Manitoba Regulation 41/94.

Visual Impairment:

The Appellant submits that she suffers from visual impairment as a consequence of the MVA and as such is entitled to an award of PI benefits.

Visual difficulties were noted shortly after the accident in the vestibular assessment done by physiotherapist [Appellant's vestibular physiotherapist #2], on June 5, 2008. In that report, [Appellant's vestibular physiotherapist #2] noted "mild saccadic eye movements with smooth pursuit (oculomotor tests) & some dynamic visual acuity involvement." The Appellant also reported blurred vision in her initial assessment with [Appellant's athletic therapist], athletic therapist, on August 25, 2008.

The appellant continued to report visual difficulties over time. [Appellant's neuropsychologist #1], in his report of February 23, 2010, notes as follows:

> "When I had asked [the Appellant] about her vision, she reported occasional blurriness. She had concerns that her right eye was not adjusting to the dark. She described a feeling as if the curtain was closing on it. She reports that she had seen a physician over this, and had been advised that her acuity was normal, and there was no suggestions provided to her. ..."

[Appellant's neuro-opthalmologist], in her report dated December 13, 2010 noted the following:

> "On examination, binocular acuity measured 20/15-1. There was no change in acuity with vertical or horizontal head-shaking.
>
> Visual fields to confrontation, pupils and optic discs were normal."

[Appellant's chiropractic neurologist], in his report of April 29, 2013, identified the following:

> "... Occulo-motor testing shows difficulty in gaze stabilization at 20° to the right horizontally, and right pursuit tracking. Optokinetic testing shows diminished right horizontal response."

[Appellant's chiropractic neurologist] noted the following in his report of July 6, 2014:

> "[The Appellant] is being treated for a central vestibulopathy, caused by a traumatic brain injury. A review of her medical records indicates she sustained this injury April 13, 2008 in a motor vehicle accident. ... There had been no improvement in her downbeat nystagmus, and [she] is maintaining convergence insufficiency. ..."

MPIC's Health Care Services' consultant reviewed the medical reports relating to the visual system and provided a report dated December 15, 2014, opining that the Appellant was not entitled to a PI award for visual impairment. Subsequently, the Appellant visited [Appellant's neuro-developmental optometrist], a neuro-developmental optometrist. He provided a report dated January 26, 2015 and noted that the Appellant suffers from convergence insufficiency and ocular motor dysfunction. He also stated:

> "Neural-Developmental Vision Therapy is strongly recommended to treat the above vision disorders and help [the Appellant] regain visual skills and stamina that she had before her car accident. Attached is the summary of symptoms and the summary of the

> vision therapy program. We expect [the Appellant] to begin to feel better 2 months into therapy and regain visual function 5-7 months into therapy."

Based on the totality of the evidence, the panel finds that the Appellant has established, on a balance of probabilities, that she suffers from a visual impairment which was caused by the MVA. However, based on the evidence of [Appellant's neuro-developmental optometrist], the panel finds that the visual impairment is not permanent, but rather appears to be treatable. Therefore, the panel finds that the Appellant has not met the onus of establishing, on a balance of probabilities, that she is entitled to an award for PI benefits for visual impairment at this time. The Appellant should note that should her circumstances change, she is free to bring new information before the case manager at that time.

Disposition:

Accordingly, based on the foregoing, the panel finds that the Appellant is entitled to an award of 5% for PI benefits for alteration of the higher cognitive or integrative mental functions, an award of 7.5% for PI benefits for vestibular impairment and an award of 2% for PI benefits for tinnitus.

The Appellant shall be entitled to interest upon the monies due to her by reason of the foregoing decision, in accordance with section 163 of the MPIC Act.

In all other respects, the Internal Review decisions of January 25 and June 27, 2011, and January 8, 2015, are hereby confirmed (save for the matter of Income Replacement Indemnity which was dealt with in the Internal Review decisions of January 25 and June 27, 2011, and which was disposed of in a separate appeal) and the Appellant's appeal is dismissed.

Dated at Winnipeg this 4th day of August, 2015.

MEL MYERS, Q.C.

JACQUELINE FREEDMAN

JANET FROHLICH