Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-14-138

PANEL:	**Ms Karin Linnebach, Chairperson** **Mr. Brian Hunt** **Mr. Neil Margolis**
APPEARANCES:	**The Appellant, [text deleted], was not present at the appeal hearing;** **Manitoba Public Insurance Corporation ("MPIC") was represented by Ms Ashley Korsunsky.**
HEARING DATE:	**August 28, 2017**
ISSUE(S):	**Whether the Appellant's ongoing left arm and shoulder symptomology is related to the motor vehicle accident of February 22, 2013.**
RELEVANT SECTIONS:	**Subsections 70(1), 71(1) and 184.1 of The Manitoba Public Insurance Corporation Act ("MPIC Act")**

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

Reasons for Decision

Background:

The Appellant, [text deleted], was injured in a motor vehicle accident ("MVA") on February 22, 2013. Following the MVA, she received Personal Injury Protection Plan ("PIPP") benefits, including Physiotherapy, Personal Care Assistance and Income Replacement Indemnity ("IRI") benefits.

In a decision letter dated December 5, 2013, the Appellant's case manager held that the Appellant's left arm/shoulder relapse was not casually related to the MVA. The Appellant filed an Application for Review of this decision. In a decision dated June 25, 2014, the Internal Review Officer upheld the case manager's decision, finding that causation cannot be established between the Appellant's current left shoulder symptoms and the MVA. The Appellant filed a Notice of Appeal to the Commission on September 23, 2014. The issue on appeal was whether the Appellant's ongoing left arm and shoulder symptomology is causally related to the MVA of February 22, 2013.

Decision:

For the reasons set out below, the panel finds the Appellant has not met the onus of establishing, on a balance of probabilities, that her ongoing left arm and shoulder symptomology is causally related to the MVA of February 22, 2013.

Preliminary and Procedural Matters:

Three Case Conference Hearings were scheduled regarding this appeal. The purpose of the Case Conference Hearings was to discuss pre-hearing matters and to schedule a date for the hearing of the appeal. The first Case Conference Hearing ("CCH") was scheduled for August 17, 2016 at 10:30 a.m. Notice of the CCH was sent to the Appellant by Xpresspost and regular mail to the address provided by the Appellant in her Notice of Appeal ("the Appellant's first address"). The Notice of Hearing sent by Xpresspost was returned "unknown" and the Notice of Hearing sent by regular mail was returned "moved". The Appellant did not attend the first CCH.

The Commission made many attempts to try to locate the Appellant over several months, including asking MPIC to check their records to see if the Appellant had provided MPIC with a new address. A second CCH was scheduled for February 13, 2017. As the Commission was not able to locate a new address for the Appellant, the Notice of CCH was sent to the Appellant by regular mail and Xpresspost to the Appellant's first address. The Notice of Hearing sent by Xpresspost was returned "unknown" and the Notice of Hearing sent by regular mail was not returned to the Commission.

As the Commission had not been able to locate the Appellant to provide her with documents, the Commission made further attempts to locate the Appellant. MPIC again checked their records and discovered that the Appellant had provided a new address to MPIC ("the Appellant's second address"). The Commission was able to deliver documents to the Appellant at the Appellant's second address and to inform her of the second CCH.

The second CCH took place on February 13, 2007. The Appellant attended the CCH and advised the Commission that she still wanted to pursue her appeal. Although the Commission was provided the Appellant's second address from MPIC, the Appellant also provided the Commission with written notice of change of address and confirmed that she could be reached by telephone. The Commission sent a letter to the parties reporting on the second CCH. The Appellant's copy was sent by regular mail to the Appellant's second address and it was not returned to the Commission.

The third CCH was scheduled for June 6, 2017. As per the written notice of change of address provided to the Commission at the second CCH, the Notice of CCH was sent to the Appellant by regular mail and Xpresspost to the Appellant's second address. The Notice of Hearing sent by

Xpresspost was returned “unclaimed” and the Notice of Hearing sent by regular mail was returned marked “return to sender – moved/unknown”. The telephone number that the Appellant provided at the second CCH was also not in service. The Appellant did not attend the third CCH.

The Appeal was then set for hearing and scheduled for August 28, 2017 at 9:30 a.m. The Notice of Hearing was sent to the Appellant by Xpresspost and regular mail to the Appellant’s second address. The Notice of the Hearing sent by Xpresspost was returned as “unclaimed” and the Notice of Hearing sent by regular mail was returned marked “moved/unknown”.

Section 184.1 of the MPIC Act provides how Notices may be given to the Appellant. It provides as follows:

> **How notices and orders may be given to appellant**
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> 184.1(1) Under sections 182 and 184, a notice of a hearing, a copy of a decision or a copy of the reasons for a decision must be given to an appellant
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> (a) personally; or
>
> (b) by sending the notice, decision or reasons by regular lettermail to the address provided by him or her under subsection 174(2), or if he or she has provided another address in writing to the commission, to that other address.
>
> **When mailed notice received**
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> 184.1(2) A notice, a copy of a decision or a copy of reasons sent by regular lettermail under clause (1)(b) is deemed to be received on the fifth day after the day of mailing, unless the person to whom it is sent establishes that, acting in good faith, he or she did not receive it, or did not receive it until a later date, because of absence, accident, illness or other cause beyond that person's control.

Subsection 184.1(2) requires the Appellant to establish that, acting in good faith, the Appellant did not receive the Notice of Hearing, or did not receive it until a later date, because of absence, accident, illness or other cause beyond that person’s control. The Appellant did not contact the

Commission to change her address after the second CCH and it appears that regular mail sent to the Appellant's second address is not being forwarded by Canada Post to a current address. As such, pursuant to subsection 184.1(2) of the MPIC Act, the Appellant is deemed to have received the Notice of Hearing that was sent to her by regular mail to the Appellant's second address which she provided to the Commission in writing on February 13, 2017.

On August 28, 2017, the hearing of the Appellant's appeal was convened at 9:30 a.m. with counsel for MPIC present. The Appellant did not attend. The Commission's Notice of Hearing provided that the time and date of the hearing are firm and that postponements will only be granted under extraordinary circumstances. The Notice also provided that should either party fail to attend the hearing, the Commission may proceed with the hearing and may issue its final decision either granting or dismissing the appeal in whole or in part.

Accordingly, the appeal hearing proceeded at 9:45 a.m. and the panel heard the submissions from counsel for MPIC. After submissions were completed, the panel advised counsel for MPIC that the panel would, as is the normal course, adjourn to deliberate and advise the parties of its decision in due course by providing a written decision. The hearing then adjourned.

Submission for the Appellant:

As indicated, the Appellant did not attend the hearing and therefore was not available to provide any clarification on any points in dispute or to be cross-examined by counsel for MPIC.

In her Notice of Appeal to the Commission dated September 23, 2014, the Appellant stated she wished to appeal the June 25, 2014 Internal Review Decision because she feels the decision was

unfair and because she "didn't really know what to expect so I did not speak on behalf of the MVA date on February 22, 2013".

The Appellant's Application for Review dated February 4, 2014, filed in response to the case manager's decision, stated as follows:

> "I would like to request a review of the above noted decision which identifies that I do not qualify for further benefits. My employer has written a letter (attached) verifying that I could no longer perform my duties post-accident. The physiotherapist I have been seeing states that they are still treating me for my original injury and recommends further treatments which I cannot afford. I would also like to know about my permanent impairment payment. Please know that on January 30, 2014 I received a complete copy of my unlocked clinical notes from [Appellant's doctor], which shows no mention of any shoulder pain prior to my accident. I would be glad to share this information with you should you so choose.
>
> This file contains complete clinical notes for the last two years which were not in the initial clinical report to MPI.
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> I would also like to mention that the date on my MRI was noted incorrectly.
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> Please know that my physiotherapist [text deleted] is prepared to draft up a report on how therapy is going and recommending further treatments. Unfortunately I cannot afford to pay for this report as it will cost approximately $200. Should MPI wish to receive this information please contact [physiotherapist] at [text deleted] Physiotherapy at [text deleted]. I feel that this information is imperative to my case."

Documentary Evidence

As the Appellant did not attend the hearing and provide any testimony on the MVA and her injuries, the panel relied on the documentary evidence from the Appellant's claim file.

In a report dated March 4, 2013, the Appellant's family physician advised that the Appellant attended to a walk-in clinic on the day of the MVA and received a prescription for naproxen. The family physician diagnosed the Appellant with mild peripheral neuropathy of her left arm and hand and muscle strains of the left side of the Appellant's body, including her neck, torso,

buttock and arm. The family physician noted that the Appellant had decreased range of motion, but normal strength in extremities. The family physician found that "there was no indication for any imaging to be done". With respect to ability to work, the family physician stated that the Appellant's job at a packaging plant is "fairly demanding in terms of the lifting and other physical tasks". The Appellant also had her own business doing demolition work on the weekends. The Appellant's pain (myalgia) and muscle stiffness were keeping her from performing her full duties, but she could return to work by March 11, 2013. The family physician was of the view that the Appellant had a very good prognosis for full recovery and did not anticipate any permanent impairment as a result of the MVA injuries.

The physiotherapist's report of March 5, 2013 provided a diagnosis of sacroiliac joint sprain, rotator cuff strain and whiplash associated disorder.

The Appellant's physiotherapist completed a return to work form dated April 12, 2013, which recommended a gradual return to work before the Appellant could commence full duties. An MPIC file note dated April 23, 2013 documents a conversation with an occupational therapist indicating that the Appellant's employer was unable to provide the Appellant with any gradual return to work plan with any reduced capacity. As such, it was determined that the Appellant would benefit from a reconditioning program before the Appellant returned to work.

The physiotherapist at the reconditioning program completed 4 reports regarding the Appellant's attendance at the program. The initial report dated April 30, 2013 documents that the Appellant's primary issue surrounded the discomfort in her left shoulder/scapulothoracic region. The pain seemed only to be alleviated by the use of morphine. The Appellant also complained of intermittent paresthesia into the ulnar nerve distribution of the left upper extremity, generalized

left lower extremity discomfort and daily occipital headaches. The assessment of the Appellant's shoulder showed strength deficits of the shoulder girdle. It was noted that the Appellant's job at the packaging plant requires her to lift heavy boxes primarily floor to waist and her part-time demolition work required heavy lifting. Therefore, the goal was to rehabilitate the Appellant to be capable of lifting 50 lbs primarily floor to waist.

The physiotherapist's 2 week progress report dated May 17, 2013 noted that the Appellant's attendance and compliance had been great and much improved upper and lower extremity strength and functional capabilities were noted. However, the Appellant continued to complain of low back pain and left lower extremity discomfort. A 4 week progress report was completed dated June 4, 2013. It states that pain-focussed behaviour had been evident throughout the program, but that attendance and compliance with the program had been good. The report documents that the Appellant's complaints of shoulder pain had greatly reduced over the course of the program and that the Appellant's shoulder range of motion was full and within normal limitations. The Appellant reported that her low back had been worse, but that she was unable to state specific exacerbating factors of her low back pain. The Appellant's body mechanics had greatly improved over the course of the program.

A discharge report dated June 18, 2013 was prepared at the completion of the reconditioning program. At that time, the Appellant indicated that her left shoulder continues to be problematic with activity and she continues to have complaints of low back pain. The Appellant indicated that her physician would like her to start on a gradual return to work program at 4 hours per day. The physiotherapist noted that no documentation was provided supporting this proposition. The physiotherapist stated that improvements were noted in terms of functional capabilities and strength and that the concept of hurt vs. harm was discussed with the Appellant. It was feasible

for the Appellant to return to work as she had demonstrated the ability to lift 50 lbs. The Appellant was provided with a detailed exercise program to be done on an independent basis.

An MPIC file note dated June 19, 2013 documents a conversation between the Appellant and her case manager where she advised that she was completing the rehabilitation program, was feeling much stronger, and was able to carry and lift more than she could prior to the program. However, the Appellant also stated that she was still experiencing a lot of pain and is emotionally worn out. She was advised that her case manager would be sending her for a psychological assessment.

An MPIC file note dated June 21, 2013 documents a conversation with the Appellant where she advises her case manager that she had made arrangements to return to work, but that her employer only has work available for her at 4 hours per day. The Appellant indicated that her low back "is still really sore" and that she spoke to her family physician, who suggested she return to work on a gradual basis. The Appellant was requesting top-up of her IRI to accommodate this return to work. It was explained to the Appellant that she had been cleared to return to work at full duties and that the whole purpose of offering her a reconditioning program was because the employer could not accommodate a gradual return to work program. Nonetheless, the case manager approved IRI top-up from June 24, 2013 and July 7, 2013 so that the Appellant could return to work on a gradual basis.

The Appellant attended the psychological assessment that was requested by MPIC on her behalf. The report of the assessment dated July 29, 2013 states that the Appellant did not meet the criteria for a psychological diagnosis and that she presented as psychologically managing well with her recovery from the MVA. However, the Appellant advised the psychologist that she was attending to psychological services for management of her pain. While the Appellant voiced

concern about her pain, particularly in her lower left back, left shoulder and left leg, she described her current pain as mild. She indicated that her back pain at times can disrupt her sleep. The Appellant was provided with instructions on breathing and implementing self-talk strategies when experiencing pain. The psychologist concluded that there are no psychological limitations which prevent the Appellant from returning to her pre-MVA employment and that she had, in fact, returned to full time duties at the packaging plant. Because her truck was involved in the MVA and she was now driving a car, the Appellant no longer operated her part-time demolition business. The psychologist noted that the Appellant may wish to consider psychological services to further discuss issues that were raised on assessment that are unrelated to the MVA.

The Appellant attended for an MRI on September 15, 2013. It revealed that the Appellant had mild tendinosis of the supraspinatus and infraspinatus with no evidence of a rotator cuff tear. There was no muscle edema to suggest muscle strain.

An MPIC file note dated September 24, 2013 documents that the Appellant contacted her case manager on September 19, 2013 to advise that her shoulder has been very sore lately, she quit her job at the packaging plant and she enrolled in a grade 12 program as she wants to get a better job. She explained that her arm “breaks out inflamed” and is awaiting results of an MRI. An MPIC file note dated September 26, 2013 documents that the Appellant contacted her case manager to advise of the MRI results. The Appellant explained that she was going to school and taking shifts at work occasionally when they needed her and when her arm is not inflamed. She asked her case manager if MPIC would consider providing her with IRI benefits.

The Appellant was referred to a physical medicine and rehabilitation specialist who provided a report to the Appellant's physician dated October 22, 2013. A nerve conduction study was performed with normal results. The specialist diagnosed the Appellant with rotator cuff tendinopathy as noted on the MRI results and it was decided that the Appellant would be treated with a corticosteroid injection.

The Appellant's family physician provided a report to MPIC dated October 31, 2013. It was the family physician's medical opinion that the Appellant's left arm and shoulder symptoms are as a result of the MVA injuries and that these injuries preclude the Appellant from performing the tasks of her pre-MVA employment. The family physician advised that she conducted a thorough chart review of all clinical visits from February 22, 2011 to the present and that the Appellant did not have any complaints of shoulder or other musculoskeletal injuries prior to the MVA. The family physician included copies of chart notes of the Appellant's visits from February 25, 2013 to October 28, 2013 concerning complaints of shoulder pain and musculoskeletal symptoms.

The physical medicine and rehabilitation specialist provided a report to MPIC dated November 13, 2013. Regarding diagnosis, the specialist stated that the physical exam demonstrated positive impingement signs suggesting rotator cuff tendinopathy. However, the Appellant reported that the corticosteroid injection did not provide any benefit in her shoulder pain which indicated to the specialist that the Appellant's rotator cuff impingement may not be responsible for the Appellant's symptoms. The specialist opined that there may be an element of myofascial pain syndrome contributing to the Appellant's symptoms. The specialist did not recommend any further diagnostic testing at that time. Regarding causation, the specialist noted that the Appellant's reports of pain were onset immediately after the MVA. As such, the specialist

opined that “based purely on history of no prior symptoms and now ongoing symptoms, one must presume a causal relationship”.

An MPIC Health Care Services (HCS) consultant was asked to review the Appellant’s medical file and provide an opinion regarding causation and ability to work. In a report dated November 19, 2013, the consultant noted there is no agreement among the clinical documentation with regard to the diagnosis both immediately following the injury and at present. With respect to the MRI findings of supraspinatus and infraspinatus tendinosis, the consultant stated that, in his view, these findings are favoured to exist independently of the MVA, probably on a pre-existing basis. The Appellant therefore might have been rendered vulnerable to the development of shoulder and upper extremity symptoms following the MVA. Further, the consultant opined that the Appellant’s decline in function in August 2013 did not occur as a probable effect of the MVA on balance, given the absence of a specific diagnosis and that the Appellant demonstrated improved strength, capacity and function in her left upper extremity following the rehabilitation program in June 2013.

The Appellant provided MPIC with an undated handwritten letter from her employer. This letter stated that the Appellant could only perform light duties upon her return to work after the MVA and that the Appellant reported she could not take on her pre-accident duties of lifting and carrying because of pain and discomfort. Her hours worked after her return to work were less than her pre-MVA hours. After only a couple of months of part-time work, the Appellant informed the company she was going back to school because of physical limitations. At the end of August 2013, the Appellant became a casual employee. The employer stated that the company is not responsible for the pain and suffering the Appellant is experiencing.

The Appellant submitted a report from her treating physiotherapist dated March 31, 2014. The Appellant attended to this physiotherapist from March 4, 2013 to May 1, 2013 for treatment prior to the commencement of the rehabilitation program and then again on March 28, 2014 for reassessment. The report notes that the Appellant was able to complete the reconditioning program, but that she reported having pain throughout the program. The Appellant reported that she gained strength to aide in her ability to perform her work duties after the program, but that the program did nothing to help with the pain symptoms. Once the Appellant completed the reconditioning program, she returned to work full time but was unable to perform to the level that the job required due to pain. Her hours were reduced down to part time and then again to casual. The Appellant then returned to school for retraining in a field that is less physically demanding. The physiotherapist noted that the Appellant had reduced range of motion in her left shoulder and that pain was reported at all end ranges of all shoulder movements. The physiotherapist indicated that the Appellant's current diagnosis is a "left rotator cuff impingement with myofascial dysfunction (query myofascial pain syndrome)".

The MPIC HCS consultant was asked to review the March 31, 2014 physiotherapist report and advise whether the report changed his previously held opinion. The consultant provided a report dated May 24, 2014, indicating that his previous opinion had not changed. The consultant opined that an initial diagnosis of left rotator cuff strain due to the MVA is supported based upon the medical information on the Appellant's file. Therefore, rehabilitation was reasonable and medically required following the MVA. However, the consultant explained that the natural history of rotator cuff strain is for improvement over several weeks. While the MRI scan of September 15, 2013 described tendinosis in the rotator cuff tendons of the left shoulder, which is synonymous with rotator cuff tendinopathy, the consultant opined that these findings are not causally related to the MVA because the current understanding of tendinosis is that it is a

degenerative condition, related to repetitive use and micro-trauma. Rotator cuff tendinosis or tendinopathy can often lead to rotator cuff impingement with shoulder pain, decreased strength and decreased range of motion. These symptoms and signs may be experienced on a fluctuating basis depending on various factors; for example, use of the shoulder, positioning and adherence to shoulder rehabilitation exercises. Rotator cuff tendinosis is a condition which might confer vulnerability of the shoulder to symptoms following trauma and/or a strain injury. However, the consultant opined that the medical information does not suggest that the Appellant acquired a long-term or chronic left shoulder condition in the MVA, despite reported shoulder symptoms. In the consultant's view, this is supported by both the physical examination findings and the MRI scan. Following rehabilitation, the Appellant's left shoulder function was documented as within normal limits regarding to strength and range of motion. At that point, shoulder symptoms were most probably representative of rotator cuff tendinopathy. While rotator cuff tendinopathy is a potential source of intermittent shoulder symptoms, it is not causally related to the collision in question. As such, it was the consultant's view that a subsequent decline in function and/or a flare in shoulder symptoms, with reduced strength and/or range of motion, did not occur as a probable consequence of the MVA.

A report dated November 18, 2014 from a social worker who was providing counselling services to the Appellant was provided to the Commission. It states that the Appellant was referred by the Appellant's family physician to address the Appellant's panic and anxiety. It was the social worker's view that the Appellant endorsed signs and symptoms of post traumatic stress disorder, triggered by the February 22, 2013 MVA and that the Appellant would benefit from longer term therapy.

The Appellant's family physician provided a report dated August 29, 2015. The report confirms that the Appellant has been a patient of her family physician since 2006 and had no complaints of chronic pain involving any aspect of her musculoskeletal system, including shoulder pain, up until the time of the MVA. The Appellant had been involved in a major MVA in 2007 in which she suffered a tibial fracture and made a full recovery without ongoing clinical complaints. Immediately following the February 22, 2013 MVA, the Appellant complained of left sided pain in her torso, arm, neck and shoulder because of soft tissue injuries. The family physician felt that the Appellant had a good prognosis for recovery at that time. However, the Appellant's recovery has been unexpectedly protracted and her original injuries have left her with chronic and disabling shoulder pain. The Appellant suffers from tendinopathy and subsequent myofascial pain and continues to rely on morphine twice daily to alleviate some of her pain. The family physician also opined that the Appellant suffered from a significant anxiety and panic disorder subsequent to the MVA. The Appellant trialed a job as a delivery driver in the summer of 2014 but was unable to hold this job due to her anxiety. The family physician opined that the Appellant's anxiety and depression symptoms arose as result of the MVA given the chronic pain and her significant losses of employment, income and self-sufficiency.

The MPIC HCS consultant was asked to review the family physician's report of August 29, 2015. The consultant noted the changing diagnoses on the Appellant's file and the progression of the Appellant's condition to chronic and disabling shoulder pain. In the consultant's view, the Appellant reported left shoulder and upper extremity pain symptoms and demonstrated mild physical impairment at her left shoulder following the Feburary 22, 2013 MVA. These findings suggested a shoulder/rotator cuff strain injury. With treatment, the Appellant was not limited from returning to work, although there were residual shoulder symptoms at the time of discharge from the reconditioning program. Since that time, the Appellant's shoulder symptoms increased

and she was provided a diagnosis of myofascial pain syndrome following the specialist's assessment in November 2013. In the consultant's view, medical causation of myofascial pain syndrome is a controversial topic and the current literature pertaining to this condition does not establish the probable causal mechanism, traumatic or otherwise. It therefore cannot be medically determined why the Appellant developed this condition at her left shoulder. The consultant reiterated that the Appellant's documented improvement following rehabilitation provided objective evidence that the Appellant had demonstrated recovery from an acute injury, consistent with a collision-related diagnosis of rotator cuff strain. In the consultant's view, the possible presence of an alternative collision-related injury for which chronic and fluctuating shoulder pain, recurrent physical impairment and absence of response to treatment might be reasonably expected is not supported by the medical information available. The consultant opined that the diagnostic shift from rotator cuff strain, to rotator cuff tendinopathy, to myofascial pain syndrome is not well explained as an effect of the MVA.

The psychologist who conducted the assessment of the Appellant after her return to work in 2013 was asked by MPIC to provide a psychological assessment update. The August 24, 2015 report noted "a number of significant changes in the psychological measures from July 2013 to August 2015" and provided a diagnosis of major depressive disorder, agoraphobia, panic disorder and posttraumatic stress disorder. The Appellant indicated that she had experienced two traumatic events, with the MVA of February 2013 being the event that has caused her the most distress. The psychologist listed a number of significant symptoms and recommended that the Appellant be seen by a psychiatrist for further evaluation. With respect to an explanation as to why these psychological diagnoses were not evident at the time of the initial assessment, the psychologist opined that it is possible the Appellant experienced a delayed onset of symptoms related to posttraumatic stress disorder. This delayed onset is not uncommon and may then have

contributed to the Appellant's symptoms of depression, agoraphobia and panic disorder. The psychologist recommended that the Appellant attend for cognitive behaviour therapy.

An MPIC HCS psychological consultant was asked to review the psychologist's report of August 24, 2015 and a report dated October 7, 2015 was prepared. The consultant noted that the July 2013 psychological assessment did not identify any psychological symptoms that met the criteria for DSM-5 diagnosis. That assessment was completed at least 4 months post-injury and indicated that the Appellant was coping well with MVA related recovery. In the consultant's view, while it is possible that MVA related PTSD could have been a "delayed response", this explanation is not supported by the medical information on file on the balance of medical probability. While there clearly appears to be deterioration in functioning and mental status, a review of the medical file does not support a causal link to the MVA. With respect to MVA-related pain management, the recent medical reviews have concluded that the Appellant's current presentation of physical symptoms as casually related to the MVA is not supported. As such, psychological treatment for this pain management would not be viewed as MVA related, thought potentially medically appropriate.

The Appellant was advised in a decision letter dated October 22, 2015 that, in MPIC's view, her psychological conditions are not causally related to the MVA.

Submission for MPIC:

Counsel for MPIC submitted that the issue on this appeal is causation and, in particular, whether the Appellant's left shoulder symptoms ongoing after August 16, 2013 are casually related to the MVA.

Counsel reviewed the facts of this matter as found in the documentary evidence. On the day of the MVA, the Appellant attended to a walk-in clinic and saw a general practitioner who prescribed naproxen. Counsel submitted that this shows that the injuries were nothing too serious and no urgent medical condition was found. Three days after the MVA, the Appellant attended to her family physician who diagnosed the Appellant with mild peripheral neuropathy of her left arm and hand as well as other injuries not relevant to this appeal. The Appellant was advised to attend for a short course of physiotherapy and that she had a very good prognosis for full recovery. Because of the Appellant's work duties, she was advised to stay off work with an estimated return to work date of March 11, 2013. Counsel submitted that no testing was done at this time and that the Appellant was told to remain off work due to her subjective pain complaints. Counsel noted that her family physician did not identify any diagnostic imaging that needed to be done.

Because the Appellant's employer could not accommodate a gradual return to work, the Appellant was referred to a reconditioning program. The April 30, 2013 physiotherapist assessment at the commencement of the program showed that the Appellant's shoulder range of motion was normal and that the Appellant's elbow range of motion was full and within normal limitations. Strength tests on both elbows was full.

The physiotherapist's 2 week progress report documented that the Appellant's disabilities of the arm, shoulder and hand had improved. The Appellant had much improved upper and lower extremity strength and functional capabilities. The Appellant's subjective information also showed improvement, with the Appellant reporting that she was starting to feel somewhat better and overall stronger.

The physiotherapist's 4 week progress report documented that the Appellant's complaints of shoulder pain had greatly reduced over the course of the program and she had full range of motion of her shoulder.

The final physiotherapist's report from the reconditioning program showed that the Appellant was discharged with the functional capacity and strength to return to work as the Appellant had demonstrated the ability to lift 50 lbs. Counsel noted that the reason the Appellant went to the reconditioning program was because MPIC was informed her employer did not have modified work available. However, the Appellant reported her left shoulder continued to be problematic with activity and indicated that her physician would like her to start on a graduated return to work program at 4 hours per day. Counsel submitted that the physiotherapist's final report notes that no documentation regarding this gradual return to work was provided to the physiotherapist. Counsel submitted that the idea of a gradual return to work after completion of the reconditioning program is not reflected in the Appellant's family physician's chart notes and queried where this would have come from. Nonetheless, MPIC agreed to provide the Appellant a 2 week gradual return to work period during which MPIC provided IRI top-up. As the Appellant had been cleared to return to work by the occupational therapist at the reconditioning program, the Appellant was advised that her entitlement to all IRI would end July 7, 2013. The Appellant did not appeal this decision.

Regarding the MRI that was conducted on September 15, 2013, counsel directed the panel to the family physician`s May 1, 2013 chart note, which states that the MRI was ordered "to reassure patient that nil beyond muscle strain causing patient's symptoms". Counsel submitted that this shows the MRI was ordered not because there was something suspicious going on, but rather to alleviate the Appellant's concerns about her left shoulder.

Counsel submitted that the Appellant returned to work in June 2013 at her pre-MVA employer without attending to her family physician. The first physician's chart note since the Appellant returned to work is dated August 16, 2013, several weeks after her return to work. It was not until that time that the Appellant reported a flare-up of her symptoms to her family physician.

Counsel referred the panel to the September 24, 2013 MPIC file note which documents that the Appellant's shoulder had been very sore, that she quit her job at her pre-MVA employer, and that she enrolled in school. Counsel noted that at the time of the Appellant's call to her case manager, she had not yet received the MRI results or attended the appointment with the physical medicine and rehabilitation specialist. Counsel submitted that quitting her job before finding out the results of her MRI and attending to the specialist was odd behaviour given that the Appellant was taking the position that it was her symptoms that were preventing her from working.

Counsel noted that there is nothing in the family physician's chart notes that show that the family physician ever advised the Appellant to quit her job. Rather, the Appellant just decided to quit work. The family physician's chart notes show that the Appellant was concerned about being laid off as her employer's business was not thriving. While the October 28, 2013 chart note states that the Appellant claims she was unable to do work at her pre-MVA employer, counsel pointed out the use of the word "claims" and that no objective tests were done that would lead the family physician to form the conclusion that the Appellant was unable to perform the duties at her pre-MVA place of employment. Counsel acknowledged that the family physician ultimately provides that opinion, but submitted the chart note documenting that the Appellant quit her job appears to show that the family physician is simply accepting what the Appellant reported to her rather than conducting any objective testing. Counsel submitted it is strange that the Appellant could no longer perform her job because of pain, yet agreed to continue to work for her pre-MVA

employer on a casual basis. Continuing to work for the employer on a casual basis supports the conclusion that her pain complaints were not the sole reason why she quit her job and that quitting had more to do with the financial stressors from a potential layoff from full time employment.

Counsel acknowledged that, in her report of October 31, 2013, the family physician is of the opinion that the Appellant's left arm and shoulder symptoms are the result of her MVA injuries and that these injuries preclude the Appellant from performing the tasks of her pre-accident employment. However, counsel submitted that the family physician provides no reason for her opinion other than that the Appellant did not have any complaints of shoulder or other musculoskeletal injuries prior to the MVA. Counsel submitted that there is no evidence of testing of functional abilities in the family physician's chart notes and therefore that the family physician appears to be basing her opinion entirely on the Appellant's self-reporting of her symptoms and inability to work.

Counsel acknowledged that the physical medicine and rehabilitation specialist provided an opinion dated November 13, 2013 stating that one must presume a causal relationship between the MVA and the Appellant's left-sided neck and shoulder pain based purely on the history of no prior symptoms and now ongoing symptoms. However, counsel submitted that the specialist is basing his opinion regarding causation only on the temporal relationship between the first report of symptoms and the MVA.

Counsel referred the panel to the November 19, 2013 HCS consultant report which concludes that the MRI findings in the Appellant's left shoulder of supraspinatus and infraspinatus tendinosis are favoured to exist independently of the MVA, probably on a pre-existing basis. The

Appellant's decline in function in August 2013 did not occur as a probable effect of the MVA on balance, given the absence of a specific diagnosis and that the Appellant demonstrated improved strength, capacity and function in her left upper extremity following the rehabilitation program in June 2013.

Counsel referred the panel to the handwritten undated letter from the Appellant's employer. Counsel submitted that this letter is inconsistent with the family physician's chart notes that state the Appellant was working nearly full time. Counsel also noted there is no indication that any testing was conducted after the Appellant's return to work to determine that the Appellant could not work full time hours.

Counsel referred the panel to the March 31, 2014 physiotherapist report that the Appellant submitted in support of her appeal to the Internal Review Office. Counsel noted that while the physiotherapist who authored the report provided therapy to the Appellant between March 4, 2013 and May 1, 2013, the Appellant did not attend to this physiotherapist again until March 2014. This physiotherapist therefore was unable to observe the improvements that followed the Appellant's participation in the reconditioning program. Counsel also submitted that the history provided by the Appellant to this physiotherapist is inaccurate as it does not recognize the improvements in the Appellant's pain as documented in the family physician's chart notes. The physiotherapist's report documents that the Appellant reported she returned to full time work after the reconditioning program, but couldn't perform due to pain. Her work hours were therefore reduced to part time and then to casual when she returned to school. Counsel submitted this is inconsistent from what is reflected in the family physician's chart notes.

The March 31, 2014 physiotherapist's report showed a left arm, shoulder and hand disability score that was a different presentation from both how the Appellant presented after the MVA and how she presented after the reconditioning program. The presentation at the physiotherapist in March 2014 showed greater disability than the Appellant was experiencing after the Appellant completed the reconditioning program. No explanation has been provided by the Appellant for the improvement in her pain and function followed by a significant decline.

Counsel referred the panel to the MPIC HCS consultant report dated May 24, 2014, where the consultant discusses the initial diagnosis following the MVA and the diagnosis after receipt of the MRI results. Counsel submitted that based on the consultant`s review of the medical information, the most probable MVA related diagnosis is left rotator cuff strain and the natural history of a rotator cuff strain is for improvement over several weeks. The MRI scan described tendinosis in the rotator cuff tendons of the left shoulder, which is synonymous with rotator cuff tendinopathy. Counsel submitted that tendinosis is a degenerative condition that was not caused by the MVA. The tendinosis may have left the Appellant vulnerable to have symptoms following the trauma due to the MVA, given the temporally related symptoms. It was therefore reasonable for the Appellant to have undergone physiotherapy and rehabilitation. However, the medical information does not suggest that the Appellant developed a chronic left shoulder condition in the MVA.

Counsel addressed the narrative report from the Appellant's family physician dated August 29, 2015. Counsel submitted that the family physician provides no reasons as to how the MVA left the Appellant with chronic and disabling shoulder pain. The family physician also provides no explanation as to how the MVA could have left the Appellant with permanent injuries in light of the fact that there were documented improvements during the reconditioning program. Counsel

also noted that the family physician's report mentions that the Appellant had trialed a job as a delivery driver in the summer of 2014, but that the Appellant was unable to hold this job due to her anxiety. Counsel submitted there is no mention of the Appellant being unable to continue as a delivery driver due to left shoulder pain. The family physician also documents mental health symptoms that the Appellant was experiencing, which counsel submitted are not explained by the MVA. This presentation of symptoms is also quite a different presentation from how the Appellant presented after the MVA.

With respect to a possible diagnosis of myofascial pain, counsel submitted that there is no known cause of myofascial pain and referred the panel to an MPIC HCS consultant review dated April 8, 2016.

Counsel submitted that the Appellant bears the onus to establish, on a balance of probabilities, that the Internal Review Officer erred in his conclusions regarding causation. Counsel referenced the lack of a definitive diagnosis in this case and the consultant's note of the multiple diagnostic labels documented in the Appellant's file. Counsel acknowledged that the Appellant is not required to prove diagnostic certainty and that the Commission can find causation in the absence of a definitive diagnosis. However, counsel submitted that the only evidence offered in support of the Appellant's position is the temporal relationship between the Appellant's pain complaints and the MVA. Counsel submitted that the Appellant has not provided evidence to support how her pain complaints in August 2013 were related to the MVA in light of improvements in her pain complaints and function following completion of the reconditioning program. Counsel submitted that there is no explanation provided as to how the Appellant's later shoulder and arm symptoms could be MVA related when one considers the medical documents and physical findings during the acute period. The Appellant's initial reports from her family physician and

physiotherapist show that no one expected any long-term problems associated with her shoulder injury. She was diagnosed with a rotator cuff strain and the MRI was scheduled simply to rule out a fracture or tear. While the MRI revealed tendinosis or tendinopathy, this is a degenerative condition caused by repetitive use or micro-trauma and was therefore pre-existing.

Counsel submitted the Appellant's own reports showed improvement during the reconditioning program with a flare-up of symptoms after her return to work. Counsel submitted that the circumstances surrounding this flare-up are unclear. It is unclear whether she was working part time or full time and it is unclear how shoulder pain would have flared-up from an MVA related injury in the course of the Appellant's return to work, especially since the employer asserted she wasn't lifting heavy amounts in the course of her return to work. It is unclear how much of the Appellant's decision to quit work concerned her fear that she would be laid off. Counsel noted that the Appellant did not attend to see her family physician until mid-August, several weeks after her return to work and that the Appellant did not contact MPIC about the flare-up in symptoms until September 2013.

Counsel submitted that the Appellant bears the onus to establish that her left arm and shoulder symptoms ongoing from August 16, 2013 are casually related to the MVA. In consideration of the evidence and circumstances as a whole and in light of the Appellant's failure to attend the hearing to provide explanations, counsel submitted that the Appellant has not met this onus and requested that the panel uphold the Internal Review Decision dated June 25, 2014.

Discussion:

The onus is on the Appellant to show, on a balance of probabilities, that her ongoing left arm and shoulder symptomology is causally related to the MVA of February 22, 2013.

The relevant provisions of the MPIC Act are as follows:

> **Definitions**
> 70(1) In this Part,
> **"accident"** means any event in which bodily injury is caused by an automobile;
>
> **"bodily injury caused by an automobile"** means any bodily injury caused by an automobile, by the use of an automobile, or by a load, including bodily injury caused by
> a trailer used with an automobile...
>
> **Application of Part 2**
> 71(1) This Part applies to any bodily injury suffered by a victim in an accident that occurs on or after March 1, 1994.

The Appellant was initially diagnosed with rotator cuff strain. MPIC accepted that this injury was caused by the MVA of February 22, 2013 and the Appellant received PIPP benefits, including physiotherapy treatment and a reconditioning program. At issue is whether the Appellant's ongoing left arm and shoulder symptomology, which was first reported to MPIC in September 2013, is caused by the February 22, 2013 MVA.

After review of the documentary evidence, the panel finds that the details concerning the Appellant's return to work, such as what symptoms she was experiencing, how many hours she worked and what duties she performed are unclear. It is also unclear as to when the Appellant's left shoulder symptoms worsened and what the circumstances surrounding this relapse or flare-up of symptoms were. As indicated, the Appellant failed to attend the hearing, provide testimony to clarify these events and circumstances and be cross-examined on this testimony.

The evidence clearly establishes that the Appellant was deemed fit to return to full work duties at the packaging plant following completion of the reconditioning program. There is no indication that the Appellant ever advised MPIC that she disputed her ability to return to work at full duties

at that time. While the physiotherapist at the program noted that the Appellant reported her left shoulder continued to be problematic with activity, the Appellant was found to have demonstrated the ability to lift 50 lbs and had full range of motion in her left shoulder. The Appellant's main pain complaint at the time of discharge from the program appeared to concern her low back rather than her shoulder. When the Appellant contacted her case manager on June 21, 2013 regarding her completion of the program, she requested that she return to work on a gradual basis because her low back was "still really sore". Despite the Appellant asserting that her family physician suggested this gradual return to work, there is no record of the Appellant having attended to her family physician after completion of the reconditioning program and before her return to work.

The Appellant attended for a psychological assessment on July 15, 2013, a few weeks after her return to work. While the Appellant reported concerns with pain in her lower left back, left shoulder and left leg, she described her current pain in session as mild. The Appellant indicated that her back pain at times can disrupt her sleep and expressed concerned about her ability to perform in her pre-MVA employment.

The Appellant did not seek medical attention for her left shoulder until over a month after her return to work. Her family physician's chart note of August 16, 2013 states that the Appellant reported being back at work since June and working nearly full-time, but was concerned that she would be laid off as the business was not thriving. While the note records that the Appellant reported ongoing left shoulder pain and feeling that she returned to work too soon, it also records that the Appellant had good shoulder range of motion.

In September 2013, the Appellant advised MPIC that her shoulder was bothering her and that she had decided to return to school. The handwritten and undated letter from the Appellant's employer indicates that the Appellant advised her employer that she was returning to school because of her physical limitations. The panel agrees with counsel for MPIC that there is nothing in the Appellant's medical file that indicates her family physician or any other health care practitioner advised the Appellant to quit working full time at her job at the packaging plant. The family physician's chart note of October 28, 2013 simply states that the Appellant "claims unable to do work at packaging factory" and that the Appellant had returned to school.

The employer's undated handwritten letter states that the Appellant's duties and hours after her return to work in June 2013 were limited due to her "pain and discomfort". The panel finds that this is inconsistent with the Appellant's report to the psychologist that she returned to full time duties and the documentation of working full time in the family physician's chart notes. Further, it is unclear why the Appellant would wait until September 19, 2013 to contact MPIC regarding IRI benefits if she felt she was unable to work full time due to do her MVA injuries. The panel notes that there is no specific mention in the employer's letter of left shoulder pain. As such, it is unclear whether it was shoulder pain or lower back pain that the Appellant felt was preventing her from performing any work duties.

The Appellant provided a March 31, 2014 physiotherapy report in support of her appeal. This report states that the Appellant gained strength in the reconditioning program she attended before her return to work, but that the program "did nothing to help with the pain symptoms". This is clearly inconsistent with the 4 week progress report from the reconditioning program which showed that the Appellant's shoulder pain had greatly reduced over the course of the program.

The panel recognizes that both the Appellant's family physician and physical medicine and rehabilitation specialist indicated that the Appellant's left arm and shoulder symptoms are causally related to the MVA. However, neither physician provides any rationale for this opinion other than relying on the temporal relationship between the Appellant's first report of symptoms and the MVA. Further, neither physician addresses how the Appellant's flare-up of symptoms several weeks after her return to work is MVA related in light of the documented objective evidence of improvement in pain and functional ability after completion of rehabilitation. In contrast, the MPIC HCS consultant provides comprehensive discussion of the various diagnoses and causation in light of the documented medical evidence in the Appellant's file.

Unfortunately, the Appellant did not participate in her appeal and therefore did not provide testimony on her left shoulder pain complaints at the time of her completion of rehabilitation and return to work, what duties she performed on her return to work, and the specifics and circumstances surrounding her relapse or flare-up of left shoulder symptoms. Further, there are inconsistencies in the reports of pain and functional ability in the documentary evidence. As noted above, the onus is on the Appellant to prove, on a balance of probabilities, that her ongoing left arm and shoulder symptomology is related to the MVA of February 22, 2013. Given the inconsistencies in the Appellant's reports of pain and her functional ability after completion of the reconditioning program and her return to work and the Appellant's failure to participate at the hearing to provide testimony on the specifics and circumstances after her return to work and the flare-up of shoulder symptoms, the panel finds that the Appellant has not met this onus. This result may have been different had the Appellant chose to participate in her appeal.

Disposition:

Accordingly, the Appellant's appeal is dismissed and the decision of the Internal Review Officer dated June 25, 2014 is upheld.

Dated at Winnipeg this 19th day of October, 2017.

KARIN LINNEBACH

BRIAN HUNT

NEIL MARGOLIS