Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-15-211

PANEL:	**Ms Laura Diamond, Chairperson** **Mr. Brian Hunt** **Ms Linda Newton**
APPEARANCES:	**The Appellant, [text deleted], was represented by Mr. Ken Kalturnyk from the Claimant Adviser Office; Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Andrew Robertson.**
HEARING DATE:	**October 3, 2019; October 4, 2019 and October 7, 2019**
ISSUE(S):	**Whether the Appellant is entitled to Personal Injury Protection Plan (PIPP) benefits for his current back condition.**
RELEVANT SECTIONS:	**Section 70(1) of The Manitoba Public Insurance Corporation Act ('MPIC Act')**

Reasons For Decision

Background:

The Appellant was involved in a motor vehicle accident ("MVA") on December 3, 2013. On June 9, 2015, he contacted MPIC to open a bodily injury claim regarding injuries to his back. The Appellant had undergone back surgery years prior to the MVA. Although he did not experience any pain immediately following the MVA, approximately six weeks post-MVA, he began experiencing pain in his right buttock. Although he attended for physiotherapy, he began experiencing right leg pain and back spasms. The pain got progressively worse with time.

He sought medical care and was seen by his surgeon. An MRI showed that screws in the Appellant's back from the previous surgery had snapped. The Appellant underwent back surgery to replace the damaged screws. The Appellant and his surgeon were of the view that this injury to his back was caused by the MVA.

The Appellant's case manager wrote to him on August 6, 2015, indicating that MPIC did not agree that the damage to the screws and injury to his back were caused by the MVA. Therefore, the Appellant was not entitled to PIPP benefits as a result of the MVA.

The Appellant sought an internal review of the case manager's decision and on October 21, 2015 an Internal Review Officer (IRO) for MPIC upheld the case manager's decision, concluding that the medical information on the Appellant's file supported the opinion of MPIC's medical consultant. The Appellant's injuries, signs and symptoms were not caused by the MVA.

It is from this decision of the IRO that the Appellant has now appealed.

Disposition:

Upon careful review of the documentary evidence and testimony, the panel concludes that the Appellant has met the onus upon him of establishing, on a balance of probabilities, that his back condition was caused by the MVA, and that he should be entitled to PIPP benefits as a result.

Evidence for the Appellant:

Documentary Evidence

The Appellant relied on reports from his orthopedic surgeon, [text deleted]. In a report dated November 12, 2014, the surgeon provided a history of the Appellant's back condition, past surgery and treatment. He indicated that he had examined the patient and reviewed X-rays which

confirmed a broken screw at L5 with increased motion at L4-5. He concluded that before the MVA the patient had been doing well with his long fusion and that his current problems stemmed from the MVA and subsequent fracture of the screws at L5. He suggested that the patient probably was stable until the accident and indicated that he had requested a new MRI scan.

[Appellant's orthopedic surgeon] provided another report dated June 8, 2015. The patient still had persistent pain in his back and left leg causing weakness. An MRI scan showed the broken screws and the flexion and extension views confirmed significant instability. He indicated that the patient would be going ahead with revision surgery.

On October 27, 2015, the surgeon provided a report regarding his visit with the Appellant six weeks following his revision surgery. He stated:

> "I also need to reiterate to you that this operation was done for revision surgery after the patient was involved in an motor vehicle accident. Prior to the motor vehicle accident he had no problems at all and no pain in his back at all. He now presented with progressive pain which necessitated the revision surgery and this is purely the result of the accident in my opinion."

The surgeon provided a final report dated May 22, 2019. In this report, he addressed suggestions by MPIC's Health Care Services consultant which had indicated that broken hardware can be a relatively common finding in post-operative cases. The surgeon opined that the fact that there was no pain until the accident and then slow progressive pain after the accident indicated to him that there was a temporal relationship between the accident and the progressive pain. Even if the rods were broken earlier, there had been enough stability of the spine to allow complete resolution of his pain. This changed after the accident. Through subsequent imaging and

intraoperatively, he found that there was a definite nonunion of the intended fusion and in his view the accident certainly caused progression of the instability at that level.

The Appellant also provided chart notes from his physiotherapist's office, [text deleted], including a chart note dated March 28, 2014. It is worth noting that this particular note mentions a two-year history of right lower buttock ache with tingling down the right hamstring to the ankle at times, which has been progressing.

The panel also reviewed chart notes from the office of the Appellant's general practitioner, [text deleted]. These notes did not show a significant history of back pain leading up to the MVA, although they do reflect a prescription for Gabapentin on March 28, 2012 for shingles with nerve pain. A note from February 3, 2014 showed a prescription for Tylenol 3. A note from April 22, 2014 noted "no back pain", while an entry dated July 29, 2014 noted "chronic back pain", which the notes then reflect as "stable" by August 7, 2014.

Testimony of the Appellant

The Appellant testified at the hearing into his appeal.

He described the back fusion surgery he had in 2007, explaining the metal screws and bars which had been inserted to hold everything in place. He described the buttock and back pain that he had experienced prior to this surgery. His pain levels were so great that he had to take OxyContin for many years. Although the surgery was successful, he experienced a great deal of pain for the two months following the surgery. Eventually, the pain went away, and except for occasional sciatica, he felt fine. After the surgery, he sometimes had to take Gabapentin, which he understood was for nerve pain associated with the sciatica.

After the surgery, his surgeon stressed the importance of keeping a strong core to support his back. The Appellant enrolled in an exercise program which included biking, walking and exercises for core strength. He also participated in a pool league. He could do things around his home such as cutting grass without worrying too much. He was active in the weeks prior to the MVA, and was even on his way to play pool when the MVA occurred.

The Appellant described the MVA and indicated that he did not attend a hospital afterwards, as he had no symptoms at that time. A few weeks later, he started to notice some pain in his buttock. At first it was not serious, but it was something new for him and it continued to slowly get worse. He attended for physiotherapy and massage.

He had a trip to [country] planned and so asked his family doctor for a prescription to help with buttock pain while on vacation, which his doctor provided in February. On vacation, he experienced a great deal of pain in his right buttock when walking up and down a steep slope and used this Tylenol 3 for the problem.

When he returned from vacation, he went for more physiotherapy for the pain in his buttock. He also continued to attend for massage therapy, which he had been doing on a periodic basis for maintenance. When asked about the physiotherapist's chart note that he had a two-year history of right lower buttock pain, the Appellant denied that he had these symptoms for two years. He indicated that he had occasionally felt some pain but that he certainly did not have sciatica on a regular basis.

The Appellant also explained that when he saw his family doctor for a physical on April 22, 2014, he had pain in his right buttock but his back felt fine at the time. That is why he reported to the doctor that he did not have back pain.

However, at later visits to the same clinic, particularly in July 2014, chronic back pain was noted. The Appellant indicated that by then he had severe sciatica as well as back pain and he was becoming concerned by the severity, thinking that something must be wrong. The pain was not going away and was now constant instead of on and off. It was pretty severe, so he felt that he needed to find out more about what was going on.

X-rays were then taken which showed two broken screws. He was very surprised and couldn't understand the reason for that happening. He went back to see his surgeon and an MRI was performed. At first, the surgeon did not recommend further surgery, but eventually, when a follow-up MRI showed that the screws had moved and things were becoming more unstable, surgery was recommended.

The Appellant had a second back surgery in September 2015. He explained that he still suffered a lot of pain since that surgery, mostly in his buttock. He now suffers from daily pain, especially when he first gets up in the morning and his mobility is more limited. He takes Percocet for the pain as well as Gabapentin. He is not in pain all the time but at certain times, especially in the morning or if he sits too long, his back will react and he has to be careful. He had to change his lifestyle, selling his home to move into a condominium with underground parking etc. He is no longer able to participate in an exercise program.

On cross-examination, the Appellant was asked about his back issues, including sciatica, between 2007 and 2013. He indicated that the sciatica would occur off and on and last maybe a day or so before going away. He described it as different from back pain, as the pain was in the leg and was fairly mild.

He was asked about the Gabapentin that he took between the surgery and the MVA and he indicated that he was taking it three times a day, morning noon and evening on a regular basis, and not just once symptoms flared. He indicated that this was prescribed for maintenance, by his family doctor, when he went off the OxyContin.

The Appellant confirmed that he did not see his surgeon for several months after the MVA. When he saw him, he told him that he had done very well after the surgery and before the MVA, exercising, playing pool and functioning, with a normal life. He did not tell the doctor about having back pain before the MVA because he did not recall having any; he only had bouts of sciatica at that time.

On cross-examination the Appellant was also asked about his referral to a neurologist. He indicated that he thinks he saw the neurologist twice for sciatica. He recalled that when he went to see the neurologist he could barely make it back to his car which was parked a block and a half away, because he had to stop and rest due to the sciatic pain. He confirmed that this was before the MVA, but that this was the only time that pain was that severe up until the MVA.

When asked about the physiotherapy chart note indicating a two-year history of right lower buttock pain, the Appellant denied a two-year history of that pain and indicated that he would have told them that he had had sciatica off and on, but certainly not continuously. The sciatica did not occur regularly, like every month, but would arise more when he did something to aggravate it. He didn’t recall the pain ever being severe or long-lasting enough for him to go back to [city] to see his surgeon.

The Appellant confirmed that he did not experience any pain and was not concerned about pain during the first few weeks following the MVA. But after that, he felt pain in his right buttock, which felt different from the previous sciatica. It was more painful and sharper and not

something he was used to. He denied having right leg pain separate and different from the buttock pain. He couldn't remember exactly when the back pain started, but stated that it was sometime in the spring, at least a couple of months after the MVA. He confirmed that at first he did not believe the buttock and back pain were related to the MVA.

The Appellant was also asked about his failure to report his back pain to his physiotherapist or to his family doctor during a physical examination. He indicated that he was there for a physical and was not a complainer, so the pain would have to be very serious for him to mention it. He had suffered pain for a long time and had become used to it; it would have to change for him to notice that something was different. Therefore, he wouldn't have mentioned it at a physical unless he was experiencing very different pain. When asked why he didn't mention stronger, sharper pain at his doctor's appointment for a general physical after the MVA, he indicated that he also had been back on OxyContin since April. He then acknowledged that he was not sure about when he received his prescription and that it could have been in 2015.

When asked why he did not mention his back pain to his family doctor in May or June 2014, if he was already having back buttock and leg pain at that time, the Appellant indicated that he would not have mentioned it unless it was really severe. He stated that he has experienced back pain since he was 15 years old so unless it was something really out of the ordinary, he wouldn't have said anything.

Testimony of [Appellant's orthopedic surgeon]

[Appellant's orthopedic surgeon] testified at the appeal hearing and was qualified as an expert in orthopedic surgery with a special focus on issues relating to the spine. During questioning regarding his training and experience he confirmed that he also has experience (in his home

country of [text deleted]) with determining medical causation and forensic medical reviews, as a founding member of an orthopedic legal group.

The surgeon described the Appellant's back surgery in 2007 as a decompression and fusion with bone grafting and fixation. Following recovery from the surgery, the Appellant did well. He was aware that the Appellant had been separately referred to a neurologist in 2010, following a prior consultation with the neurologist in August 2008. However, the surgeon did not have a copy of the first consultation.

The surgeon testified that broken screws do occur from time to time, following such surgeries, in the absence of a traumatic incident. When this happens, the patient would normally complain of pain. In this case, the Appellant had no complaints of pain until the MVA, when the extent of pain rapidly escalated. So, in his view, without the definitive proof of an X-ray the day before the MVA and the day after, the Appellant's complaints of pain following the impact pointed to a causal relationship between the screws breaking and the MVA.

He had not seen the Appellant for many years between the surgery and the MVA and his assumption was that the patient was experiencing a reasonably healthy lifestyle. That changed after the MVA.

The surgeon noted that in the 2007 surgery, the Appellant had a bone fusion as well. Therefore, a screw breaking could mean that there would be more stress applied to the bone graft. The patient may not experience severe pain immediately following the MVA where the breaking of the screws happen. The development of pain may be delayed until a stress fracture develops in the fusion mass.

The Appellant's first reports of pain in the right buttock a month or so after the MVA could be related to damage to the nerve during impact or could be due to irritation, ongoing compression or permanent damage to nerve fibers. It would not be unusual for this symptom to come and go as these symptoms can typically wax and wane over time depending on activity and position. That kind of irritation would also respond to massage and physiotherapy.

The surgeon agreed with the statement expressed by MPIC's Health Care Services consultant indicating that screws can break in the absence of an incident and disunion of vertebrae can also occur as a result, in the absence of an incident. If there is an incomplete union of intended fusion, constant motion will result in metal fatigue. However, once the vertebrae have fused after a period such as a year, there would be a strong resulting union and it would take significant force to break it.

The surgeon was asked to comment on the statement of MPIC's Health Care Services consultant which indicated that hardware screw failure in the absence of an event is not uncommon, with literature reporting an incidence of hardware failure ranging anywhere from 3-15%. He agreed and was then asked whether this would indicate that 85-97% of screw failures occur due to trauma. The surgeon, who had participated in the publishing of the statistics, indicated that the 3-15% statistic actually represented a statistic of overall failure of screws with no causation attributed and no relation to or mention of trauma either way.

The surgeon confirmed that he did not see the Appellant between April 2007 and November 2014.

He was asked to expand upon the conclusion in his reports that, based upon the imaging and his intraoperative findings, the MVA had caused the failure of the screws and the Appellant's back pain and symptoms. The surgeon indicated that where there is a nonunion following back surgery, the nonunion is diagnosed by two things. The first is the patient's complaint of persistent pain. The second involves X-rays taken in bending positions to see if there is movement. The fact that the patient had not seen him for seven years prior indicated stability and a lack of pain. Yet after the MVA, the Appellant came back with pain and progressive instability on X-rays. Intraoperatively during the second surgery, the surgeon found that the movement concerns related to break down of the fusion mass. Accordingly, he remained of the opinion that the MVA caused progressive instability and the Appellant's subsequent symptoms.

On cross-examination, the surgeon confirmed that the Appellant had some issues with bladder control following the first surgery and that this had to do with an atrophy of muscles of the leg, as far as he could recall. He had not recorded the Appellant as suffering from other issues following the surgery. The neurologist's reports indicated some right foot S1 changes, which he confirmed could be sciatica. He reviewed a copy of a report provided to him by [text deleted] in March 2011 where the neurologist mentioned a history of S1 radiculopathy, which is sciatica.

The surgeon was asked whether anything had been nicked during the first back surgery. He indicated that the reports showed there was a small dural tear (dural is the covering of the nerve).

He indicated that he had never diagnosed a muscular impingement following surgery.

He confirmed that his stated opinion that the Appellant was doing very well up until the MVA was based on the history provided to him by the Appellant as well as the fact that he had not seen him for all those years. He confirmed that his opinion that the MVA had caused the screw breakage and the need for the revision surgery was primarily based on the differences in his

condition which the Appellant described before and after the MVA, as well as the lack of documentation of any other treatment, X-rays or anything to indicate that there were ongoing problems. It was his understanding that the Appellant had no back pain until the MVA and slow progress of pain afterwards, based on the Appellant's advice to him. He was aware that the Appellant did not have immediate back pain following the MVA but that this developed over time and that the back pain was activity related and variable from day to day.

The surgeon confirmed that the physiotherapy chart notes from March 2014 regarding lower buttock aches with tingling down the right hamstring were consistent with the complaints of leg pain and back pain after the MVA which the Appellant had described to him.

When asked about the improvement in the buttock and radicular leg pain which the Appellant experienced after physiotherapy (documented in a physiotherapy note dated April 25, 2014) the surgeon described two different aspects of pain, including mechanical and neurogenic components which can occur independently or together. It is possible to improve one with physiotherapy.

When asked whether the Appellant taking Gabapentin morning, noon, and evening as maintenance treatment for sciatica would suggest that the Appellant was not doing well after his first surgery, the surgeon indicated that while Gabapentin is a great drug for nerve pain, it does not help with mechanical back pain. He believed it would have helped with the S1 radiculopathy mentioned by the neurologist, but it would not affect back pain.

The surgeon was also asked whether the Appellant's failure to report back pain to his doctor during a physical examination in April 2014 and his failure to report any back symptoms in May and early June 2014 was inconsistent with the slow progressive pain development following the MVA which the surgeon had described. The surgeon indicated that there could be a delay in the

development of pain and that he was not sure of how long that delay would be. He remained of the view that the Appellant's development of pain following the MVA could be described as slow and progressive.

When asked whether the Appellant's pre-MVA history of sciatica, and usage of Gabapentin, along with some difficulty walking and referral to a neurologist suggest that the Appellant was not doing well before the MVA, the surgeon did not agree, as there is a difference between back pain and leg pain.

When asked to explain the delay in presentation of back pain, the surgeon indicated that once the screws were broken, more stress was placed upon the bone graft and a stress fracture resulted. Before the MVA, the bone graft had the support of the mechanical instruments. The screw can break and a nonunion develop over months as a stress which becomes acute. There need not be any pain associated with the initial breakage of the screws. Some individuals are very happy, with no discomfort, but X-rays show broken screws. But a stress fracture can develop over time and overload the bone graft and fusion mass, because the screws are no longer there to support it. Without X-rays from the day before the MVA and the day after, to show that the screws were intact the day before the MVA, there was no 100% science to prove this. However, the surgeon remained of the view that the MVA led to instability of the bone graft.

Evidence for MPIC:

Documentary Evidence

MPIC relied upon documentary evidence including physiotherapy, case manager and physician chart notes as well as reports from its Health Care Services (HCS) medical consultant.

Physiotherapy chart notes from [physiotherapist office], dated March 28, 2014 noted a “2 year hx right lower buttock ache with tingling down the right hamstring to the ankle at times, has been progressing”.

A note from April 11, 2014 indicated that treatment such as daily stretching was helping a lot. A note dated April 25, 2014 indicated that the Appellant no longer had radiating leg pain and his back was feeling better.

The Appellant’s case manager created a note to file on June 16, 2015. This note documented the Appellant’s experience of pain in his right buttock approximately six weeks post-MVA which was treated with physiotherapy. The pain then subsided. Approximately the end of January 2014, the Appellant began experiencing back spasms which went away after six weeks. He then began experiencing right leg pain which got progressively worse with time.

Chart notes from the Appellant’s general practitioner showed a prescription for Gabapentin on March 28, 2012. The chart notes also showed that the Appellant did not report back pain until July 2014, and that during April visits of that year he reported that his back felt fine.

Finally, MPIC relied upon three reports from [text deleted], a Health Care Services medical consultant.

The first report, dated August 5, 2015 made note of the Appellant’s pre-existing back problems, failure to report injuries following the MVA, and the absence of evidence showing reported lower back problems shortly following the MVA. He noted the April 22, 2014 physician clinic notes where the Appellant reported no back pain at that time during a normal physical exam. The first report of back pain was not documented until July 2014, eight months after the MVA and so, a temporal relationship could not be established.

[HCS medical consultant] also cited:

> The understanding that hardware / screw failure in the absence of a specific event is not uncommon (literature reporting an incident of hardware failure ranging anywhere from 3-15%).

In a further report dated August 15, 2016 [HCS medical consultant] reviewed the report from the Appellant's surgeon dated October 27, 2015. He disagreed with the surgeon's statement that the Appellant had no problems and no pain in his back at all prior to the motor vehicle accident, by relying on the March 28, 2014 physiotherapy note of the two-year history of right lower buttock ache with tingling down the right hamstring to ankle. He also noted the Appellant's ongoing sciatic pain, which the surgeon had attributed to "more muscular impingement". He noted an assessment by a nerve specialist who advised that no treatment was required other than medication for pain as well as clinic notes which did not make reference to the MVA.

He went on to comment that:

> The evidence obtained from this clinic note indicates [the Appellant] was experiencing problems with the buttock and leg prior to the incident in question. In other words [the Appellant] was not pain free prior to the incident in question and was in fact having problems with the back. The evidence suggests [the Appellant] was assessed by [Appellant's orthopedic surgeon] at some stage after the spinal fusion and before the incident in question as well as by a nerve specialist, which would support the position that [the Appellant] was having problems with the low back and right leg following the spinal fusion (i.e., had not recovered to the extent he had no problems or as was pain free.)

In his final report, dated June 24, 2019, [HCS medical consultant] reviewed a report from the surgeon dated May 22, 2019. He stated:

> [Appellant's orthopedic surgeon] documented that [the Appellant] did not have pain until the accident and then slow progression of pain afterwards. This is clearly not borne out in the other documents submitted to the claim file. It appears that [Appellant's orthopedic surgeon] opined a temporal relationship exists between the incident in question and the progressive pain, based on this understanding. The

> totality of evidence does not support [Appellant's orthopedic surgeon]'s understanding.
>
> [Appellant's orthopedic surgeon] documented that subsequent imaging and intraoperatively it was found that there was definite nonunion of the intended and fusion at L4-5 and therefore the accident certainly did not cause progression of the instability of the L4-5 level. I was not able to locate medical evidence supporting this opinion.

Finally, [HCS medical consultant] addressed the surgeon's statement that "Whether the screws were broken prior to that or not does not really alter the fact that the patient was pain-free until the accident and the pain developed thereafter". [HCS medical consultant] opined that "This statement is without merit.… [Appellant's orthopedic surgeon] did not make reference to evidence that might support his statement."

Testimony of [HCS medical consultant]

[HCS medical consultant] was qualified and testified as an expert in musculoskeletal medicine and forensic file review. He advised that he had reviewed the Appellant's medical file and prepared several reports. He reviewed information regarding the incident in question, medical assessments which took place following the MVA and communications between the Appellant and his MPIC case manager. As a result of this review, he concluded that a medically causal relationship could not be established between the MVA and the Appellant's reported back problems associated with the broken screws in his back.

The Appellant did not undergo assessment after the MVA, in the days or weeks after that would help determine what potential conditions could arise out of the MVA. There was no evidence that any injury took place at all, with chart notes from April 2014 showing no reference to back pain or problems and the first notation of back problems appearing July 2014. That documentation in July 2014 did not establish a temporal relationship between the MVA and the

onset of back pain. In the absence of bodily injury to the Appellant and the first documentation of back pain in July, it was his opinion that the later diagnosis and documentation of screw failure was not a probable outcome of the MVA. In his view, the experience of trauma to the back that would jeopardize the hardware of bony structures would be a painful experience and present some level of dysfunction shortly after a traumatic event of that magnitude. He would have expected to see a report of problems in the lower back within a week following the MVA.

In his testimony, [HCS medical consultant] confirmed that the reference to hardware/screw failure in his report of August 5, 2015 does include hardware failure due to bone trauma and non-trauma, without distinguishing between the two. When asked on cross-examination why his report placed the reference to literature reports of hardware failure ranging from (3-15%), directly behind his note that "such failure in the absence of a specific event is not uncommon", [HCS medical consultant] indicated that he did not intend that statement to appear as though he was clarifying the previous phrase by providing statistics for hardware failure in the absence of trauma.

In a review of the physiotherapist's chart note of March 28, 2014, referring to the two-year history of lower buttock ache, [HCS medical consultant] drew the conclusion that this was a problem resulting from complications from the Appellant's original back surgery, and that the symptoms had persisted post surgery. He did not know if that was the same side that had been affected pre-surgery, but believed that the buttock pain would most commonly be related to the fusion and hardware and stemmed from the old surgical procedure, particularly if the reticular nerve had been irritated which, in his experience most likely would come from the back. He believed this stemmed not just from a muscular component but also comprised neurological symptoms in reference to the leg, showing nerve dysfunction and irritation which would require

medications to help with those neurological symptoms. As there is no reference to the MVA in the chart notes, he concluded that this was part of the surgical process.

The report to the physiotherapist on April 25, 2014 that his back pain was feeling better suggested that the Appellant's condition was improving, there was no longer a real concern about a back issue and the leg issues were getting better.

[HCS medical consultant] also noted the Appellant's past history of using various forms of pain medication and an anticonvulsant, Gabapentin, used to treat nerve pain. He also explained that the surgeon's reports had been based upon the assumption that the Appellant had no problems of back pain at all prior to the MVA, which was not borne out by his records. He was having some problems and they were significant if he was taking Gabapentin at those levels. [HCS medical consultant] did not agree that the levels of Gabapentin prescribed would relate to the Appellant's diagnoses of shingles.

When asked why a therapy chart note of a history of buttock pain led to the conclusion that the Appellant was having problems with his back, [HCS medical consultant] stated that the most probable reason the Appellant was having buttock pain was radiculopathy. Various causes of radiculopathy were possible, but a high percentage of same were due to back pathology. The Appellant had residual problems with nerve irritation, which most often stem from back problems. [HCS medical consultant] indicated that if such a patient came into his office with this clinical presentation he would not tell them that their back was perfectly fine and they have a pinched nerve. Rather he would tell them that they have back problems, possibly with a disc, degenerative or nerve related.

He did not believe it was plausible that screws were broken but that the pain developed over time after this caused a stress fracture in the fusion. It did not make sense to him that there could be

enough trauma to fracture hardware and alter the spinal structure without back pain shortly after the MVA.

Although admitting to limited experience with orthopedic surgery, [HCS medical consultant] felt that the issue was one of causation and that one did not need surgical expertise to address forensic concerns. In forming his opinion, the surgeon was relying upon what the Appellant had reported to him as a slow progressive increase in back pain, without documentation to support this.

On cross-examination, [HCS medical consultant] admitted that he could not speak to the magnitude of the MVA or dispute the assertion that the Appellant's car was "totalled". He also agreed that in reviewing the physician's chart notes between 2012 and 2015 there was no mention, prior to the MVA, of back pain, buttock pain or tingling down the leg. As well, the surgeon's evidence confirmed, he agreed, that the last report of the Appellant's sciatica was documented in March 2011. However he still believed, based upon the physiotherapy notes, that the Appellant had a two-year history of back pain between 2012-2014.

Although [HCS medical consultant] agreed with the surgeon's comments that pain from broken screws can be delayed by as much as several months, this would only occur, he noted, if the screws broke through the passage of time, later altering the stability of the spine. But acute events occurring to break the screws would require significant force and the patient would present with pain at a much earlier point. Where a compression fracture occurs through the passage of time, it may not be symptomatic until it has progressed, but in the acute traumatic sense, he did not think that would be common.

Also on cross-examination, [HCS medical consultant] was presented with the surgeon's explanation for the reasons behind the Appellant's symptoms: i.e. 1) the screws broke as a result

of the MVA and 2) this in turn led to greater flexion of the lower spine resulting in irritation of the nerve and giving rise to buttock pain and tingling in the leg a month later and 3) several months later that same greater flexion of the lumbar spine led to a stress fracture in the bone graft. [HCS medical consultant] disagreed. In his view, the more reasonable explanation is that since the MVA took place the Appellant had no problems and did not report pain, the problem started prior to the MVA. The Appellant had pre-existing ongoing sciatic pain and back problems, most likely including screw failure, which irritated the nerve. Treatment helped resolve that problem, which was better in April, but the back ultimately decompensated in July.

Submissions:

Submission for the Appellant

Counsel for the Appellant submitted that the testimony of the Appellant and his surgeon showed that while he had severe back pain prior to his 2007 surgery, he was able to function normally after the surgery. He experienced periodic bouts of sciatica, which were referred to a neurologist, but no longer had to take OxyContin, and remained on Gabapentin as a preventative measure for nerve pain/sciatica. The surgeon's testimony confirmed that Gabapentin is useful for nerve pain but not for mechanical back pain. The dosage of Gabapentin was also increased when the Appellant had a bout of shingles.

Throughout the years following the 2007 surgery, the Appellant was able to play pool, go to the gym regularly and exercise to maintain his core strength. He was relatively pain free for several years prior to the MVA. This was supported by his general practitioner's chart notes going back to March 2012, with no mention of back pain in these notes prior to the MVA. The neurologist reports (to which the surgeon referred) dated back to March 2011, so there was no evidence of ongoing back problems or even sciatica for almost three years prior to the MVA. Then, on

February 3, 2014, two months after the MVA, in preparation for a vacation, the Appellant was given a prescription for T3, which he testified was for right buttock pain. Upon his return from vacation, massage therapy and physiotherapy helped to decrease that pain, by late April 2014.

However, in late June or July 2014 the Appellant's back pain became severe enough that he was sent for an MRI which demonstrated that two screws in his back had broken. A follow-up MRI confirmed this condition, eventually leading to additional spinal surgery.

Counsel for the Appellant relied upon several medical reports and testimony from the Appellant's surgeon. The Appellant had admitted that he felt no pain immediately following the MVA. The surgeon indicated that it is possible that the screws had broken without any pain. Initial symptoms of pain in the right buttock and tingling down the leg were most likely a consequence of irritation of the nerve due to inflammation, as the breakage of the screws would allow for greater flexion of the lower spine, resulting in greater stress on the muscles and ligaments in the area. This condition could respond to massage therapy and physiotherapy.

However, this resulting increased movement of the lower spine eventually led to a stress fracture of the bone graft at one level. The surgeon indicated that this fracture was confirmed by both pre-surgical scans and intraoperative manipulation. This process leading to the stress fracture could have taken several months. The back pain, which appeared at a later stage, would have been a consequence of the stress fracture.

The surgeon indicated that it would not be possible to be 100% certain when the screws broke, as no X-rays have been taken the day before and then the day following the MVA, which would be necessary to achieve this standard of certainty. Counsel submitted that this was not the appropriate standard in any event. Based upon the lack of symptoms prior to the MVA when he had not returned to the surgeon for assistance and the lack of documentation in his physician's

chart notes for at least a year and a half prior to the MVA, it was the surgeon's view that the MVA was the cause of the Appellant's back pain and the need for further surgery.

Counsel submitted that the surgeon's outline of the scenario explaining the progression of the Appellant's symptoms was reasonable. This included:

1) The stresses from the MVA broke the screws.

2) A few weeks later, due to increase flexibility of the lower spine, the nerve became irritated, causing pain in the right buttock and tingling down the leg. These symptoms responded to physiotherapy and medication, and waxed and waned.

3) The constant flexion of the lower spine eventually resulted in a stress fracture of one of the bone grafts in the lower spine. This resulted in the additional symptoms of severe back pain several months later.

Counsel addressed [HCS medical consultant]'s opinion that this scenario was not likely and that the MVA was not the cause of the Appellant's back injury. [HCS medical consultant] asserted that the Appellant had a two-year history of buttock pain, which was noted in a physiotherapy chart note. He also considered the Appellant's visits to the neurologist to address his sciatica prior to and in March 2011, and his prescriptions for Gabapentin as evidence of this ongoing history of pain.

Counsel submitted that on cross-examination, [HCS medical consultant] admitted that there was no evidence of a two-year history of back symptoms in the general practitioner's chart notes. Further, it was submitted that [HCS medical consultant]'s use of statistics in regard to the incidence of hardware failure was misleading. In his report [HCS medical consultant] had referred to an "understanding that hardware/screw failure in the absence of a specific event is not uncommon (literature reporting an incidence of hardware failure ranging anywhere from 3-15%)" The implication of this statement, it was submitted, was that 3-15% of screw failures are due to non-traumatic causes. However, the surgeon, who is quite familiar with those studies,

stated unequivocally that none of these studies dealt with causation and that the figure of 3-15% referred to *all* failures. Counsel submitted that [HCS medical consultant] either did not understand the studies to which he referred or was trying to muddy the waters. His testimony confirmed that he had no idea what percentage of screw failures occur in the absence of trauma.

Counsel submitted that the surgeon is a proven expert on spinal injuries and surgery, while [HCS medical consultant] testified that he has never performed spinal surgery. It was submitted that [HCS medical consultant] had conceded that the surgeon's experience with spinal surgery, spinal fusion and screw breakage was much more than his own. Further, the surgeon had experience with forensic reviews, which he had done in his practice in [text deleted] and thus had sufficient experience in determining cause and effect within an insurance environment. For all of these reasons, counsel submitted that the surgeon's evidence should be given greater weight by the panel than the weight accorded to the evidence of [HCS medical consultant].

Counsel also noted that the Appellant testified in a straightforward, credible manner. He had made no attempt to deny the absence of back pain immediately following the MVA, although this did not help with his MPIC claim. He was consistent when describing his pre-MVA history of sciatic pain as well as the initial onset of right buttock pain a few weeks after the MVA and the onset of back pain several months later.

Counsel took the position that the evidence showed that, on a balance of probabilities, the MVA of December 3, 2013 resulted in the breakage of the screws in the Appellant's spine and that all of his subsequent pain symptoms followed from that. Therefore, the Appellant should be entitled to PIPP benefits. He asked that AICAC refer the question of defining and quantifying these benefits to the Appellant's case manager, indicating that although the Appellant was retired and

not seeking IRI benefits, other expenses connected to his condition and the second surgery had been incurred.

Submission for MPIC

Counsel for MPIC framed the issue in dispute as whether the fracture of the screws and failure of the back fusion were caused by the MVA. According to MPIC, [Appellant's orthopedic surgeon]'s theory (as expressed through this testimony) that the Appellant was doing well up until the time of the MVA but then suffered from slow progressive pain after the MVA, showing a clear temporal connection between the MVA and the onset of pain, was not a true picture of the Appellant's condition based on the information from various care-provider documentation on file. [Appellant's orthopedic surgeon]'s views were based upon the Appellant's subjective pain reporting and counsel submitted that the Appellant was not a credible historian. It was not a question of the Appellant being dishonest, but rather that preference should be given to the more consistent and objective information on file, such as chart notes were made contemporaneously.

In reviewing the Appellant's testimony, counsel questioned the reliability and credibility of his evidence when he stated that his buttock and leg symptoms after the MVA were different from his previous sciatica in that they were sharper and more painful and not something he was used to. He could not explain why he didn't report that pain for such a long time, even during a physical examination with his general practitioner. Counsel suggested there was no plausible explanation provided for his failure to report the symptoms in either April or June 2014 and suggested the lack of such symptom reporting meant that this contradicted the theory of slow progressive pain after the MVA.

Further, notes of conversations the Appellant had with his case manager contain different information from the physiotherapy and general practitioner chart notes. He advised the case

manager that although he did not experience pain after the MVA, he felt pain in his right buttock six weeks afterwards, which subsided, and then back spasms at the end of January 2014 which went away after six weeks. Then his leg pain got worse over time. The chart notes, on the other hand, show right buttock pain three months after the MVA and not six weeks, and no evidence relating to back spasms in early March 2014 or April 2014 there is a prescription for T3 in February 2014 which is not explained in any of the notes.

The Appellant's lack of memory, not just regarding dates but also regarding the specific progression of his condition, was evident multiple times in his testimony. For example, he had difficulty remembering when he saw the neurologist, whether or not he had previous physiotherapy treatment at [physiotherapist office] before March 2014, whether he had an MRI prior to the MVA and whether he had reported a two-year history of buttock pain to the physiotherapist. These inconsistencies suggest that the history he gives of his condition is not reliable and that greater reliance should be placed upon contemporaneous information such as the physiotherapy and general practitioner chart notes, particularly regarding the history of the development of his pain condition.

In reviewing [Appellant's orthopedic surgeon]'s testimony counsel suggested that his assertion that the Appellant was doing well before the MVA and developed slow progressive pain after the MVA, for which the MVA was responsible, was not entirely correct, given the Appellant's ongoing reports of sciatic pain. The file contents show a discontinuous development of pain post-MVA and not a progression. This suggests the Appellant was not suffering from slow progressive pain post-MVA but the surgeon denied this in spite of the long period post-MVA with no back pain, followed by a report of severe chronic pain in July 2014.

In regard to the surgeon's theory, as put forward in the submission of counsel from MPIC, that there were three steps in the process between the breakage of the screws and the Appellant's ultimate pain condition, counsel contrasted the surgeon's evidence that the actual breakage of the screws can be painless, with [HCS medical consultant]'s evidence that trauma sufficient to break the screws would be likely to cause pain and injury. In addition there did not seem to be any particular basis for [Appellant's orthopedic surgeon] to put forward the idea that the onset of pain could be so delayed yet still be caused by the MVA.

Although counsel recognized that [Appellant's orthopedic surgeon] does have a great deal of expertise in the field of surgery, his opinion on causation should still be questioned, based as it is on his discussions with the Appellant and the Appellant's reporting of symptoms.

Counsel submitted that although there may not be reports of back pain in the records prior to the MVA, buttock pain occurred, was documented post-MVA and had been happening before the MVA. The failure to report back pain after the MVA for such a lengthy period, in spite of contact with both physiotherapist and doctor, leads to the conclusion that it is not reasonable to attribute causation of the Appellant's back condition to the MVA. On a balance of probabilities, he submitted, the Appellant had not proven that the failure of the screws in his back related to the MVA and therefore, the appeal should be dismissed.

Discussion:

The onus is on the Appellant to show, on a balance of probabilities that his back condition was caused by the MVA, thereby entitling him to PIPP benefits. The MPIC Act provides:

> **Definitions**
> 70(1) In this Part,

> **"accident"** means any event in which bodily injury is caused by an automobile; (« accident »)
>
> **"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, but not including bodily injury caused …

The panel has reviewed the documentary evidence on file, as well as the testimony of the Appellant, his surgeon, and [HCS medical consultant].

We have considered counsel for MPIC's comments regarding the reliability of the Appellant's memory and therefore his credibility. The panel notes that the Appellant does of course have a long-standing history of back pain. He then underwent major back surgery in 2007 with a lengthy and painful recovery. He recovered from this surgery but also encountered what he described as sciatic issues, consulting with a neurologist for buttock pain and suspected radiculopathy.

Then, after the MVA the Appellant experienced some buttock pain, and some leg pain and tingling followed by full on back pain, leading to another back surgery.

The documentary evidence confirmed these issues, with some documents showing a reading on the analog pain scale of 10 out of 10. The panel recognizes the fact that the Appellant has suffered from a lengthy history of pain, which may tend to blend together somewhat over time.

However, the Appellant's testimony was consistent with his surgeon's analysis of his condition, including its documentation and history.

The Appellant's pre-MVA history was confirmed by the evidence of his surgeon.

The panel accepts the surgeon's evidence regarding the difference between the reports of sciatic or neuropathic pain with possible radiculopathy and their lack of relationship to the Appellant's back pain or back surgery. He did not believe this was in any way connected to the back pain or surgery, which is why it was referred to a neurologist. He received appropriate treatment, (massage and physiotherapy) which dealt with that pain, although it did recur from time to time. We also accept the surgeon's testimony that Gabapentin was prescribed to address this neuropathic pain (and later shingles) and that, in his view, it is not useful for mechanical back pain. The Appellant described this as a different kind of pain from the back problems which led to his surgery and which he experienced following the MVA and the surgeon agreed with this.

While we understand and appreciate [HCS medical consultant]'s observations regarding the temporal lag in the Appellant's reporting of back pain between the MVA in December 2013 and July 2014, [Appellant's orthopedic surgeon] explained this temporal lag clearly, succinctly and reasonably. [HCS medical consultant] was at something of a disadvantage as he had never seen the patient, who [Appellant's orthopedic surgeon] had assessed and treated over a lengthy period. [Appellant's orthopedic surgeon] had the added advantage of actually having operated on the Appellant's back twice and having made intraoperative observations.

Spinal surgery is [Appellant's orthopedic surgeon]'s specific area of expertise, having seen and operated upon thousands of patients over the years. He is also aware of and familiar with forensic principles of causation analysis. He was very familiar with the medical literature regarding the statistical occurrence of screw breakage and quite clear when explaining the limitations of the literature in drawing any conclusions regarding the causes of breakage.

The panel finds that the Appellant's surgeon presented a reasonable explanation for the cause of the Appellant's symptoms and back condition.

In his view, the screws broke as a result of the MVA. This in turn led to greater flexion of the lower spine, resulting in an irritation of the nerve and giving rise to right buttock pain and tingling in the leg approximately one month later. This was confirmed by the Appellant's testimony and information contained in the Application for Review which he filed on August 24, 2015. His testimony also indicated that the buttock pain that began following the MVA responded to massage and physiotherapy, with some improvement. In February 2015 he asked his general practitioner for a prescription for T3 to take to [country], where his leg pain increased, followed by back pain reported in mid-March.

These back pain reports arose, according to the surgeon, as the greater flexion in his lumbar spine (enabled by the breakage of the screws) increased, with the spine becoming more unstable. This then led to a stress fracture in the bone graft, which resulted in severe back pain, ultimately leading to a second surgery.

The panel accepts the evidence of the Appellant's surgeon that this condition was caused by the MVA and have accorded it a great deal of weight in this appeal. The Commission finds that the Appellant has met the onus upon him of showing, on a balance of probabilities, that the back symptoms and condition which led to his second back surgery were caused by the MVA.

The Appellant's appeal is hereby upheld and the Internal Review Decision of October 21, 2015 is overturned. The Appellant shall be entitled to PIPP benefits arising from injuries sustained in the MVA. The matter will be referred back to his case manager for review and determination of his benefit entitlements. The Commission will retain jurisdiction should the parties be unable to agree on remedies in this regard.

Dated at Winnipeg this 5th day of December, 2019.

LAURA DIAMOND

BRIAN HUNT

LINDA NEWTON