Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-10-087, AC-14-042

PANEL:	**Laura Diamond, Chairperson** **Brian Hunt** **Linda Newton**
APPEARANCES:	**The Appellant, [text deleted], was represented by [text deleted];** **Manitoba Public Insurance Corporation ('MPIC') was represented by Anthony Lafontaine Guerra.**
HEARING DATE:	**Friday February 26, 2021; Monday March 1, 2021; Tuesday March 2, 2021; Wednesday March 3, 2021 Thursday March 4, 2021; Friday March 5, 2021**
ISSUE(S):	**Whether the Appellant is entitled to IRI Benefits beyond November 30, 2008;** **Whether the Appellant's PIPP benefits were properly terminated pursuant to Section 160(a) of the MPIC act.**
RELEVANT SECTIONS:	**Section 83(1), 110 (1) (a) and 160 (a) of The Manitoba Public Insurance Corporation Act ('MPIC Act') and Section 8 of Manitoba Regulation 37/94**

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

Reasons For Decision

Background

The Appellant was injured in a motor vehicle accident (MVA) on July 5, 2008. As she stood on the street in conversation, a passing motor vehicle struck her on the elbow area of her left arm.

She sustained soreness and bruising to her left arm, which worsened overnight and over the next few days. She sought treatment from her family doctor, and was off work from her job as a [text deleted] with a professional association. Her family doctor continued to investigate her condition, provide treatment and recommend that she remain off work. She was in receipt of Income Replacement Indemnity (IRI) benefits from MPIC.

At MPIC's request, she attended for independent physiotherapy and psychological assessments. The independent physiotherapist and MPIC's Health Care Services medical consultant did not believe that she continued to suffer from a medical condition arising out of the MVA that would disable her from working at her employment.

The independent neuropsychologist diagnosed a pain disorder caused by the MVA. MPIC's Health Care Services psychological consultant agreed and approved psychological treatment benefits. She was referred to a psychologist for treatment and attended to him for therapy for almost 3 years. She also continued to see her family doctor regularly. She prescribed medication and referral to various specialists for investigation into why her pain persisted. She was referred to a physical and rehabilitation specialist with expertise in the area of chronic pain and continued to attend to him for treatment, including trigger point dry needling, for several years, until the specialist retired in December 2017.

However, both the neuropsychologist and psychological consultant were of the view that the Appellant's psychological injury did not continue to prevent her from working at her job. Her IRI benefits were terminated on November 30, 2008 by a case manager's decision of March 31, 2010. This decision was upheld by an Internal Review Officer (IRO) on May 6, 2010.

MPIC also engaged private investigation to conduct surveillance of the Appellant in her daily activities. Reports and videotapes of this surveillance were obtained and reviewed by the independent physiotherapist, the independent psychologist and the Health Care Services medical and psychological consultants. Some reports and videos were compared with the activity and function forms which MPIC had asked the Appellant to fill out. MPIC concluded that the Appellant did not have a pain disorder and found that she had knowingly provided false or inaccurate information to MPIC. A case manager's decision of August 29, 2013 terminated all of the Appellant's PIPP benefits pursuant to s. 160(a) of the MPIC Act and an IRO upheld this decision on December 10, 2013.

It is from these Internal Review Decisions (IRD) of May 6, 2010 and of December 10, 2013 that the Appellant has now appealed.

Issues and Determination

The first issue before the panel is whether the Appellant knowingly provided false or inaccurate information to MPIC therefore allowing it to terminate her benefits pursuant to section 160(a) of the MPIC Act. The panel must also determine whether the Appellant was able to work or whether she was entitled to IRI benefits beyond November 30, 2008.

Following a review of the documentary evidence on file, the testimony of the witnesses and the submissions of the parties, the panel determined that the Appellant has not met the onus upon her to show that she has not provided false or misleading information to MPIC. However, the panel also concluded that the Appellant, based upon the clear evidence of several caregivers, has met the onus upon her to show, on a balance of probabilities, that she was not able to return to work as of November 30, 2008. After considering the timing of the Appellant's misrepresentations to

MPIC, the diagnosed psychological and pain conditions which mitigated her behavior at the time, and the manner in which she later presented to her caregivers, the panel has concluded that the termination of the Appellant's benefits should be substituted with a suspension of benefits for the period between November 30, 2008 and July 23, 2010.

Evidence for the Appellant

The Appellant provided several medical reports from caregivers, in support of her appeal. She also testified at the hearing, along with her family doctor, physical rehabilitation specialist and psychologist.

The Appellant

The Appellant testified and was cross-examined at the hearing of her appeal.

The Appellant was approximately [text deleted] years of age at the time of the MVA in July 2008. She had been employed as a [text deleted] with a professional association for over a year. The job involved a lot of typing and data entry as well as various duties such as emailing, booking flights, creating pamphlets and preparing booklets, photocopying, sending membership mail-outs, scheduling and generally assisting labour relations officers, the directors and administrative assistants. She explained that she had hopes and ambitions of eventually becoming a labour relations officer and that she loved her job.

In addition to her work, she had an active recreational and social life filled with camping, motorcycle riding, visiting with friends, shopping, playing with and training dogs, gardening and home renovations. She was physically active and engaged to be married, having jointly purchased a first home.

The Appellant described the MVA. She was standing at the side of the street in conversation with her fiance's family when she was hit at the elbow on her left arm by a passing SUV. She could not estimate the speed of the vehicle as her back was turned to it but it felt really hard. She described an intense, burning pain. She went home and applied ice, but felt pain which interfered with sleep that evening and then continued, along with a headache, during the next day, a Sunday. The pain intensified on Monday as she was getting ready for work. She found it very difficult to carry out her duties at work, due to the pain, burning and sharp sensation in her arm and hands, and headache. She left work early but her symptoms continued. She called and then visited her family doctor over the next couple of days. Her symptoms increased. Despite various forms of treatment they continued and she never was able to return to work.

The Appellant then described a variety of difficulties she encountered with daily tasks such as shopping for groceries, caring for her dog, driving or even sitting for longer than fifteen minutes. All of these things caused pain. She could not have performed her work duties, suffering as she did from a burning pain in her arm, numb hand, tingling. Pain radiated from her elbow through her wrist and hand, up her arm into her shoulder and neck and then down into her back.

She continued to seek treatment from her doctor and many specialists. She tried counselling, trigger point dry needling, and many different medications. Some of this took the edge off her pain, or provided temporary easing like a Band-Aid, but not in a sustained way or enough for her to go back to work. She had difficulty performing everyday household chores and housecleaning.

The Appellant described some strategies for coping with pain that she had learned and employed through Cognitive Behaviour Therapy (CBT) with her psychologist, [text deleted]. She understood that she suffered from a chronic pain condition and that depression and anxiety

played into this. As a result, she had trouble with her relationships. Overall she had a lack of zest for life, could not go out in public and did not feel part of society.

When MPIC stopped funding her psychological treatment, she could not afford to see [Appellant's psychologist] anymore. The specialist who did her dry needling treatments retired and she has not been able to find another doctor who would provide that.

The Appellant also attended for two independent assessments arranged and funded by MPIC. One was with a physiotherapist, [text deleted]. The other was with a neuropsychologist, [text deleted]. She was in so much pain on the afternoon when she saw [physiotherapist] that she used marijuana that morning, for pain control, something which she said she did not often do. She found these encounters exhausting and painful. The sessions with [neuropsychologist] had to be spread out over a few days. All were difficult and caused her pain and intense emotional distress.

The Appellant addressed video surveillance of her which MPIC submitted. She explained that the activities depicted in these videos were limited. When shopping, she leaned on carts for support. When walking her dogs, she limited herself to short walks as even holding the leash was difficult. She said these videos definitely did not represent an accurate description of her everyday function, which fluctuated as a result of many different factors. Some of the videos showed her helping her mother, who was not able to drive for some time, as well as her younger brother. Some days she can go out and do multiple things, but she pays for it that night and even the day after, or longer. She found it difficult to recall exactly what she had done on which days but knows that she had to rest a lot and often, and was in a lot of pain at night. She felt it was a blur.

The Appellant stated that she had not lied on her MPIC function forms or activity logs. She did not intend to mislead anyone when she filled them out. She never exaggerated her condition, but rather, filled out the forms “to the best of her ability and recollection at the time”. Sometimes, she filled out daily logs in batches of several forms at a time, days later, but she testified that she has been open and honest with MPIC and has been wrongfully accused of exaggerating, misleading and providing false information.

She explained that because of her lost income, they had to sell their house and move to a rural area. Still, she did not feel capable of returning to her former job because of the pain she experienced on a day-to-day basis, as well as the psychological conditions she was trying to deal with. She still has difficulty typing, picking up the phone and sitting for longer periods. All those things aggravate and intensify the symptoms in her back, neck, arm, shoulder, wrist, hand and fingers.

The cross-examination of the Appellant touched upon on the details of the MVA, her account of it, and her subsequent reporting to caregivers. She was asked why she did not call an ambulance, the police or attend at the hospital until a few days later, if the vehicle hit her with the force she described. She admitted that the vehicle had not spun her around, as some reports indicated, but that she couldn’t recall everything that happened at the scene. She couldn’t recall exactly what she had told her family doctor about where her pain was when she first went to see her.

Cross-examination also covered her work history, history of other MVAs and MPIC claims, and injuries from other accidents.

The Appellant could not recall much about the physiotherapy treatments that she underwent, except for agreeing that she may have had some treatments on [text deleted] and then later, a few at the [hospital]. She recalled seeing her family doctor about every month.

The Appellant was asked about filing the function and activity forms and the videotaped surveillance evidence was reviewed with her, at length and in detail, for the panel. She watched the videotapes depicting her activity driving, walking dogs, shopping in stores, driving her mother to pick up food at restaurants, hanging Halloween decorations above her head using both of her arms without apparent restriction, attending appointments, going to her mother's condo, using her left hand to buy coffee at a drive-thru, carrying cups of coffee, and driving her brother to and from school. She was then methodically referred to the information she had supplied on her daily activity forms for the same period.

The forms did not reflect this variety of activities and often stated that the Appellant had driven to visit her mother and rested on the couch for most of the day. Some of the forms allocated an hour driving to her mother's place, when she admitted it actually took only 5 or 10 minutes. Some of the forms showed long periods of resting on the couch on days when the videos showed her driving and doing errands during that same period.

She acknowledged that there were more activities on the videotapes than she had indicated on the forms, but added that the forms were often filled out days later, in batches, when she had difficulty recalling exactly what she had done. On numerous occasions she did not explain in any detail, but repeatedly stated that she had simply filled out the forms to "the best of her ability and recollection at the time".

In regard to many of the activities depicted, the Appellant was also asked why she appeared to be doing things which her function forms indicated she could not do. She replied that it wasn't that she could not do them at all, but rather, that it caused her difficulty to do them and that she might suffer for it later in the day, with pain, symptoms and fatigue. When pressed regarding which forms were completed on a timely basis and which were done in batches, she could not recall.

When asked about information she gave to her medical caregivers during the periods of activity depicted in the videos, where she had indicated to them that she had continuing issues with severe pain and an inability to return to work, she could not recall what she communicated at the time. This line of questioning also covered some of the representations made to [neuropsychologist] during her initial assessment, in her attendance at [rehabilitation clinic] and her drug and medication history. The Appellant could not recall these details.

[Appellant's family doctor]

[Text deleted] has been the Appellant's family doctor since 1995.

[Appellant's family doctor] provided numerous medical reports regarding the Appellant's MVA injuries, as well as copies of her clinical notes. She testified at the appeal hearing and was qualified as a primary care physician. .

She first saw the Appellant in regard to the MVA a few days afterwards, on July 9, 2008. She recorded injuries to the left elbow (most tender) as well as to the shoulder. Pain and problems with movement were also documented.

The doctor provided sickness certificates to keep the Appellant off work, at first to investigate the injuries through x-ray. Traumacet and Naproxen were prescribed for pain, as the Appellant was suffering from a lot of discomfort. When the pain continued on for longer than had been expected, a bone scan was ordered, but came back negative. Due to some sensory deficit and numbness in the fingers, she sent her for nerve conduction tests and at one point, to a neurologist to rule out neuropathy and radiculopathy. She recommended physiotherapy, hoping to relieve the pressure in the neck, but limited progress was made in range of motion (ROM) and the Appellant still complained of pain. Her sleep was affected so Amitriptyline was added to her medications. The doctor became concerned that her patient was not improving, and reduced physiotherapy, in case it was too aggressive.

She continued to recommend that the patient remain off work. Although she did try to encourage her to go back to work, hoping that she would improve, efforts to ease her pain were not effective and she began to encounter emotional problems which required help, perhaps related to a worsening of her depression. She suffered from insomnia, pain and stress. The doctor felt that the loss of her work had caused a deterioration in her mental state. The anti-depressant medication that she was taking prior to the MVA was increased. She also began to suffer from abdominal pain, diarrhea and general weakness.

[Appellant's family doctor] found that the Appellant's condition was becoming more complex than had been expected. The neurology consult had not revealed anything which could be improved by surgery, so it seemed the problem was post-traumatic myofascial pain associated with traumatic impact. She referred the Appellant to a physiatrist, [text deleted], who diagnosed myofascial and local pain. This was consistent with her own findings and helped to explain the complex pain. She referred her to a rehabilitation specialist, [text deleted], to help determine why

the recovery was so prolonged and what might assist. He recommended dry needling, which was later performed by [rehabilitation physician].

By this time, the Appellant still had general limitations of function and the doctor concluded that her patient was still not able to return to work. She had quite severe pain and often felt unwell, and objective measurements showed limited movement and function on her left side. The doctor knew that her secretarial job required a lot of physical involvement, such as typing and carrying things. With her severe pain, limited movement and often feeling unwell, her function was not good and she was not able to do tasks like typing and carrying files during an 8-hour workday.

Her working diagnosis was of myofascial pain syndrome associated with traumatic impact from the MVA, with prolonged pain and the resulting stress on the Appellant. Mood disorders such as anxiety and depression were also noted and counselling and medication provided. She continued to see the Appellant on a mostly monthly basis.

A fall and injury to her foot and leg may have aggravated her MVA related symptoms as well.

The doctor also followed the Appellant's progress with the psychological treatment she was receiving with [Appellant's psychologist]. With the therapy and medication, the Appellant showed some mental and emotional improvement. But her pain, discomfort and lack of function continued and the doctor did not believe the Appellant was overacting or lying. She remained physically disabled but although it was not certain and was difficult to predict, the doctor held on to hope that at some point she would be able to return to work.

In cross-examination, the doctor agreed that she did not have any information about what the Appellant had done to seek care between the time of the MVA and her coming to see her for the first time after the MVA. When she first saw her, she advised her to continue with immobilization of her arm while possible fractures etc. were investigated. Her assumption was that the Appellant was not driving during the months that followed, more due to her pain and the limitations on her movement than her medications.

She acknowledged that even after extensive therapy the Appellant was not getting better, so she recommended some sessions be paused, in case the treatment was adding to her dysfunction and pain. She changed the Appellant's medication from Traumacet to Oxycocet, because the pain was not responding to the former, and was still chronic and severe. She was aware of possible side effects and potential for addiction and reviewed these with her patient. The dosage was not high and the Appellant was not particularly sensitive to it, so the Appellant was not prevented from driving while taking it.

When asked about projections that the Appellant might be able to return to work in late fall 2008, the doctor replied that while she was always willing to discuss options for return to modified work, the Appellant's condition was complicated. She was not trying to move her back to work, as she was not ready for it.

The doctor was asked about the Appellant's fall in February of 2014, which took her to the [hospital]. The doctor's notes from a subsequent office visit soon after that did not mention the fall, but the doctor surmised that she may have decided to wait to receive and review the emergency room report from that visit. She did recall reviewing the medications which the hospital had prescribed and recommending some changes.

The doctor confirmed that although she was aware that the Appellant had been seeing [Appellant's psychologist] for psychological support, she had not seen all of his reports. Nor had she seen reports written by [MPIC's HCS medical consultant], [MPIC's HCS psychological consultant], [neuropsychologist] or [physiotherapist]. She had not viewed the surveillance videos.

[Rehabilitation physician]

[Text deleted] is a retired physical and rehabilitation physician who treated the Appellant.

He provided a report dated July 24, 2014 as well as clinical notes. He testified at the appeal hearing and was qualified as an expert in the assessment and treatment of chronic pain conditions.

The doctor's practice often involved consultations with and suggestions to family doctors regarding chronic pain conditions. He offered treatment in the form of myofascial trigger point needling centering around soft tissues and taut muscles that are often the initiators of chronic pain. A trigger point is a hard painful nodule within a taut muscle band which is found through a palpitation technique. He also described the treatment as dry needling.

The doctor described two layers of pain that are involved with chronic pain conditions. One is acute injury which may involve bone or an injury to a nerve. This is usually an injury that lasts approximately 3-6 months (or a little more for a lesion or cut). He described conditions lasting beyond 3 months as chronic pain, which comes on after the injury should have healed and the person still has subjective pain. This may not be objectively visible, and the patient may appear normal while still suffering. As he palpates an area, relying on the patient's reporting, he can

often find trigger points or joint tenderness to identify the painful area. The treatment tries to find the trigger points and stimulate them with needling.

The doctor described myofascial pain syndrome as chronic pain that has gone on longer and has trigger points involved. There is a psychological component to all pain, even acute pain. He explained over-stimulus through the network of nerves and areas of the brain registering pain. An irritable area can bombard the spinal cord over time, overwhelming the brain's ability to assess pain and changing its neuroplasty and ability to handle pain. The brain develops more receptive areas to handle the pain, allowing the chronic pain to continue. Increases can occur in the sympathetic nervous system, with central sensitization. The doctor explained that the literature in this area of study has ballooned over time.

He began seeing and treating the Appellant in 2010 for pain she was experiencing as a result of a vehicle striking her elbow in 2008. He described his examination and assessment of the Appellant and some of the abnormal findings of restrictions in range of motion, soft tissue tension and pain in her neck, trapezius, shoulder, back and elbow. He discovered taut muscle bands when palpating underneath the shoulder, in her lats, pectoral muscles, sternum and clavicle, shoulder blades and forearm. She also noted tingling in her wrists and the funny bone area of her elbow.

The doctor's clinical notes also mentioned a second MVA, but her condition was not much changed as a result.

The doctor described the trigger point treatment. The muscle twitches, breaking down the spasm to release, usually providing some relief of pain within 24 hours. The procedure can be very painful and the Appellant found it so, but she managed it and was willing and cooperative in spite of the pain. The duration of the pain relief is variable.

After a fall on the ice, the Appellant reported more pain and he found that her right side had become more irritated. He also noted that the Appellant was easily upset. He finds that chronic pain causes patients to be emotionally labile and to periodically break down in his office and cry. He found the Appellant to be straightforward and very legitimate in her approach. He never had any sense that her pain was less than she was describing. She had some psychological support and he recommended pursuing that to try and alter her viewpoint regarding her circumstances and to combat resulting signs of anxiety, depression and hopelessness. But even that kind of support does not guarantee that the patient will be helped.

He continued to treat her through 2017, when he retired. Her condition varied as it normally does with chronic pain patients, but she never improved enough to return to her functional level. Some days were better than others but she was never able to do what she did before the MVA. She had pain when trying to maintain any static posture. The pain would build until it reached the point where she could not concentrate or continue. When he retired, he believed the Appellant would benefit more from the team approach offered by a pain clinic. His report of July 24, 2014 was written in an attempt to ask MPIC to get her this kind of services, but this did not really happen.

His diagnosis was set out at page 4 of that letter. He indicated that it was based upon physical examinations and histories taken during multiple visits.

The diagnoses were stated as:

> This [age] woman has experienced a considerable amount of pain in the left head, neck, upper extremity and torso that has created a significant alteration in her functional and psycho-emotional state since being struck by a motor vehicle in July 2008. Her diagnoses include:
>
> 1. chronic non-cancer soft tissue pain affecting the head, neck and shoulders (left >> than right) and left forequarter leading to central sensitivity.
> 2. myofascial pain syndrome with affected muscles of neck and shoulders (left >> than right) and left forequarter demonstrating tender taut muscle bands with trigger points.
> 3. psycho-emotional reaction (anxiety and depression) related to the continual, unrelenting pain, sleep disturbance, physical limitations and continuous frustration – all conditions that have arisen since July 8, 2008.
> 4. left sided thoracic outlet compression.

[Rehabilitation physician] believed that there was a causal relationship between the Appellant's widespread pain problems and the MVA. Although he understood that she loved her job and wanted to continue to work at it, he believed that from the time he saw her, 2 years after the MVA, she was significantly restricted in what she could do. He was aware of her workplace duties, which involved a lot of computer work, and office work with files and phones. The reaching and static, non-supportive positions involved require a significant amount of muscle contraction to stabilize and the muscles have quicker fatigue time, which would then start the pain process. He stated that most sedentary work takes quite a bit of muscular power to maintain the position of sitting and working, so he had no problem believing that this would hurt the Appellant.

He believed that she was committed to getting better. She never resisted treatment or backed away from any treatment suggestions made to her. She maintained a steady attitude and

responsiveness without magnifying or exaggerating her symptoms. He didn't feel she was being untruthful about her condition, and found her to be truthful and forthright. But he noted that if you were to see her at the grocery store or outside walking or driving, you would not know that anything was wrong. Chronic pain is a subjective feeling, but it is still pain. She could move her arm and neck a lot of the time when out and active, but then would have to go home and rest for a day or two afterwards, which would not be visible. That is how people deal with chronic pain.

He believed that the last time he saw her at the end of 2017, the Appellant still had a chronic pain condition and that by that last treatment she had still not made a recovery from her chronic pain condition.

On cross-examination [rehabilitation physician] agreed that he had not seen or treated the Appellant right after the MVA when the initial mechanism was most acute. However, he did not agree that the details of the particular MVA would change his understanding of her diagnosis or prognosis. Pain can change over time. His focus is on the relationship of pain signals up to the brain and coming back down again. He follows the biological psychosocial aspects of the pain through its physical and emotional aspect in the entire milieu of previous experiences and expectations. It is not as clear as seeing a broken arm.

He acknowledged that he did not believe she had much of an injury to her elbow (without judging the significance of the MVA) but it was the catalyst to get the process rolling in her brain. Although she suffered a less serious soft tissue injury than breaking an arm, he could not say that she didn't have an injury. He acknowledged that he may not have correctly recorded all the details of the MVA, such as the speed of the vehicle and that he saw her two years after the MVA.

The doctor also indicated that as time passed, there were periods where the Appellant's injury would be less painful and more usable, but they were not able to predict what she could or couldn't do at any specific time. She was not able to depend on her left upper extremity to do activities she wanted to do. It is typical to see reports of some days better than others. One can have a reasonable day and perhaps overdo it. Then, a couple of days go by where she cannot do a lot and is unable to perform activities or work for long periods of time.

The doctor was aware and had noted that the Appellant had taken antidepressant medication in the past.

He confirmed that it was his view that the Appellant has been and continues to be willing to undergo treatment or activities in order to improve her condition, but that in fact her condition has not improved very much if at all. He agreed that at this point in time she would have a very difficult time returning to a semblance of the work life she had prior to the MVA. She found psychological treatments to be very helpful but he was not aware of the reason why MPIC was no longer funding for such treatment. He had envisioned a team approach; a combination of occupational and physical therapy, along with counselling, working together to help give the Appellant other options for how to think about her pain.

The doctor confirmed that he had not reviewed medical opinions prepared by [MPIC's HCS medical consultant], [MPIC's HCS psychological consultant], [neuropsychologist], [text deleted] or [psychologist], or the reports of [physiotherapist]. Nor had he reviewed the surveillance reports and videos or the level of function forms completed by the Appellant.

[Appellant's psychologist]

[Text deleted] is a clinical psychologist who assessed and treated the Appellant between June 2010 and April 2013. He provided reports dated July 23, 2010, May 2, 2011, July 6, 2011, August 7, 2012, and March 28, 2013, as well as clinical progress notes.

He testified at the appeal hearing and was qualified as an expert in clinical psychology.

[Appellant's psychologist] indicated that he assessed and treated the Appellant for the psychological effects of her pain experience since the MVA. She displayed frustration and pessimism, and was discouraged and worried about the impact of her condition on her life. She was taking antidepressant medication and exhibited significant discomfort and pain behaviours during the initial assessment. He concluded that she was suffering from above average pain severity and a pain-related disability impacting her daily life. His treatment approach used techniques for dealing with chronic pain such as self-coaching, distraction, prayer and hope. This included discussing catastrophic fears and thoughts about the nature of pain.

He diagnosed a chronic adjustment disorder, with onset of psychological symptoms, depression, anxiety and a chronic depressed mood. Since the stressor (pain) had not remitted, her pain condition continued. When he first saw her she was already using some active pain coping strategies but had been experiencing pain for such a long time that it had significantly disrupted her life. The more chronic a condition becomes, the more difficult it is to experience gains or improvement.

His treatment began with introducing pain coping strategies. He recommended more sessions to deal with her mood symptoms. He began Cognitive Behavioural Therapy (CBT) to introduce principles of pain self-management. This is a psychological approach which can be used alongside or in lieu of medications. It involves the role of thinking and behaviour on pain signals. Relaxation strategy instruction is included. This theory looks at the biopsychosocial generators of pain, including the psychological and social factors which may influence and amplify pain. The Appellant was a willing participant in this therapy but he recalled her missing at least one appointment due to higher levels of pain.

Although he indicated in his reports that the Appellant had stopped driving, this was an error and he confirmed that she was in fact continuing to drive. The therapy reviewed pain coping strategies and pacing strategies for her activity level, as well as sleep hygiene. Communication methods with her care providers and family were reviewed to optimize levels of support. He believed that it was important to find ways to remain active. This helps sustain a sense of control, increases social contacts, promotes well-being and decreases rumination and feeling stuck without distraction. He encouraged the Appellant (and all his patients) to try to work.

The doctor discussed the ways in which her depressed mood might present. There may be reduced behaviour, less smiling, pessimistic mood, quieter affect and slower motions. He described the difference between counselling of a more supportive nature and active treatment. Counselling is recommended when additional information and techniques had been exhausted or there seemed to be a plateaued response to psychological treatment.

[Appellant’s psychologist] indicated that he had the opportunity to review the surveillance reports and videos. He observed that in the videos the Appellant seemed to carry lighter bags

than family members, and undertook brief walks with the dogs (limiting to just what was necessary). He noted several instances of her adjusting her gait when walking or grocery shopping, sometimes leaning on refrigerators or display cases for support.

But [Appellant's psychologist] also expressed concerns regarding the surveillance data. Such data is problematic just a snapshot of behaviour. By the time he viewed the data it was between 3 to 4 years old and functions can change significantly during that time, in one way or another. The condition and function of individuals suffering from chronic pain can change from day-to-day and fluctuate drastically, depending upon sleep quality and level of stress. He did not find the footage particularly helpful in determining whether the Appellant was psychologically disabled. It is very difficult to ascertain psychological functioning by watching a brief sample of public behaviour. Internal mood may not always be expressed externally.

He was of the view that the Appellant could not work at the job she had at the time of the MVA. The surveillance information did not reveal an ability to work at an office type job. It was improbable that she could have returned to work at her regular full-time employment, due to her difficulty in sustaining daily activities and ongoing symptoms of pain and disordered mood. Following his last appointment with the Appellant in early 2013, he was of the view that it was unlikely she could return to any regular employment, due to her ongoing pain and continued symptoms of depression.

He believed the Appellant had reported her symptoms consistently over different sessions. He never noted that she exaggerated her symptoms or was faking any aspect of her condition. He would have recorded any exaggeration or malingering in his chart notes and none of his notes suggested there was malingering. In his opinion the Appellant continued to suffer from a

psychological condition resulting from the MVA and her psychological and pain condition prevented her from returning to work at her past employment.

On cross-examination, [Appellant's psychologist] advised that he had not reviewed [neuropsychologist]'s first report and was not aware of any validity issues or concerns reported by her at that time. He does not typically administer such tests for the detection of malingering, as his approach is more treatment than assessment focussed. He does assessment in order to see where the patient's symptoms are at and recommend treatment. Beyond the pain behaviors he noted, such as some shifting in her chair, etc., he did not notice behaviours such as guarding or using her arm as a prosthetic.

He was not aware of a past formal history of psychological issues or depression requiring medication prior to the MVA. When the Appellant first came to him, she was already utilizing some pain coping strategies.

He indicated that he had been provided with a copy of [MPIC's HCS psychological consultant]' report to review but that he did not have a copy of it with him at the hearing. He had also received a copy of [neuropsychologist]'s second report with the surveillance videos, but did not reference it, as he did not find it relevant to the current question. He had noted some passive coping strategies in the videos, but had not reviewed the function or activity forms in order to compare them with the video footage. He did not have a record of reviewing medical reports from [MPIC's HCS medical consultant], [Appellant's family doctor], or [physiotherapist].

Evidence for MPIC

In addition to numerous medical reports and case managers' notes on the Appellant's file, MPIC called upon two members of its Health Care Services team who testified that the hearing.

[MPIC's HCS psychological consultant]

[Text deleted] is a psychological consultant for MPIC's Health Care Services team.

He reviewed the Appellant's file and provided reports dated March 23, 2010 and January 10, 2012. He testified at the hearing and was qualified as an expert in the field of clinical psychology and forensic document examination.

[MPIC's HCS psychological consultant] indicated that when he first reviewed the file, the MVA was described as a relatively minor event. There seemed to be a mismatch between the Appellant's reaction, which involved a variety of pain complaints, and the nature of the MVA. Since different variables can be more significant for some individuals while others can be more resilient, he recommended an independent assessment with a neuropsychologist. He reviewed this report, from [neuropsychologist], which followed testing over the course of a few days. He noted that while [neuropsychologist] had explored some concerns regarding possible symptom magnification, she concluded that the Appellant fell below the test range for malingering. He concluded that pre-existing psychological factors including variables such as personality style (Cluster B traits, possible borderline, histrionic or narcissistic personality disorders) were impacting the Appellant's perceived ability to cope. He agreed with [neuropsychologist]'s diagnosis of a chronic pain condition related to the MVA.

But he did not believe that this pain condition prevented the Appellant from returning to work. Based upon the medical reports, he thought that it was important for her to use her arm and to be active. Getting back to work would help her psychologically. He believed that she would benefit from psychological treatment such as CBT to assist with managing her pain and getting back to work. [MPIC's HCS psychological consultant] agreed that she should continue such treatment with [Appellant's psychologist].

He observed that [neuropsychologist] had noted a more severe presentation than [Appellant's psychologist] reported.

[MPIC's HCS psychological consultant] reviewed the surveillance reports and videos along, with [neuropsychologist]'s assessment of them. He reviewed the psychological documents on file and looked at the videos themselves, extensively, day-by-day, to see what she was doing.

[Neuropsychologist] had changed her opinion about the Appellant's diagnosis after her review. [MPIC's HCS psychological consultant] concurred. The surveillance done in the months following the MVA showed quite a different presentation than [neuropsychologist] had seen in her time with the Appellant. Although a person might not always outwardly display psychological symptoms of how they are feeling, they may still experience some psychological symptoms. But none of the aspects of the Appellant's psychological diagnosis which had been displayed to [neuropsychologist] were observable in the surveillance videos.

He reviewed the description of the Appellant's presentation to [neuropsychologist], with its references to using her arm as though it was in a sling or as a prosthetic, and contrasted this with the videos, where she could be seen moving her left arm freely during multiple trips to a coffee

shop, and using her arm for grocery carts and dogs with no limitations or grimacing. He did not see the kind of pain behaviours presented to [neuropsychologist] and which were described in the activity and function forms the Appellant filled out for MPIC.

Instead he saw a person engaged in normal day-to-day activities such as driving, shopping and going for coffee. She was shown sitting in her vehicle for pretty long periods of time, even though she had indicated that she could only sit for 15 minutes or a half hour at a time. He did not see evidence of her employing overt active or passive coping strategies.

[MPIC's HCS psychological consultant] indicated that a diagnosis of a pain disorder based upon self-reports of adopting a sick role in all domains of life does not work if the patient is selective when showing those symptoms, instead of realistically seeing it across all aspects of behavior. While it is possible for patients to have some good days among bad ones, there were quite a few data points in the surveillance across different days and months where he could see the Appellant engaging in the same repeated activities, without really demonstrating any bad days in terms of her abilities. He would expect to see more bad days across several data points such as these.

[MPIC's HCS psychological consultant] thought that the Appellant's presentation to [Appellant's psychologist], in July, was very different than the way the Appellant had presented to [neuropsychologist] in January 2010. The defined sick role and description of extensive effect of the MVA on her life which were presented to [neuropsychologist] did not appear when she saw [Appellant's psychologist].

[Neuropsychologist] came to the conclusion that this magnification was for the purpose of secondary gain and [MPIC's HCS psychological consultant] agreed with her. The pattern of

behaviour did raise the issue of malingering, and he concurred with [neuropsychologist]'s finding of probable symptom magnification with misleading information to MPIC about functional abilities. Her different presentation to [Appellant's psychologist] 6 months later could have led him to view the behaviours on the videos through a different lens and caused him to come to different conclusions.

On cross-examination, [MPIC's HCS psychological consultant] acknowledged that he did not have any expertise in treating patients with chronic pain. He understood that pain is a subjective thing and that one's resiliency could depend on various factors in psychological make-up. He acknowledged that the Appellant had tested below the cut-off levels for malingering in [neuropsychologist]'s testing and that malingering was not identified by [Appellant's psychologist] through his assessment and treatment. The Appellant's continued pursuit of treatments such as the dry needling treatment did not mean that malingering was not a factor.

[MPIC's HCS psychological consultant] indicated that his initial opinion that the Appellant's possible symptom magnification was not malingering was changed because of the surveillance footage, and its contrast with the level of function and activity forms. He was asked about the distinction which the Appellant had made between not being able to do something at all and doing it with difficulty while internalizing that difficulty through the use of pain adaptations techniques. He was also asked about the limited value of footage from select days, but was of the view that the variety of the video footage over time and over several days provided sufficient data points to form his opinion.

He was also asked why [Appellant's psychologist] had reviewed the same footage but testified that he did not believe the Appellant had magnified or exaggerated her condition. [MPIC's HCS

psychological consultant] acknowledged that these were important things for her treatment provider to consider, that [Appellant's psychologist] had a history with the Appellant with the opportunity to see her over time, and that he had expertise in treating patients with chronic pain conditions.

[MPIC's HCS medical consultant]

[Text deleted] is a medical consultant for MPIC's Health Care Services team.

He reviewed the Appellant's file and provided reports dated January 16, 2009, March 19, 2009, July 23, 2009, July 28, 2009, June 20, 2011, July 26, 2019 and November 18, 2019.

He testified at the hearing and was qualified as an expert in sports medicine and forensic document review.

He described his forensic review of the Appellant's file and preparation of several written opinions to determine if physical injury from the MVA was preventing the Appellant from returning to work at her regular work duties. He concluded that the file did not contain objective medical evidence of a physical impairment of function preventing the Appellant from performing sedentary work and that she did not have a medical condition arising from the MVA preventing her from performing her regular work duties.

Although there were a lot of references to pain, pain is subjective. Pain levels can't be objectified. Some people can function with pain while others cannot, so it is hard to quantify how it impacts function. There was an absence of other changes in things like diagnostic imaging, to indicate that she had structural damage leading to an impairment or disability.

He noted that the MVA itself did not seem significant or produce significant impact. Although the independent physiotherapist had noted some pain focused behaviour and the Appellant was later diagnosed with a myofascial pain syndrome, pain which might be coming from the muscles and soft tissue could not really account for the Appellant's heightened pain behaviour. There was no obvious associated medical condition.

[MPIC's HCS medical consultant] was asked to comment upon some of the findings of loss or range of motion and tight muscles noted in physical examinations of the Appellant by her caregivers. He was of the view that these would not significantly affect function in a sedentary job. He theorized that some of the reduction in range of motion could have been caused by the initial immobilization of the elbow joint following the MVA, causing stiffness, and that once it was determined that there was no fracture he would encourage using the arm more actively.

[MPIC's HCS medical consultant] also testified that he had watched the surveillance videos and concluded that the Appellant's reported functional limitations were not in keeping with the activities depicted. Watching the videos, he was not able to identify any visible signs of physical impairment which would prevent regular work or activities. She was functioning quite normally over that time. He did not believe that this was a result of the Appellant's medication (Oxycocet) which can minimize pain but would not restore normal function where an underlying condition affects movement. The Appellant's presentation was consistent over several days and the videos showed an individual who looked very normal and able to do things. She did not show signs of having a hard time performing tasks or slowing down. Her movement patterns were those of a normal individual not experiencing physical limitations or pain, able to function quite normally in her daily activities.

[MPIC's HCS medical consultant] broke this observation down further for the panel with a detailed analysis of a variety of the activities and movements depicted in the videos. He was particularly struck by the smoothness of the Appellant's movements while doing things like getting in and out of her vehicle, driving, shoulder checking, purchasing coffee, etc. She showed good rotation, smooth, easy movement and reasonable strength. Although he was aware that she had been treated for a pain condition, her presentation in the videos made it difficult to understand how she could have such pain while still being as functional and active as depicted in the videos.

On cross-examination, [MPIC's HCS medical consultant] recognized that pain is a complex issue, but concluded that the Appellant did not have a significant medical condition as a result of the MVA. He had very little understanding of the Appellant's particular job, the duties required, or of the broad variety of tasks and requirements that might arise for different jobs which are classified as sedentary.

He described myofascial pain syndrome as another term for soft tissue pain. It involves soreness and tenderness to the touch but doesn't signify a significant serious injury. In his view, the Appellant's doctors wanted to help their patient, but she should have been encouraged to go back to work, since the objective findings would not disable her from sedentary activities or simple tasks.

He acknowledged that the videos represented snippets of time and that they did not depict her in an office setting performing duties such as typing, answering the phone, filing, using the computer, and sitting at a desk for hours at a time. Nor did they capture the evenings she spent

recovering at home or how she reacted to the lengthy, difficult days spent at the independent physiotherapy and psychological assessments.

When asked about the Appellant's explanation that she had filled out the function and activity forms to reflect the difficulty she had with various activities rather than asserting that she could not do them at all, [MPIC's HCS medical consultant] indicated that he did not observe any difficulties or limitations in the videos and that all the activities he observed were done in a normal way.

Submission for the Appellant

Knowingly Providing False or Misleading Information

Counsel for the Appellant stressed that s. 160(a) of the Act requires intent. The Appellant must have intentionally provided false or inaccurate information to MPIC.

Although he acknowledged that the Appellant's daily activity logs did not always match up exactly with what was observed in the videos, he submitted that there is no evidence the Appellant was told that she was required to fill out the forms to any particular degree of accuracy. The forms were set up in a vague and ambiguous manner. Her evidence was that because of her pain levels late in the day, she was not always able to fill out the forms on a daily basis. She then completed them in batches instead, making it more likely that she might forget some of the day-to-day minutiae at those times. He submitted that the substantive truth of what the Appellant was doing on those days was accurately reported.

As for the level of function forms, counsel submitted that the forms speak to the difficulty associated with various tasks, but that difficulty was not defined. The forms do not speak about limitations or inability, which the Appellant is alleged to have claimed. The Appellant interpreted difficulty to mean that the activity caused her to experience pain and filled out the forms accordingly.

Counsel also criticized the video footage as inherently flawed in that on some days no activity at all is observed, and even on days where some "useful" data was obtained, the cameras were selective, and did not roll all day long, capturing only short clips of 5 minutes of activity. Only 6 days of data were filmed over the course of a 90-day period. The evidence established that pain is subjective and that people suffering from chronic pain conditions can have good days and bad days. This kind of video data did not reveal how a particular activity was tolerated.

The Appellant had never told MPIC that she was not able to drive, and in fact, she had been advised to try to stay active, so she tried to stay active and to break her activities up into smaller segments, if possible.

[Appellant's psychologist] had the opportunity to review the surveillance data as well as the reports prepared by [neuropsychologist] and [MPIC's HCS psychological consultant] which concluded that she had magnified her symptoms and provided false or misleading information. He confirmed that he did not agree with this conclusion. He found this data from 2008 and 2009 to be of limited use in determining the level of function of his patient, and noted several instances which showed a person actively coping with ongoing pain by carrying lighter bags, taking shorter walks with her dogs and using passive coping techniques like adjusting her gait while walking or using items for support.

Counsel submitted that while the medical professionals that MPIC relied upon either assessed the Appellant on a limited basis or never met with her at all, the medical professionals who treated her over a lengthy period all reported that they believed she was truthful about her symptoms and was not faking her condition or engaging in symptom magnification. They reported that her symptoms had remained consistent throughout the duration of treatment.

Counsel also urged the panel to pay particular attention to the occupational therapy report of October 29, 2015 by [OT] who conducted a thorough review of the information on file. She was of the impression that due to flaws in the instructions on the activity and function forms, in the manner and interpretation of the video footage and in [physiotherapist]'s assessment of work level ability and demands of the job, the information did not establish that the Appellant exceeded her reported level of function or knowingly provide false or inaccurate information.

Counsel submitted that the Appellant sustained both physical and psychological injuries as a result of the MVA which had a profound effect on her quality of life and robbed her of employment. She had not ever provided false or misleading information to MPIC in this regard.

Ability to Hold Employment Beyond November 30, 2008

The Appellant saw her family doctor shortly after the MVA. She was sent for physiotherapy, which did not produce the desired result. Her doctor sent her for bone scans, x-rays and other follow up investigations and consultations with specialists. She continued to treat her injuries and pain. The doctor testified at the hearing and was clear that she had not wanted the Appellant to return to work while she was experiencing severe pain. She remained off work through the summer and fall of 2008.

While following the Appellant's care by a number of specialists, the family doctor continued to complete MPIC forms indicating that the Appellant should remain off work. There were a number of activities which she believed the Appellant could not do over the course of an 8-hour work day or could do only occasionally.

[Rehabilitation physician] treated the Appellant for her pain condition, primarily through dry needling treatments which he described as quite painful and providing only temporary relief. Yet the Appellant continued to reliably pursue these treatment and he was of the impression that she genuinely wanted to get better. His reports and testimony described details of her consistent pattern of reported symptoms over a period of several years, her ongoing struggle with pain and the ways which it impacted her both physically and psychologically. He confirmed diagnoses of chronic pain, myofascial pain syndrome, psycho-emotional reaction related to the pain and its effects, and left sided thoracic outlet compression.

Counsel also relied upon the reports and testimony of the Appellant's psychologist, [text deleted]. His initial assessment noted above average levels of pain severity and catastrophic thought, with some use of active pain coping strategies. Severe levels of depressive symptoms, a chronic adjustment disorder with depressed mood, a pain disorder associated with psychological factors and general medical condition and chronic health problems were preventing the Appellant from returning to work. Her global assessment of functioning was low and indicated difficulty with day-to-day life. He treated the Appellant over several years, reporting that she derived benefit from these treatments and was quite motivated to return to some kind of employment. But his final report and testimony concluded that the Appellant was unlikely to return to any regular employment, as pain stemming from her initial injuries and continued symptoms of depression would likely make any further rehabilitation difficult.

Her family doctor confirmed that the Appellant continues to seek treatment with her for her pain, roughly every month.

In the circumstances, counsel submitted that the Appellant has been unable to work since the MVA and that there is an abundance of objective medical evidence to support this finding.

Remedy

Counsel submitted that the two issues before the panel are inextricably linked. The Appellant was unable to work, was entitled to receive IRI and thus cannot reasonably be said to have knowingly provided false or inaccurate information. The issue is whether the Appellant was entitled to IRI after November 30, 2008 and counsel submitted that this is particularly so given that the surveillance footage was captured during the month prior to the IRI cut-off date and the period of time immediately afterwards. If the panel dismisses the appeal on the ground of entitlement to IRI after November 30, 2008 then the question of whether she knowingly provided false or inaccurate information would be moot in the circumstances. Counsel submitted that this is an "all or nothing scenario" and urged that both appeals be granted, and that she be entitled to IRI benefits, with interest.

Submission for MPIC

Counsel for MPIC submitted that from a physical perspective the evidence showed that the Appellant demonstrated abilities that equaled or exceeded the physical demand level of her employment.

From a psychological perspective, the evidence showed that the Appellant did not exhibit a pain disorder associated with psychological factors related to the MVA and did not demonstrate a

psychological disorder that would have rendered her unable to work. She had knowingly provided MPIC with false and inaccurate information pertaining to her activities and abilities.

Knowingly Providing False or Inaccurate Information

Counsel submitted that the Appellant presented to MPIC and her healthcare providers as someone who had sustained injuries from the MVA that were significant enough to disable her from sedentary employment. She held her arm in a prone position while meeting with her case manager and reported to her physiotherapist that she was unable to use her left arm. She completed function forms in August 2008 expressing difficulty in nearly every category:

> My daily activities are limited to minimal movement due to pain in my neck, shoulder, upper back and pain & numbness in my left arm and hand. A normal daily activity like going to the grocery store for groceries and going to grab an item with my left hand accidentally causes excruciating pain in my left arm and hand, neck and upper back.

In September, the Appellant continued to self-report a significant disability of the arm shoulder and hand. In October, she completed another function form in which she again expressed difficulties with every activity, with associated pain and numbness in her left arm. In December, she completed another function form with her case manager, then amended and signed it to confirm a similar depiction of an individual who is extremely limited in functioning.

When she attended for an independent physiotherapy exam her presentation was consistent with her previous reporting to MPIC and her healthcare professionals. She reported inability to hold a glass in her hand, increasing left arm and back pain, and presented with many pain behaviours, including muscle guarding.

After her case manager terminated her IRI the Appellant sought internal review and told the IRO that her life was turned upside down and that she had progressively gotten worse. An assessment by [rehabilitation specialist] dated November 30, 2009 noted ongoing guarding and protection of range of motion on the left side, while recommending increasing activity.

Then, an independent psychological assessment identified maladaptive coping behaviors aimed at reducing perceived pain, including guarding and avoiding use of her left hand in a manner consistent with her function forms.

Altogether, counsel submitted, the representations of the Appellant to this point (July 2008 to January 2010) were that she was completely disabled and not using her left arm and hand because of constant numbness and fear of pain. These representations were made directly to MPIC and to medical practitioners such as Robertson and [neuropsychologist]. The Appellant knew they would relay this to MPIC and provide opinions impacting her benefits. It was submitted that is why the Appellant exaggerated her symptoms in both her description and presentation.

[Neuropsychologist] noted some concerns about exaggeration and maladaptive coping. She initially explained this behaviour as stemming from a psychological condition, based upon the Appellant's reports of maladaptive coping strategies and levels of resilience. After viewing the videos she reversed course, indicating that none of this information was consistent with the video footage. None of the symptoms reported or demonstrated to her or reported in the function forms, were seen in the footage. Throughout the footage, she was seen to engage in activities that were in direct contradiction to the functional limitations she had described and reported.

[Physiotherapist] also noted discrepancies between the videos and the many representation made by the Appellant. She omitted activities from her activity logs, leaving out many activities that took place in between the identified activities on the forms.

In regard to the Appellant's credibility, counsel noted that she presented as combative at times, selective in her recall and unable to accept the possibility of facts regarding which she readily admitted she had no knowledge. There were many instances of her not providing information or providing misinformation, from questions regarding her smoking of marijuana, to details of her involvement in other MVAs, other injuries and EI benefits.

He submitted that the Appellant is not a credible witness, which is important when pain is a largely subjective complaint.

Counsel submitted that there was sufficient evidence to find that the Appellant provided false and inaccurate information to MPIC regarding her abilities and activities on multiple occasions. She had provided information that she was less able than she was shown to be in the videos and was reducing her level of activity as a result, when in fact, by November 30, 2008 she was far more able than she presented and represented.

Ability to Hold Employment Beyond November 30, 2008

Counsel addressed both the physical and psychological aspects of the Appellant's ability to perform the duties of her employment.

Physical

From a physical perspective, he submitted there is little objective evidence supporting the inability of the Appellant to return to work after November 30, 2008 because of MVA related injuries.

[Physiotherapist] examined the Appellant and found that her demonstrated abilities were self-limited but consistent with the demands of sedentary employment. Although he did not have objective information regarding the physical demands of her job, he assumed that it would be classified as sedentary employment. This finding of sedentary employment was not contested by the Appellant.

[MPIC's HCS medical consultant] testified that based upon what he observed in the videos, there was no real impairment of function and the Appellant appeared to have the ability to accomplish a range of tasks with her left hand. Based on her abilities, she and her employer could have simply assumed her ability to do the sedentary job.

Although her family doctor testified regrading her own observations, she admittedly did not review the surveillance videos or the independent assessments. She was focussed on treating the Appellant's reports of pain, which were admittedly based upon subjective reports. Although the Appellant may experience pain, that pain is not sufficient to result in an impairment of function and MPIC submitted that from a physical perspective, it was not. Counsel urged the panel to prefer the evidence of [physiotherapist] and [MPIC's HCS medical consultant] and find that by November 30, 2008, the Appellant should have recovered from her MVA related injuries and from a physical standpoint, was probably able to return to her employment.

Psychological

From a psychological perspective, counsel submitted that the issue is whether the Appellant had a psychological issue that rendered her unable to adequately cope with pain, even if the pain was caused by a relatively insignificant event.

[Neuropsychologist] indicated that individuals with a personality profile like the Appellant's generally experience difficulty coping with even minor stressors. In such individuals, there is a pre-existing tendency to exaggerate symptoms of emotional distress and her scores were so atypically high that [neuropsychologist] concluded that she was presenting with a high degree of symptom magnification.

Later, once she had the opportunity to view the videos, [neuropsychologist] changed her initial opinion, concluding that the Appellant did not exhibit a pain disorder associated with psychological factors related to the MVA. There was really no psychological explanation for the symptom exaggeration/magnification she displayed.

Counsel acknowledged that [Appellant's psychologist]'s assessment and evidence were different form the assessment conducted by [neuropsychologist] but noted that he had not performed the same tests as [neuropsychologist] or encountered the same symptom magnification. He based many of his findings upon the Appellant's self-reports and his picture of the Appellant in July 2010 was markedly different than the one received by [neuropsychologist] months earlier. Most importantly, [Appellant's psychologist] did not say that a psychological condition prevented the Appellant from working in 2010 and did not respond to the opinions of [neuropsychologist] and [MPIC's HCS psychological consultant].

Therefore, counsel for MPIC submitted that the Commission should prefer the evidence of [neuropsychologist] and [MPIC's HCS psychological consultant] and find that, by November 30, 2008, the Appellant had recovered from her MVA related injuries to the point where she was probably psychologically able to return to her employment.

Remedy

Counsel for MPIC submitted that there is sufficient evidence to support both IRDs and dismiss both appeals.

While the panel might find that the Appellant had satisfied her onus to show that she did not have the physical and psychological ability to work beyond November 30, 2008 but still go on to find that she knowingly provided false information to MPIC, the two decisions are so intertwined that this is an unlikely scenario. In the event that the Commission were to find that the Appellant was unable to carry on employment beyond November 30, 2008, there would not exist much justification for terminating benefits at that date, and substitution of a lesser penalty might be warranted. If the Appellant was unable to work during this time, the majority of her presentations and representations would not rise to the level of being false or inaccurate.

Therefore, the threshold issue is whether the Appellant was able to perform the essential duties of her employment beyond November 30, 2008 and counsel submitted that she was.

Discussion

The MPIC Act provides as follows:

Entitlement to I.R.I. for first 180 days

> 83(1) A temporary earner or part-time earner is entitled to an income replacement indemnity for any time, during the first 180 days after an accident, that the following occurs as a result of the accident:
>
> (a) he or she is unable to continue the employment or to hold an employment that he or she would have held during that period if the accident had not occurred;
>
> (b) he or she is deprived of a benefit under the *Employment Insurance Act* (Canada) to which he or she was entitled at the time of the accident.

Events that end entitlement to I.R.I.

> 110(1) A victim ceases to be entitled to an income replacement indemnity when any of the following occurs:
>
> (a) the victim is able to hold the employment that he or she held at the time of the accident;

Corporation may refuse or terminate compensation

> 160 The corporation may refuse to pay compensation to a person or may reduce the amount of an indemnity or suspend or terminate the indemnity, where the person
>
> (a) knowingly provides false or inaccurate information to the corporation;

Meaning of "unable to hold employment"

> 8 A victim is unable to hold employment when a physical or mental injury that was caused by the accident renders the victim entirely or substantially unable to perform the essential duties of the employment that were performed by the victim at the time of the accident or that the victim would have performed but for the accident.

The onus is on the Appellant to show, on a balance of probabilities, that she did not knowingly provide MPIC with false information, and that MPIC was not entitled to terminate her PIPP benefits.

She also has the onus to show that as a result of the MVA she was not able to return to employment, and therefore entitled to receive further IRI benefits, beyond November 30, 2008.

Whether the Appellant Provided False or Misleading Information:

The first issue before the panel is whether the Appellant knowingly provided false or inaccurate information to MPIC therefore allowing it to terminate her benefits pursuant to section 160(a) of the MPIC Act.

Counsel for the Appellant submitted that pursuant to this section, the Appellant must have intentionally provided false or inaccurate information to MPIC. MPIC relied upon the fact that the Appellant's daily activity logs did not completely match up with what was recorded in the surveillance videos. Nor did her level of function forms. Further, the Appellant's presentation in independent examinations conducted by [neuropsychologist] and [physiotherapist] are alleged to contrast with the abilities depicted on the videos and with some of her reporting to other caregivers.

Counsel for MPIC took the position that there is sufficient evidence to find that the Appellant provided false and inaccurate information directly and indirectly to MPIC regarding her abilities and activities on multiple occasions. The Appellant represented that she was less able than she was shown to be in the surveillance videos and was reducing her level of activity as a result. In fact, MPIC's position was that on November 30, 2008, the Appellant was far more able than she presented and represented, and accordingly, MPIC was justified in terminating her benefits pursuant to section 160 of the Act.

The panel has reviewed the function and activity forms completed by the Appellant. We have also reviewed and considered the videotapes reviewed and discussed at the hearing. In considering these forms and videos alongside the Appellant's presentation to

[physiotherapist] in January 2009 and [neuropsychologist] in January 2010, the panel has found that the Appellant exaggerated her symptoms and condition to both of these professionals.

When compared to the video surveillance, function and activity forms were not complete. There are many omissions in regard to the Appellant's daily activities and indications on the forms that, for example, she could not sit or drive for longer than 15 minutes, that she had spent whole days resting on the couch, and that she could not do anything with her left arm or hand.

The Appellant's forms expressed difficulties in nearly every category. For example, an August 14, 2008 entry indicated that:

> My daily activities are limited to minimal movement due to pain in my neck, shoulder, upper back and pain & numbness in my left arm and hand. A normal daily activity like going to the grocery store for groceries and going to grab an item with my left hand accidentally causes excruciating pain in my left arm and hand, neck and upper back.

Counsel for MPIC submitted that all of these forms, reports and statements to doctors should be looked at together, and not in isolation, in order to appreciate the context in which the Appellant exaggerated her symptoms in both description and presentation.

The panel notes that the videos showed that over a period of days the Appellant was far more active and fluid in her movements than she had indicated in the forms or to the independent assessors. As [physiotherapist] reported after his review of the videos on December 5, 2013, the Appellant under-reported her activities in her activity logs, neglecting to report a number of errands performed while she was reportedly resting on the couch.

The limitations or difficulties which the Appellant described in the forms and in some conversations with her case managers were not apparent upon viewing the videotapes. There was an absence of visible pain behaviours such as hesitancy in motion or guarding, or of any limited range of motion in her left arm or hand. We did not see any lack of fluidity in her movements, or any deterioration in her capabilities and activity levels throughout the course of the day. Whether the Appellant was seen easily entering and exiting her vehicle, driving and shoulder checking, using her left arm to carry and manipulate bags and cups of coffee, hanging decorations or picking up trash, she appeared to move comfortably and smoothly with no apparent difficulties or issues.

[Physiotherapist] Report

In contrast, around the same time period, the Appellant presented for her examination with [physiotherapist] (on January 12, 2009) in a much different fashion. The examination was marked by significant self-limiting and pain limited behaviours, making thorough examination difficult. All manual handling testing was self-limited. Her symptoms appeared to be related to a significant pain focus, a chronic or persistent pain condition or syndrome. Examination did not determine any objective impairment, although range of motion of the left shoulder was limited by active guarding and subjective report of pain. These were not considered to be her maximal abilities, but rather the level of effort which she was willing or able to provide during this examination. Further psychological assessment was recommended.

[Neuropsychologist] Report

When MPIC, after a significant and unexplained delay, acted upon the recommendation for psychological assessment identified in [physiotherapist]'s report, they requested that the

Appellant attend for an examination with [neuropsychologist], a neuropsychologist. The Appellant attended for testing and assessment over a period of three days.

[Neuropsychologist] noted that the Appellant presented with a complicated case. During the evaluation, psychological factors appeared to play a significant role in her reporting of symptoms of pain in and level of function.

[Neuropsychologist]'s diagnosis was as follows:

Axis I:	307.80 Pain Disorder associated with Psychological Factors
Axis II:	Cluster B personality traits
Axis III:	By history: symptoms of myofascial pain in her left arm
Axis IV:	None reported
Axis V	GAF = 50

[Neuropsychologist] described the Appellant as holding her left arm in a rigid position reminiscent of the posture created by the use of a sling and using her right arm for all activities, as if the left hand were a prosthetic rather than an appendage with fine motor capabilities. The Appellant told her that she tended to not move it due to issues of pain and that she had problems with numbness in her fingers which reduced coordination in her left hand. Problematic validity measures were noted. The Appellant was described as tearful when describing difficulties in her life, though she did not exhibit any obvious signs of clinical depression.

[Neuropsychologist] concluded that the validity indicators suggested that the Appellant sees herself or makes attempts to portray herself as someone who is psychologically well-adjusted while experiencing a degree of somatic suffering, to a level that was extreme when compared even to the norms for chronic pain populations. She engaged in maladaptive patterns of thought regarding her level of pain and disability.

However, the Appellant's score was below cut-off levels for measures assessing malingering. [Neuropsychologist] recognized symptom magnification along with maladaptive thoughts and coping behaviours and recommended Cognitive Behaviour Therapy (CBT).

Based on these reports by [physiotherapist] and [neuropsychologist], MPIC's psychological consultant determined that the Appellant suffered from a chronic pain condition and authorized a course of psychological assessment and treatment by [Appellant's psychologist].

Follow Up Reports

After reviewing the file along with videotaped surveillance, [physiotherapist] provided a follow-up report on December 5, 2013. In that report he noted the discrepancy between the video activities and many of the representations made by the Appellant to him. He pointed out that she also omitted a number of activities from her logs.

[Physiotherapist] then reviewed reports from other professionals such as [neuropsychologist] and [Appellant's family doctor], noting the marked discrepancy in her claims of reported limitations to various healthcare professionals from the observed behaviours and functional abilities depicted on the videos. He compared some of the difficulties and limitations expressed in the reports with the activities on the surveillance videos which demonstrated her performing the following activities:

- sitting for extended periods (over 30 minutes)
- driving
- walking
- pushing
- carrying with either arm (including carrying a small dog)
- light lifting with either arm (including lowering a small dog to the ground level with the left arm)
- loading and unloading her vehicle
- opening and closing her vehicle's door

- gripping
- bending
- reaching overhead

> During the video, the claimant does not observe (sic) demonstrating any pain behaviours throughout the video. She is observed using the left arm freely, including steering and driving a vehicle, accepting beverage cups with the left upper extremity, carrying shopping and plastic bags, carrying and lifting her dog, smoking, shopping, pushing a shopping cart, walking and sitting.
>
> This is in stark contrast to the limitations she has reported to various healthcare practitioners, particularly [neuropsychologist]'s report, in which she described Ms. Shier as holding the left upper extremity in a rigid posture similar to that of the arm being in a sling, and treating the arm as if it was a prosthetic.

[Neuropsychologist] was asked to view the videotapes and other documentation and reported again on May 27, 2011, changing her initial opinion. She concluded that the Appellant did not exhibit a pain disorder associated with psychological factors related to the MVA. The result of her follow-up review left no psychological explanation for the Appellant's symptom exaggeration/magnification. She believed this behaviour was more commonly seen among individuals feigning their symptoms for secondary gain.

The panel notes that many of [neuropsychologist]'s comments in this regard appear to focus upon the Appellant's lack of physical manifestations, which do not necessarily fall within her particular area of expertise. However, in addressing the Appellant's self-reporting to MPIC, doctors and psychologists, [neuropsychologist] stated that:

> Unfortunately, none of the above is consistent with the surveillance footage of [the Appellant] obtained by [investigator service]. Review of this footage reveals [The Appellant] exhibiting none of the symptoms either reported or demonstrated in her evaluation with me, or those reported within the Claimant's Reported Level of Function forms she completed between August, 2008 and January, 2009. Throughout this footage, [The Appellant] is also seen to engage in activities which are in direct contradiction to the functional limitations she described in her evaluation with me, and those which she reported within her Claimant's Reported Level of Function forms to MPIC. In particular, her activities within this footage contradict the limitations she reported in terms of

> standing, walking, sitting, or driving due to ongoing neck and back pain, and her inability to use her left arm and hand.

[Neuropsychologist] stated that this was inconsistent with her previous diagnosis of a pain disorder associated with psychological factors. Her diagnosis had been based in large part upon the Appellant's self-reported information regarding her adoption of the sick role across all domains of her life. This diagnosis would not be consistent with an exhibition of symptoms of pain and loss of functional ability in some settings but not in others. It is particularly suspect when an individual reports extreme symptoms of pain and pain-related disabilities during formal evaluations, but does not appear to be at all limited by symptoms during the performance of day-to-day activities, when they are not aware they are being observed. This is an indication that they have not adopted a sick role or become entrenched in a pattern of anxiety.

[Neuropsychologist] concluded that the surveillance footage provided a confirmation of the suspected symptom magnification noted in her first evaluation and suggested that the Appellant exhibits a level of functional capacity which greatly exceeds the level of disability reported during the assessment of January, 2010.

Having reviewed the Appellant's forms and reports to MPIC, as well as the video footage and the reports of [neuropsychologist] and [physiotherapist], the panel concludes that, in her reports on the forms and in her encounters with [physiotherapist] and [neuropsychologist], the Appellant did exaggerate her symptoms and level of distress and disability. As will be more fully discussed below, this stands in marked contrast to the manner in which the Appellant later presented to her other consistent and ongoing caregivers, such as [Appellant's family doctor], [Appellant's psychologist] and [rehabilitation physician]. Her more moderated presentation to these caregivers, which included, for example, a demonstration of the development of some coping

skills and willingness to pursue and participate in further treatment (some of which were difficult or painful) highlights for the panel the discrepancies in the forms and in her presentation to the independent assessors in January 2009 and January 2010.

The Appellant testified that she does not recall when she completed her forms and that she completed some of them, even those called “daily” logs, in batches, instead of on a regular basis. She argued that she had no instruction from her case manager as to how to properly complete the forms, although these are single page forms which are fairly straightforward. She was accurate in terms of the time and identification of the activities she did list in the logs, but omitted many activities that took place in between the identified activities.

As counsel for MPIC noted, the Appellant presented as combative at times and selective in her recall. She had very clear recall regarding certain issues. Yet on the majority of questions regarding her failure to identify activities seen in the videos in her logs, or regarding possible exaggerated descriptions of her condition in the forms, she repeatedly indicated that she could not recall events or that she had completed the forms to the best of her ability and recollection at the time.

The panel found that she sometimes responded defensively and did not adequately explain inconsistencies between the documents, videos and her testimony. While we recognize that memory fades with time and the Appellant will not have good recall of all events, this does not explain these numerous inconsistencies. As a result, the panel did not find her to be a consistent, reliable witness, particularly regarding the events surrounding the completion of the logs and the activities depicted in the videos.

When combined with this lack of reliability in the Appellant's answers, particularly on cross-examination, the discrepancies between the forms and visits with [neuropsychologist] and [physiotherapist] and the videos, lead us to find that the Appellant failed to meet the onus upon her to show, on a balance of probabilities, that she did not provide false or misleading information to MPIC.

Accordingly, the panel finds that the Appellant did exaggerate her symptoms and condition and thus knowingly provided false or inaccurate information to MPIC.

Whether the Appellant was Able to Return to Employment

The second issue before the panel is whether the Appellant is entitled to IRI benefits beyond November 30, 2008. Counsel for the Appellant took the position that as a result of injuries sustained in the MVA, including in particular a psychological pain condition, the Appellant was substantially unable to perform the essential duties of her employment and was unable to hold any employment.

MPIC took the position that from a physical perspective the evidence supported a conclusion that the Appellant demonstrated abilities that equaled or exceeded the physical demand level of her employment. From a psychological perspective, the evidence supported the conclusion that the Appellant did not exhibit a pain disorder associated with psychological factors related to the MVA and did not demonstrate a psychological disorder that would have rendered her unable to return to work.

The onus is on the Appellant to show that, on a balance of probabilities, she was unable to hold employment as a result of MVA injuries. In addition to her own testimony, the Appellant

provided several reports from three different caregivers who all reported and testified at the appeal hearing that the Appellant was disabled from working due to a chronic pain condition.

The Appellant's family doctor, [text deleted] had been treating the Appellant since she was 12 years old. She saw the Appellant twice in the few days following the MVA. After a thorough initial assessment she was not able to identify anything like a fracture but continued to be actively involved in the treatment of the Appellant, through many appointments, including supportive counselling sessions.

In trying to assist the Appellant with her pain she referred her to a number of different specialists. She indicated that she would never close the door on possible improvement in the Appellant's condition and future ability to return to work. But her reports and testimony confirmed her opinion that as a result of the MVA, the Appellant suffered from chronic myofascial pain that prevented her from returning to work.

[Rehabilitation physician], in his testimony, approached the Appellant's condition with a focus on her pain. He assessed and treated the Appellant. His procedure involved the identification of taut muscle bands and trigger point needling. He saw and treated her over 40 times between May 2011 and October 2017, a period of over 6 years. His treatment and chart notes revealed a consistent pattern of the Appellant's reported symptoms over a period of several years. His diagnosis (set out in his report dated July 24, 2014) of chronic and myofascial pain with psycho-emotional reaction and left sided thoracic outlet compression led him to conclude that her presentation was consistent with a central sensitization syndrome:

> Neither the improvement of functional state nor the acceptance of the changes that have arisen in her life since the accident of July 8, 2008 have a set, predictable time to improve. At the present time, [The Appellant] remains

> unable to work in any occupation for which she has training or skill… There is a considerable degree of unpredictability in her symptom severity preventing her from being able to reliably and dependably predict her functional ability hour to hour, day to day. All of these issues severely impact her ability to function in her personal and vocational life.

In his testimony, [rehabilitation physician] explained the negative feedback loop which can arise with pain conditions and why the Appellant continued to experience such high levels of pain even in the absence of findings on more traditional testing such as bone scans and x-rays. He provided clear and understandable testimony to explain why he believed that the Appellant suffered from an MVA related pain condition and why she was not able to work as a result.

The psychologist who treated the Appellant, [Appellant's psychologist], has a great deal of experience and expertise in the treatment of chronic pain. He saw the Appellant for more than 25 sessions, between 2010 and 2013, and provided several reports in addition to his testimony at the hearing. He indicated that he had been provided with and viewed the videotape surveillance but that he did not find them to be relevant or helpful to the question of the Appellant's ability to work. He noted that the surveillance portrayed instances of an individual actively coping with ongoing pain by carrying lighter items and taking brief walks with the dogs, which he had reviewed as a means to try and stay active. He noted seeing techniques of passive coping by adjusting gait and leaning on things.

He did not believe that the surveillance data was very useful in determining whether the Appellant could maintain activities in a work-related setting, without behavioral data collected under similar conditions, such as repeated tasks over a longer period and over multiple days.

[Appellant's psychologist]'s report of March 28, 2013 reviewed the history of his treatment of the Appellant. He indicated that at her last session she continued to report significant difficulties with day-to-day activities due to pain, fatigue, medication side effects and depressive symptoms. Although he reviewed some of the skills she learned in treatment and the moderate benefits she had found, these had not translated into functional gains:

> From a psychological standpoint I feel that it is currently unlikely that [The Appellant] will return to any regular employment, as pain stemming from her initial injuries and continued symptoms of depression will likely make any further rehabilitation difficult.

In his testimony he noted the improbability that the Appellant would be able to return to regular full time employment due to her depressive symptoms, ongoing pain and functional limitations.

Counsel for MPIC argued that, as in *AC-12-177* and *AC-14-019*, the Appellant's dishonesty negated the opinion of her caregivers. He argued that their assessments of her were based upon her subjective reporting to them and as such made up unreliable data. Therefore, he urged, less weight should be given to their opinions.

But the panel notes that all of the three caregivers upon whose reports and testimony the Appellant relied saw her many times over extended periods. They had ample opportunity and the expertise to assess her credibility and the validity of her symptoms and complaints.

[Appellant's family doctor] examined her many times and identified and recorded physical results such as decreased range of motion. She also conducted counselling sessions with the Appellant to address her psychosocial concerns.

[Rehabilitation physician] did not rely solely upon the Appellant's subjective experience and complaints, but conducted a physical examination at each appointment before providing the corresponding dry needling treatment to the taut muscle bands he identified.

[Appellant's psychologist] has many years of experience in this area and was acknowledged as an expert in the assessment and treatment of chronic pain. He saw the Appellant regularly for a lengthy period of time.

Both [Appellant's psychologist] and [rehabilitation physician] have the education, training and experience to identify symptom magnification, yet neither identified this as a cause for concern in the Appellant's case. Both expressed their considered opinion at the Appellant was still not able to return to work.

The panel has given a great deal of weight to the evidence of these three expert witnesses. All are experienced in their fields, with high levels of training. All had ample opportunity, over the course of many sessions and several years to assess the Appellant, her condition and her abilities and all concluded, clearly and unequivocally, that the Appellant did not have the ability to return to work.

The experts who reported to and testified for MPIC were all of the view that the Appellant was able to return to work.

In weighing the evidence on this issue provided by MPIC (in the documents, the reports and the testimony of [MPIC's HCS medical consultant] and [MPIC's HCS psychological consultant]) we have also considered some of the questions highlighted in the OT report of [OT], who conducted

a review of the videos and a forensic review of the documentation on the Appellant's file. She commented upon the process followed by [physiotherapist] and MPIC in reaching their conclusions regarding the Appellant's ability to return to work. She noted that [physiotherapist] had admitted that there was no reliable information about the job demands, assuming that it was sedentary based upon information found in the job description. She stated that a job description is not equivalent to a physical demands analysis and contains no weights, forces or detail regarding physical demands. Conclusions based on this description could not be considered reliable.

The panel agrees that in order to establish a claimant's ability to return to work at a particular job, MPIC's assessment often includes information about the claimant's abilities, such as a Functional Capacity Evaluation (FCE) and the demands of the particular job, such as a Job Demands Analysis (JDA) or Physical Demands Analysis (PDA).

None of these assessments were provided in this case.

[Rehabilitation physician], in his evidence, explained that to use the term sedentary work simply as work sitting in a chair, for example, is an oversimplification of the various demands such employment makes upon individuals, particularly on a full-time basis.

Based upon the Appellant's description of the job during his examinations, he was of the view that she would have problems working and pain with both sitting and standing. Typing, reaching for phones and computers and holding her arms in non-supported static positions require a significant amount of muscle contraction to stabilize. The muscles have a quicker fatigue time and he believed this would cause pain for the Appellant. In the static posture required to type, the

pain would build and get to the point where she could not concentrate and continue. Such an employee is undependable and unreliable because one never knows how long they can function while trying to hold back the pain.

In establishing the Appellant's ability to work, MPIC relied upon the opinions of [physiotherapist] and [MPIC's HCS medical consultant] regarding the physical aspects and [MPIC's HCS psychological consultant] for the psychological aspects. All worked with the assumption that the Appellant's job was sedentary based on the job title of receptionist and some general duty descriptions which had been provided. But without the full weight of the information to be obtained in the FCE, JDA, and PDA reports, these opinions do not carry the same weight as those of the Appellant's experienced caregivers who treated her consistently over a long period of time and had the opportunity to learn about the demands of the job and her challenges.

Accordingly, after weighing the evidence presented by the parties, the panel finds that the Appellant has met the onus upon her of showing, on a balance of probabilities, that she was not able to perform the essential duties of her employment.

Whether the Appellant's Benefits Were Properly Terminated

Having found that the Appellant provided false or misleading information to MPIC, but that she was not able to perform the essential duties of her job, the panel must now examine whether the Appellant's PIPP benefits were properly terminated. While she would still be entitled to IRI benefits based upon her inability to return to work, s.160 of the MPIC Act does allow MPIC to refuse to pay compensation or to reduce, suspend or terminate this benefit, as a result of false or misleading information.

The panel must therefore determine the appropriate consequences for the contravention of s. 160(a) of the Act in this case.

Counsel for MPIC has acknowledged in his submission that if the Commission finds that the Appellant was unable to carry on her employment beyond November 30, 2008, there would not exist much, if any, justification for terminating benefits as of that date and the substitution of a lesser penalty may be warranted. Counsel for the Appellant did not specifically articulate any argument regarding an alternative remedy to the termination of benefits, other than their reinstatement.

Nevertheless, the panel has considered the Appellant's position in the context of the legislation, and specifically has considered whether the Appellant's psychological and pain conditions constitute mitigating factors such as would militate in favour of substituting some consequence other than the termination which was imposed by the IRD.

While the panel has found that the Appellant was exaggerating and embellishing her difficulties during her reports to her case manager, [physiotherapist] and [neuropsychologist], we find that she was still undergoing substantial difficulties relating to her MVA at that time. She testified and the panel accepts the evidence that the Appellant was suffering from ongoing emotional, psychological, social and financial stressors after the MVA. Her wedding was significantly delayed, her hopes of advancing to a higher position at work were lost and she had to sell her home to move to a more affordable area. In addition to all of this, the Appellant was clearly diagnosed with a chronic pain disorder and suffers from depression and significant emotional distress/distressed psychological state.

[Neuropsychologist] initially identified Cluster B personality traits that would increase her vulnerability to the development of maladaptive coping strategies. She observed maladaptive thoughts which are typical of individuals who exhibit a psychogenic component to their reported symptoms:

> Although, given the context of this evaluation, it is possible that [the Appellant]'s presentation represents a deliberate attempt to exaggerate her symptoms for the purpose of facilitating her disability claim, on the balance of probabilities, her presentation seems to be more related to a number of psychological factors influencing her perceived ability to cope…

[Appellant's psychologist] diagnosed a chronic adjustment disorder with depressed mood. The diagnosis included a pain disorder associated with both psychological factors and a general medical condition.

The panel finds that the weight of evidence established that the Appellant suffered from a chronic pain disorder, adjustment disorder with depressed mood and maladaptive coping strategies, such as to mitigate her behaviour in the provision of false or inaccurate information to MPIC. Accordingly, the Commission finds that the Appellant has met the onus of showing, on a balance of probabilities, that the termination of benefits should be varied and we find that her PIPP benefits should be suspended, rather than terminated.

The panel must next determine the appropriate length of the suspension.

In making this assessment, we have taken into account the date range of the bulk of the forms and logs she completed as well as the videotape surveillance. This takes us from the termination of the Appellant's benefits on November 30, 2008 through January 2009. We have also

considered the Appellant's presentation during her independent assessments. The Appellant's exaggerated presentation to [physiotherapist] occurred on January 12, 2009, while her exaggerated presentation to [neuropsychologist] occurred on January 28, 2010.

Then, on July 23, 2010, the Appellant presented to [Appellant's psychologist] for an assessment. As counsel for MPIC noted, her presentation at this appointment (and her presentation to other caregivers in the period of time which followed) was of a more moderate nature. [Appellant's psychologist] did not come across the same issue of symptom magnification as did [neuropsychologist]. He noted and testified that she was already using a few active pain self-management strategies and had good family support, although he felt she would benefit from some pain education and an introduction to additional coping skills such as relaxation and activity pacing. At that time, her prognosis for gain was fair and he recommended that symptoms of depression as they related to her condition could be treated concurrently.

Accordingly, the panel is of the view that the Appellant's benefits should be suspended for the period of time surrounding her exaggerated reports and presentations to MPIC, [physiotherapist] and [neuropsychologist]. By July 23, 2010, the Appellant was able to engage in and avail herself of treatment provided by [Appellant's psychologist], [Appellant's family doctor] and [rehabilitation physician] who, as previously noted, did not raise concerns regarding symptom magnification or exaggerations of pain.

Therefore, the Commission finds that the Appellant's PIPP benefits should be suspended from November 30, 2008 until July 23, 2010 and that benefits after July 23, 2010 should be reinstated.

Accordingly, the Appellant's appeal from the IRD of May 6, 2010 is allowed and the IRD of December 10, 2013 is upheld in part. The decisions are hereby varied to suspend the Appellant's PIPP benefits, including IRI, between November 30, 2008 and July 23, 2010. The reinstatement of the Appellant's benefits effective July 23, 2010 is hereby referred back to MPIC for case management.

Dated at Winnipeg this 17th day of May, 2021.

LAURA DIAMOND

BRIAN HUNT

LINDA NEWTON