

Automobile Injury Compensation Appeal Commission

**IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-17-023**

PANEL: Pamela Reilly, Chairperson
Janet Frohlich
Brian Hunt

APPEARANCES: The Appellant, [text deleted], was represented by Mr. Sean Young from the Claimant Advisor Office; Manitoba Public Insurance Corporation ('MPIC') was represented by Ms. Ashley Korsunsky.

HEARING DATES: January 26; January 27; and January 28, 2021.

ISSUE(S): Whether the Appellant is entitled to PIPP benefits relative to her neck surgery performed on February 22, 2016.

RELEVANT SECTIONS: Section 70(1) The Manitoba Public Insurance Corporation Act ('MPIC Act').

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

Reasons for Decision

Issue:

Is the Appellant entitled to PIPP benefits relative to her February 22, 2016 neck surgery? That is, was the February 22, 2016 cervical spine surgery medically required in the management of the Appellant's neck condition because the motor vehicle accidents of January 21, 2005, June 10, 2009 and September 2, 2009 (the "MVs") caused her neck condition?

Decision:

The panel finds that the MVAs and the Appellant's neck condition are causally connected and therefore she is entitled to PIPP benefits in relation to the February 22, 2016 surgery. The panel therefore rescinds the IRD dated December 1, 2016.

Background:

At the time of the hearing, the Appellant was [text deleted] of age. The Appellant is a physiotherapist with 27 years experience. She owns her own clinic, which specializes in the treatment of pelvic floor dysfunction; a specialty that the Appellant pioneered. In 2008, the Appellant obtained her Masters in Science Rehabilitation in Pelvic Floor, and in 2012, she obtained her PhD in Urogynae-Colorectal Medicine. She holds certification as a Canadian Clinical Women's Health Specialist and Pelvic Floor Physiotherapist. She has published peer-reviewed articles, as well as her own book on her specialty. She works with medical students to help them understand pelvic floor health.

The Appellant was involved in three motor vehicle accidents ("the MVAs") dated January 21, 2005; June 10, 2009; and September 2, 2009. The Appellant underwent cervical spine surgery on February 22, 2016. The Appellant seeks Personal Injury Protection Plan (PIPP) benefits for her neck condition, which raised the question of whether the MVAs caused a cervical spine injury that later required surgery.

Appellant testimony and documentary evidence:**MVA January 21, 2005 ("the 2005 MVA")**

The first MVA occurred on Friday, January 21, 2005. The Appellant was twelve days away from her [text deleted] birthday. She was travelling northbound in the median lane on [street], which consists of two northbound travel lanes and two southbound travel lanes. There is no median barrier. A vehicle attempting to make a left turn southbound, from an east side road, entered the Appellant's northbound lanes and struck the Appellant's vehicle on the front passenger side. The force of the collision spun the Appellant's vehicle across the southbound lanes and into the far ditch where the vehicle came to rest, facing south. The front and left side air bags deployed. The Appellant's

new SUV sustained over fourteen thousand dollars in damage and was not driveable. The Appellant did not immediately attend to the hospital. She was worried about picking up her [child] from [school]. Therefore, once police had secured the scene, she accepted a ride from a bystander who drove her to the school.

The Appellant said that immediately after the 2005 MVA, everything hurt. The seatbelt had bruised her chest during the impact. She could not fully open her jaw and had ringing in her ears. The Appellant particularly noted feeling that her head no longer fit properly on her body; it felt crooked, or lopsided. She had never experienced this sensation before. On the day of this accident, the Appellant attended her physiotherapy clinic where a colleague treated her. He recorded his physical findings as left and right sided neck limited range of motion and neck tenderness, left and right limited shoulder range of motion, left shoulder/scapula/chest and thoracic/rib tenderness, as well as cervical segmental dysfunction. Her colleague recorded a diagnosis of class 2 whiplash cervical strain (“WAD II”).

Over the weekend and into the following week, the Appellant also experienced unexplained nose bleeds. She cancelled patients because of the nosebleeds and her inability to lean forward.

Pelvic Floor Certification course, [overseas]

The Appellant had pre-booked airline tickets for January 29, 2005 to attend a 1-month post-graduate certification in pelvic floor muscle rehabilitation and incontinence, at [university], [overseas]. This program would finalize her certification for which she had been preparing since 2004. The Appellant was anxious about the nosebleeds and therefore secured an appointment for an x-ray the day before her trip to satisfy herself that it was safe to travel.

The x-ray imaging report of the Appellant’s cervical spine and facial bones stated that there was a “marked reversal of normal lordosis of the mid cervical spine centered at C4-C6 level. This is presumably related to muscle spasm.” The report also mentioned minimal narrowing of the disc spaces at C4-C5 and C5-C6, which could be related to the

Appellant's positioning during the x-ray. The imaging report did not record any fracture or dislocation.

The Appellant's doctor told her that it was safe for her to travel. However, the Appellant must be careful of her neck muscles, which were very aggravated and had very bad muscle spasm. To accommodate her neck injury the Appellant upgraded her ticket to first class, which afforded her a recliner seat that greatly reduced the strain on her neck.

During her 1-month certification course in [text deleted] and because of her neck pain, the Appellant altered her schedule. Rather than participating in her planned clinical treatment and teaching, she simply attended lectures as a student. The Appellant testified that she experienced increased muscle spasm with lots of pain, nausea and dizziness, along with tinnitus and hearing difficulty in her left ear. The Appellant emailed her case manager from [text deleted] and advised that she felt she was improving as long as she did not bend forward with her head down as this caused dizziness, headache, light-headedness and nausea. She utilized the physio equipment at the university and received physio treatment from colleagues. The Appellant had a referral to a neuro-ophthalmologist upon her return to [text deleted] (circa Feb. 24, 2005) to assess these symptoms. The Appellant returned to full time work on March 8, 2005.

Post 2005 MVA, post [overseas] trip symptoms

The Appellant first consulted with neuro-ophthalmologist [text deleted] on April 8, 2005. In her report, [neuro-ophthalmologist] stated that the Appellant's tinnitus and dizziness were secondary to cervical muscle spasm evidenced by significant postural abnormality. [Neuro-ophthalmologist] referred to a second consult in November 2005 in which the Appellant described significant difficulty with motion sickness associated with light-headedness and persistent, intermittent tinnitus.

[Neuro-ophthalmologist]'s report noted that the Appellant had a history of tinnitus and neck problems with "subluxation of C3 on C4" and this caused "symptoms of her head becoming 'locked' while turning in bed..." The Appellant testified that she told [neuro-

ophthalmologist] (as well as her MPIC case manager) that during the period when she nursed her infant daughter, she woke up and felt as though her neck would 'lock' at C3-C4. The Appellant attributed this to ligament laxity caused by hormonal changes during and after pregnancy. The Appellant testified that by 'lock' she meant she felt a kink in her neck. Her neck felt stiff, rather than painful, it did not crack, and the stiffness resolved the same day with easy movement. She said it "maybe happened...3 times", it was not a problem, and she never experienced this again after 2001 when she stopped nursing. Her prior tinnitus also resolved at the same time. The Appellant testified that she never had a pre-existing neck problem.

The Appellant testified that [neuro-ophthalmologist] believed that the Appellant's severe muscle spasms were causing the Appellant to hunch forward. Therefore, following the doctor's advice, the Appellant worked on improving her posture. (She testified that her posture was good prior to the 2005 MVA.) Improving her posture resulted in some improvement, however, the Appellant said that her neck pain did not go away, nor did the feeling that her head was lopsided on her body. The Appellant said the lopsided feeling changed from a list to the left, to a list the right. The Appellant gestured down the front and to each side of her neck, and said those neck muscles became painful, which she called referral pain. She experienced deep aching pain in the back of her neck at C5 and C6. The Appellant said that by 2006 she could turn her head to the right and experienced referral pain down her right arm, which resolved when she turned her head forward.

By 2006, the Appellant described her pain as chronic with flare-ups, depending on movement, which created referral pain down the right arm. She monitored this referral pain, which in turn, informed her about how to moderate her movements to avoid flare-ups of pain. The Appellant said that she occasionally experienced referral pain down both arms. She described "burning, aching, and prickling" on her right arm that would go away but then show up on her left arm. Sometimes she could not properly shoulder check and occasionally got a ride to work.

The Appellant said that from 2005 through 2006 into 2007 the neck pain and prickling arm sensations progressed, despite her efforts at posture correction and exercise. By 2007, she experienced pain down both arms, which caused the Appellant concern about spinal cord involvement. A significant bump was now noticeable on the back of the Appellant's neck and her doctor referred the Appellant for MRI, EMG and nerve conduction studies.

The Appellant met with neurosurgeon [text deleted] in December 2008 to review and discuss the results of her September 2008 MRI image. The imaging report stated that the Appellant's cervical alignment was normal and, among other results, there was disc bulging at C3-4 with osteophyte formation. There was moderate spinal canal stenosis at C4-5, C5-6, and C6-7 levels.

[Neurosurgeon] confirmed that the imaging supported the clinical findings. He recorded the Appellant's history of the 2005 MVA and recorded that her "neck pain persisted and progressed over the past 18-24 months" and now involved a dull and aching radiation of pain into the shoulders and arms, but not below the elbow. The neurosurgeon noted that the Appellant's neck range of motion was mildly restricted in both flexion and extension with some discomfort at the base of the neck and tightness of the paravertebral muscles. He noted no deformity of the cervical segment. He concluded that the clinical presentation suggested some mechanical cervical pain and recommended that the Appellant pursue regular physiotherapy with the goal of stabilizing the cervical segments.

Appellant's level of function and pursuit of education

The Appellant testified that she followed medical advice and continued to work on strengthening exercises to effect the stabilization of her cervical spine. She continued to work in and build her clinic. In cross-examination, she disagreed that her neck pain did not interfere with her work. The Appellant explained that her neck pain interfered with both her activities of daily living and her work. There were times when she cancelled patients. To avoid cancelling, she developed strategies such as moving her neck as little as possible, of putting a pillow under her arm for support during examinations, or resting a hip on the edge of the patient's bed. This is documented in the October 2009 Job

Demands Analysis report, which stated the Appellant “will half sit on the treatment table to reduce stooping.”

Despite the lack of medical documentation from October 2006 to June 2009, the Appellant disagreed that she did not receive physiotherapy treatment. She testified that she worked with physiotherapists and if she had neck problems while at work, she could retreat to a treatment room and request a staff person to provide a heating pad. She could also receive an acupuncture needle from a colleague to relieve her pain. She said that she loved her work and worked through her pain until 2015, at which time her neck condition deteriorated and she had no choice but to stop working.

Between 2006 and 2012, the Appellant, in addition to building her clinic, continued to pursue her education. Her research involved obtaining patient questionnaires similar to those that she had previously obtained from her patients in her clinical practice. Her support staff tabulated the data from the questionnaires. She agreed she was busier when it came time to write up her thesis, which she completed in approximately June 2008, resulting in her Master’s certification.

The Appellant testified that in September 2008 she began studies to obtain her PhD as a Canadian Clinical Specialist. This included a university statistics course, which she completed in December 2008. She continued with a research study on pelvic floor health. This study involved a comparison between public domain information of pelvic health and more directed education. That comparison then considered what impact the directed education could have on pelvic floor symptoms. The Appellant testified that she gave many one-hour seminars about pelvic floor health care and the attendees completed an online survey. Others collated the statistics from the surveys and the Appellant wrote her PhD thesis based upon the results. After her third MVA, which caused the Appellant’s finger sprain, she had to hire a typist, because she could no longer type. In approximately June 2012, the Appellant successfully defended her thesis and obtained her PhD.

MVA June 10, 2009 (“MVA #2”)

On June 10, 2009, while stopped at a red light, another driver rear-ended the Appellant. She said that there was no damage to her vehicle as the other vehicle struck her trailer hitch. However, the Appellant testified that MVA #2 caused her neck pain to flare-up: she experienced a lot more discomfort and referral pain down both arms. The Appellant obtained physiotherapy treatment through her clinic. The physiotherapist documented symptoms in the Initial Therapy Report, which included “headache, L tinnitus, R ache deep down in R forearm”, and diagnosed “cervical strains and headaches, injury category 1”. The Appellant continued with her home exercise program.

MVA Sept. 2, 2009 (“MVA #3”)

On September 2, 2009, again while stopped at a red light, another driver rear-ended the Appellant. She testified there was not a lot of damage to her vehicle as again, the other vehicle struck her trailer hitch. In addition to suffering further cervical whiplash injury, which included symptoms of “R sided neck tightness and pain, headache, dizziness and ‘flickering’ L eye”, the Appellant injured her right index finger, which became swollen and painful. During her examination of September 3, 2009, the physiotherapist diagnosed cervical whiplash category 1 (WAD I) and light sprain to the Appellant’s right index finger. During her examination of September 8, 2009, the Appellant’s medical doctor diagnosed category 2 whiplash-associated disorder (WAD II) and finger pain.

The Appellant testified that her finger injury was particularly concerning because her pelvic floor therapy practice required use of that finger during examinations. She reduced her patient load to half because of her finger strain, as documented in her physician’s Primary Health Care Report.

Through physiotherapy and home exercise, the Appellant’s finger injury resolved over time. However, although she temporarily focused her efforts on treating her finger, the Appellant’s neck had “never stopped being a problem”. The Appellant testified that she was never able to see the number of patients she wanted because her neck pain would flare-up. She explained that she persevered until a particularly bad flare-up of neck

muscle spasm in May 2015 when she experienced tingling in both arms and then an “electric shock” on her back. The ‘electric shock’ and tingling sensation in both arms occurred again over the next couple of weeks, particularly when she tried to sit up.

Medical investigations post-MVAs and surgery

The Appellant made an appointment to consult with a neurologist on August 5, 2015. In the interim, she took care to avoid lifting anything of notable weight, stopped carrying a purse, and “could not make it a whole day without lying down”, which would alleviate the symptoms. At the time of the August 2015 appointment, she had a cervical x-ray, which showed evidence of osteophytic formation, some narrowing of the disc spaces and slight kyphotic deformity at C4-5. An MRI of September 18, 2015 showed osteoarthritic degeneration and disc protrusions at multiple levels with a combined result of stenosis extending from C3 to C7. The neurosurgeon reported being concerned with the Appellant’s “electrifying sensation” and the “subtle increased signal within the cord.” The neurosurgeon referred the Appellant to [neurosurgeon #2] for further consult. She learned that the wait would be 18-24 months.

The Appellant began to experience new symptoms in November and December 2015, which included dizziness, low resting heart rate, chest pains, tingling in her back and generally feeling unwell. These symptoms concerned her enough to consult with the [clinic] while waiting for her referral to [neurosurgeon #2]. Prior to meeting with the specialist at the [clinic], the Appellant forwarded her September 20, 2008 and September 18, 2015 MRI images, as well as her August 5, 2015 x-ray image for interpretation and comment. At the Appellant’s meeting with the [clinic] neurosurgeon in December 2015, they reviewed the [clinic]’s interpretations of her past imaging reports. The interpretation of her September 18, 2015 MRI noted her normal lordotic cervical curve had reversed to become kyphotic, and the interpretation of the August 5, 2015 x-ray noted that a “prior hyperflexion sprain” could also explain the etiology of the cervical degenerative disc disease. The radiologist stated this opinion without knowledge of the Appellant’s MVA history.

The Appellant met with [neurosurgeon #2] on December 17, 2015 who advised that her neck issues were serious. He recommended physiotherapy and anti-inflammatory medication. They discussed a surgical option and, if the Appellant's symptoms became intolerable, he could fit her in for surgery in February 2016. The Appellant said that because her neck symptoms were changing fast she felt she had no choice but to proceed with surgery as soon as possible. The next morning she requested [neurosurgeon #2] perform the C5-C6, C6-C7 anterior cervical discectomy and fusion ("ACDF"), as discussed.

[Neurosurgeon #2] performed the ACDF surgery on February 22, 2016. The Appellant said that immediately upon sitting up from the surgery she felt that her head sat perfectly. Over the next few days, she felt her neck muscles relax to normal. Over the next few weeks, various symptoms such as tingling in her arms and abnormal heart rate, returned to normal. She had no pain. She followed [neurosurgeon #2]'s advice and began walking until she was walking 16 kms per day, two months post-surgery. She started to swim an hour every day to build back her strength.

The Appellant testified that some symptoms started to return and she reduced her swimming to 15 minutes per day. She underwent another MRI on November 11, 2016. The imaging report recorded, among other things, "new disc protrusion at the junction above the level of fusion (C4-C5) which results in eccentric left-sided cord impingement and left foraminal stenosis." The Appellant referred to this new disc protrusion as "adjacent segment disorder". The Appellant understood this to be a risk of spinal fusion in which vertebral segments next to the fused segments take on more of the burden of neck movement. In other words, there was nothing new going on with her neck, the symptoms were a remnant of her MVA injuries. The Appellant continued to be very careful of her neck but understood that another spinal fusion may be necessary to correct the issue at C4-C5, all of which she believed was caused by the 2005 MVA and aggravated by MVAs #2 and #3 (the "2009 MVAs").

During cross-examination, the Appellant reiterated that between March 2005 and 2015 her neck pain interfered with activities of daily living. Her neck pain interfered “a lot” with her ability to work. The Appellant said that since the 2005 MVA, if her neck pain was particularly bad, she requested that her staff block off periods of the day without bookings. Although she tried to avoid it, she occasionally cancelled patients because of her neck pain. The Appellant reiterated how she modified her patient treatment, as previously stated. She found ways to adapt, and worked within the limits of her pain, not wanting it to interfere with her work.

The Appellant did not consult with her physician about her neck pain but nonetheless, imposed her own restrictions upon her work hours to manage her pain. After MVA #2, the Appellant received 13 physiotherapy treatments for her neck, and continued her home exercise program. She was very protective of her neck and reluctant to have anyone touch it. She utilized treatment available at her clinic such as acupuncture needles, heat, or ultrasound, which staff likely did not document.

Testimony of [neurosurgeon #2]

[Neurosurgeon #2] is the neurosurgeon who performed the Appellant’s ACDF on February 22, 2016. He provided his CV. He has fifty years of medical experience, 90% of which comprises dealing with spinal pathology and surgical management. The panel qualified [neurosurgeon #2] as an expert in neurosurgery and he testified for the Appellant.

In response to a question about the cause of the Appellant’s cervical degenerative changes, [neurosurgeon #2] stated in his medical report dated December 12, 2019 as follows:

... the [Appellant] has a very specific temporal symptom relationship to the motor vehicle accident[s] which would argue that the symptoms may have been precipitated by the accidents, but one can in no way categorically state that the accidents are indeed the cause...

The history in my consultation in 2015 would elude [sic] to the fact that her symptoms began soon after these accidents and therefore, a conclusion was drawn that they probably precipitated the onset of symptoms.

[Neurosurgeon #2] confirmed this opinion in his sworn testimony. He acknowledged that cervical spondylosis (i.e. degeneration of the vertebral column) is common. In cross-examination, he testified that the condition is more common starting in the [text deleted] age group. He testified that the early onset of cervical degeneration in someone as young as the Appellant ([age]) was unusual.

[Neurosurgeon #2] commented on the Appellant's January 2005 x-ray imaging report. He testified that while the "reversal of normal lordosis" might be caused by an anatomical anomaly, the reversal "can also be a reaction to a more dynamic situation such as muscle spasm or pain." A reversal of normal lordosis caused by muscle spasm would appear in an x-ray.

[Neurosurgeon #2] commented on the Appellant's 2008 MRI that showed osteophyte formation. He agreed the term 'bone spur' is synonymous with osteophyte and explained that osteophytes can grow quite quickly because the bone will react to injury. He stated that because imaging (whether an x-ray or MRI) is sensitive to bony structures then osteophytes should have shown up on the Appellant's January 2005 x-ray if they were in fact present.

He pointed out the "very specific timeline" from an August 5, 2015 x-ray to a December 11, 2015 x-ray, which showed a "rapid progressing" from a normal curve in the cervical spine (lordosis) to a "loss of the normal cervical lordosis." [Neurosurgeon #2] said that he based causation upon the following features: the Appellant's normal spine in 2005, a denial of previous neck problems, the unusual development of cervical degeneration in someone as young as the Appellant, and the Appellant's drive to work through her pain.

In cross-examination, [neurosurgeon #2] agreed that it is common to see cervical spondylosis in patients who have not experienced an injury. When questioned as to

whether “sustained neck flexion or extension” positions can cause the degenerative process, he said that it was difficult to draw a correlation between cervical degeneration and a workplace. In general, he stated that smoking is a risk factor, working underground is a risk factor, and there appears to be a higher propensity for neck issues in the Asian population. However, [neurosurgeon #2] did not concede that the Appellant’s job duties were a factor in her neck degeneration. In response to the question of whether he would expect someone [with the Appellant’s symptoms] to not be working as much, he responded, “I don’t think the number of hours is indicative of anything in particular. I don’t think it means anything in and of itself.”

MPIC counsel referred [neurosurgeon #2] to the neuro-ophthalmologist report of January 2, 2006, which recorded the Appellant’s “past history of neck problems with subluxation of C3 on C4.” [Neurosurgeon #2] conceded that he was not aware of this information. However, he testified that the term “subluxation is not a term we use – it’s often in relation to requiring surgery.” He said the term seemed odd because this generally meant a “misalignment” as opposed to “instability” however, the 2005 x-ray did not show any misalignment. He testified, “there’s no subluxation” and said it was a “bizarre statement in the middle of a report.”

[Neurosurgeon #2] reiterated that, in his opinion, the Appellant’s self-reports and the radiological history made a very strong argument for traumatic etiology. In re-direct on the question of a prior subluxation, [neurosurgeon #2] stated that if a prior neck problem was “incidental, a one off, or treatment for an unrelated thing, I would disregard it as being irrelevant.”

In cross-examination, MPIC counsel referred [neurosurgeon #2] to the 2008 MRI and asked if he agreed that he would not expect to see those types of spinal changes resulting from a 2005 cervical strain. [Neurosurgeon #2] did not agree, and testified that imaging cannot “show how one injury becomes multi level or not”. He stated that the Appellant “did not have neck trouble in 2005 and then she did in 2008. That’s what you can conclude.”

[Neurosurgeon #2] responded to a further question about whether mild narrowing of the

disc spaces could be a sign of degeneration. He testified that the radiologist's statement in the 2005 x-ray that "minimal narrowing of the disc spaces at C4-C5 and C5-C6...could also simply be related to positioning" was non-committal and therefore [neurosurgeon #2] did not know whether such a finding was significant or not.

In response to questions from the panel, [neurosurgeon #2] agreed that multiple traumas can speed up the cervical spine degenerative process and that it "does not take awful much" force to cause rapid extension-flexion of the neck.

In response to the panel's question about whether he considered cervical lordosis to be a structural change, [neurosurgeon #2] answered "I think it is considered to be a structural change now because it is seen on imaging. Because it seems to persist afterwards." He referred to the MRI image dated September 20, 2008, which recorded normal alignment of the cervical spine in comparison with the December 2015 x-ray that showed loss of the normal cervical lordosis at C4-C5. He cautioned against comparing two different imaging modalities but nonetheless stated that bony structures will appear on both modalities. He noted that radiology did not comment on any misalignment in the 2008 MRI.

Finally, in response to a question from the panel, [neurosurgeon #2] responded that surgery fails to achieve complete relief. Therefore, a patient's symptoms can return post surgery because they are a remnant of the original neck issue. [Neurosurgeon #2] testified that the Appellant's fusion surgery created stress on the adjacent disc spaces, which likely led to the Appellant's symptoms now associated with C4-C5.

Testimony of [MPIC's HCS medical consultant]

[MPIC's HCS medical consultant] is a Health Care Service consultant for MPIC whose role is to conduct a forensic file review and provide opinions as to causation. In addition, he advises on a wide variety of issues, which assist MPIC case managers to render decisions about PIPP benefits. [MPIC's HCS medical consultant] has been performing this service since 1996. He provided his CV.

[MPIC's HCS medical consultant] explained that he conducted a forensic review of the Appellant's claim file. This involved reviewing all of the medical reports and treatment records provided by the Appellant's health care professionals. In turn, he answered specific questions put to him by the Appellant's case manager or MPIC counsel and provided a final written opinion. The panel qualified [MPIC's HCS medical consultant] as an expert in sports and musculoskeletal medicine including neck, back and spinal injuries. [MPIC's HCS medical consultant] testified for MPIC.

[MPIC's HCS medical consultant] concluded in his written report that the 2005 MVA did not cause a cervical spine injury, which would accelerate a degenerative process in the Appellant's cervical spine. He based this conclusion on his understanding that the Appellant's symptoms improved and she regained her level of function after suffering a WAD II injury during the 2005 MVA. That is, the Appellant suffered "a neck strain that responded nicely over time and she was able to return to normal function with reasonable time and care." [MPIC's HCS medical consultant] testified that in fact, it was impossible to determine whether a neck strain would accelerate the degenerative process because there are many factors that can lead to this process such as occupation, activities, genetics, smoking or other factors that affect general health.

Referring to the Appellant's January 27, 2005 x-ray, [MPIC's HCS medical consultant] noted the imaging report statement that there was "marked reversal of normal lordosis", as well as the statement that there was "minimal narrowing of the disc spaces at C4-C5 and C5-C6". He concluded that in 2005 the Appellant's "discs are undergoing changes at those levels". However, he also conceded that the narrowing could be due to positioning, as stated in the imaging report, which may lead the radiologist to assume the spaces are narrow when, in fact, they are not.

[MPIC's HCS medical consultant] compared the January 27, 2005 x-ray with the September 20, 2008 MRI imaging report (the "2008 MRI"), which stated the alignment of the Appellant's cervical spine was normal. This indicated that the prior loss of lordosis was not a permanent alteration of the cervical spine. The 2008 MRI also documented a

moderate spinal canal stenosis (i.e. narrowing) at the C4-5, C5-6, and C6-7 levels with an element of spinal chord compression at the C5-6 level due to disc protrusion. He concluded that because of the Appellant's level of improvement since the 2005 MVA, her return to normal functioning, and the absence of a significant injury, he did not expect to see the level of cervical spine decompensation shown in the 2008 MRI.

[MPIC's HCS medical consultant] explained that by the Appellant's return to "normal function" he meant that she appeared able to do what she normally did prior to the 2005 MVA. He noted that there was no documentation confirming impairment, no record showing that the Appellant could not perform her regular duties and no documented neurological consequences. [MPIC's HCS medical consultant] provided examples of "neurological" consequences such as a patient describing tingling in their fingers, or a loss of strength or reflexes. Without such evidence, it was difficult to connect the 2008 MRI findings to one event. [MPIC's HCS medical consultant] testified that the evidence did not lead him to conclude that the Appellant suffered a significant injury after the 2005 MVA. Therefore, he concluded that the 2005 MVA played an insignificant role, if any, in the Appellant's cervical spine, multi-level changes seen in the 2008 MRI.

[MPIC's HCS medical consultant] conceded that he was unaware, based upon his review of the documents, that the Appellant's condition apparently deteriorated in 2006 and 2007. He said that the documentary evidence showed the Appellant working with a therapist and then increasing her work hours. Such evidence did not support a worsening condition. [MPIC's HCS medical consultant] agreed that being a health care professional the Appellant might have been more tolerant of her symptoms than the average person might.

[MPIC's HCS medical consultant] commented on the January 2, 2006 neuro-ophthalmologist report, which stated the Appellant had "a past history of neck problems" with C3-C4 subluxation. To him, the term "subluxation" meant there is some abnormal movement. [MPIC's HCS medical consultant] admitted that there was no confirmation of spinal instability between 2005 and 2015 and understandably could not say what the

Appellant's neck condition was as of January 2006. He nonetheless concluded that the Appellant had a pre-existing neck condition.

Speaking further to the 2008 MRI, [MPIC's HCS medical consultant] stated that the findings showed multiple level changes including varying degrees of bony disc changes and narrowing of the spinal canal. This could potentially render the nerves more irritated. He testified that these are not common findings and the involvement of multiple levels spoke to a long-standing process. [MPIC's HCS medical consultant] said that it was extremely unlikely that muscle strain would result in these multi-level degenerative changes. Based upon his understanding that the Appellant's muscle spasm had improved, her neck curvature returned to normal, and her work function returned to normal, [MPIC's HCS medical consultant] concluded that muscle spasm had no impact on the later health or integrity of the Appellant's discs or spine.

In response to questions about the June 10, 2009 MVA ("MVA #2"), [MPIC's HCS medical consultant] concluded that the minor collision caused the Appellant a mild cervical strain that possibly exacerbated her cervical disc disease. By "cervical disc disease", he meant the Appellant's condition documented in the 2008 MRI. In response to questions about the September 2, 2009 MVA ("MVA #3"), [MPIC's HCS medical consultant] concluded that the "very minor rear collision" had a low probability of causing an injury. However, the Appellant had prior neck problems so a minor event would lead to a minor exacerbation of her pre-existing neck condition.

[MPIC's HCS medical consultant] responded to questions about MVA #3 (which resulted in the Appellant's diagnoses of cervical whiplash – WAD II, as well as right index finger strain) specific to the Appellant's Level of Function ("LOF") reports. These LOF reports were requested in response to the Appellant's loss of function due to her right index finger strain.

[MPIC's HCS medical consultant] concluded that the degenerative neck changes identified in the 2008 MRI explained the Appellant's 2009 limited neck range motion. He said that the lack of documented neck deterioration between 2008 and 2009 was a good

sign. He therefore concluded that MVAs #2 and #3 (the “2009 MVAs”) were not really a factor for her neck, based upon the circumstances of the accidents and the Appellant’s “lack of real functional [neck] issues following those accidents.” [MPIC’s HCS medical consultant] concluded that the 2009 MVAs did not play a role in the Appellant’s worsening neck symptoms between 2014 and 2015.

[MPIC’s HCS medical consultant] responded to questions about the various medical reports that document the Appellant’s worsening neck condition between 2014 and the time of her anterior cervical disc fusion (ACDF) surgery in February 2016. A September 2015 MRI documented a reversal of the normal spinal curvature and the acute onset of bi-lateral radicular symptoms. He agreed with [neurosurgeon #2] that radiologists may interpret imaging results differently, depending upon lighting conditions, education and experience. He said that it was not possible to correlate the spinal cord signal changes identified in the September 2015 MRI to an event such as the 2009 MVAs. Spinal cord signal changes would only affect treatment. [MPIC’s HCS medical consultant] reiterated that over 7 years (2008 – 2015) it would be hard to attribute the changes to the minor 2009 MVAs.

He commented on the lack of “significant presentation” between the 2005 and 2008 MRIs. By “significant presentation”, he provided the following examples: loss of function, ongoing symptoms that limit function, deterioration as shown on x-rays. [MPIC’s HCS medical consultant] concluded that the 2009 MVAs really did not have an impact. He testified that there was “very, very low probability” that the 2009 MVAs had an impact on the September 2015 MRI. [MPIC’s HCS medical consultant] opined that the Appellant would have suffered the degenerative changes that led to her surgery, irrespective of the MVAs.

[MPIC’s HCS medical consultant] agreed with [neurosurgeon #2] that a highly stressed (bone) structure may lead to more rapid osteophyte formation. Events that increase the load on bone can lead to the development of new bone, including spurs. However, [MPIC’s HCS medical consultant] could not comment upon how quickly bone spurs

(osteophytes) may develop because the timing depends on the demand on a particular area.

[MPIC's HCS medical consultant] agreed with [neurosurgeon #2]'s opinion that cervical lordosis is considered a structural change. That is, a fluctuation from normal to abnormal would be a structural change to the spine. [MPIC's HCS medical consultant] agreed with [neurosurgeon #2]'s opinion that multiple traumas can speed up a degenerative process. [MPIC's HCS medical consultant] added that the level of trauma is a key factor when considering progressive degenerative changes. [MPIC's HCS medical consultant] declined to consider the January 27, 2005 x-ray (which documented a "marked reversal of normal lordosis of the mid cervical spine") as representative of a structural change of the Appellant's cervical spine. He said that it was not possible to determine when that change occurred; that is, there was no way to determine the Appellant's day-to-day routine and how that affected her presentation at the time of the 2005 x-ray.

In response to [neurosurgeon #2]'s opinion that there was a temporal relationship between the MVAs and the need for surgery in 2016, [MPIC's HCS medical consultant] confirmed his written opinion that he did not find the same correlation. He noted the 2005 neck strain with the loss of lordosis, which improved with time. He noted the 2008 MRI showing multi-level changes but which he believed had no significant affect on the Appellant's functioning; saying that there are gaps with level of function that negate a finding of a temporal connection between 2005 and 2015. [MPIC's HCS medical consultant] said that while all of the changes occurred after the MVAs, from his review of the file, he could not conclude that there was a temporal connection.

Appellant submission:

The Appellant's representative reviewed the relevant medical documentation. He stressed the Appellant's love and dedication to the success of her profession and clinic. He noted the Appellant's fortitude in working through her pain as evidence of her dedication. This is a credit to her. He pointed out that the Appellant's neck pain did not abate from the 2005 MVA and while she returned to work, her pain nonetheless affected

her job performance. He referred to the Appellant's testimony that she occasionally cancelled patients, blocked out time to rest at work, and altered her position when working with clients. Even her clients noticed the Appellant's change in practice. The Appellant's representative noted that her finger injury definitely led to days off work. The Appellant's profession provided her with an understanding of how to best restrict or modify her workday and put her with colleagues who could treat or assist her.

The Appellant's representative submitted that [MPIC's HCS medical consultant] based his opinions upon the premise that the Appellant suffered pre-existing cervical spine problems. [MPIC's HCS medical consultant] conceded that the Appellant's medical records do not show billings for neck issues pre-MVAs, the period 2000-2005. The representative pointed out that [MPIC's HCS medical consultant] relied upon documentation, which showed that the Appellant returned to work. However, he submitted, this documentation does not mean that the Appellant recovered.

He referred to the [clinic] reports and comparisons of the Appellant's September 2008 MRI, September 2015 MRI and August 5, 2015 x-ray. He pointed out that the assessment concluded, based upon the MRI comparison, that the 'disc spur complex at C5-C6 and C6-C7 have [sic] not changed.'" He also referred to the [clinic] conclusion that the x-ray image "raised the possibility of prior hyperflexion sprain at this level" (i.e. C4-C5). The [clinic] specialist raised this question despite having no knowledge of the Appellant's MVA history. Appellant's representative tied this information with [neurosurgeon #2]'s comment that osteophytes (bone spurs) can develop quickly in response to injury. [Neurosurgeon #2] cautioned about comparing two different modes of imaging, but nonetheless pointed out that imaging is sensitive to bony structures, and therefore if bone spurs had been present in 2005, they should have shown on the x-ray.

The Appellant's representative submitted that [MPIC's HCS medical consultant] placed emphasis on the documented report that the Appellant suffered C3-4 subluxations to conclude that the Appellant had a pre-existing neck condition and that her cervical degeneration was already under way. However, the Appellant explained this reference

to subluxation and testified that hormonal changes during nursing caused her stiff neck and tinnitus, and these completely resolved. She did not have neck issues as borne out in the Manitoba Health billing record.

The Appellant's representative argued that in fact, the starting point is the January 27, 2005 x-ray. This imaging report is, at best, equivocal in concluding cervical degeneration. The more important finding is that in 2005, there was no evidence of osteophyte formation but in 2008, there is evidence of osteophyte formation as well as spinal degeneration. The inference is that the 2005 MVA injured the Appellant's cervical spine, which ultimately led to osteophyte formation and cervical degeneration.

The representative concluded by submitting that on a balance of probabilities the evidence shows a cervical injury caused by the serious 2005 MVA, which progressed. The Appellant suffered two further MVAs in 2009. He submitted that the panel should prefer [neurosurgeon #2]'s opinion that there is a temporal and causal relationship between the 2005 MVA and the Appellant's neck problems, which resulted in her February 22, 2016 cervical discectomy and fusion.

MPIC submission:

MPIC counsel submitted that the burden of proof is on the Appellant to show that, on a balance of probabilities, her MVAs caused her spinal stenosis and radiculopathy. Counsel submitted that the Appellant has not met this burden based upon a totality of the evidence.

Counsel referred to the testimony of [neurosurgeon #2] who stated that cervical spondylosis is common and that a person as young as age [text deleted] could possibly experience the condition. Both [neurosurgeon #2] and [MPIC's HCS medical consultant] agree that radiculopathy and cervical spinal changes can occur without trauma.

Counsel referred to a 2018 Worksite Assessment to point out that a pelvic floor assessment could take approximately 30-45 minutes, and the Appellant explained that most patients require her to sustain trunk flexion/rotation and neck flexion/rotation positions for longer durations. [MPIC's HCS medical consultant] testified that occupation, and in particular, the Appellant's occupation, which required flexion of the neck, can place high demand on the neck and therefore affect the degenerative process. Counsel submitted that the Appellant increased her work hours between 2005 and 2009. The relevance of the Appellant's increased hours is that this increased the duration of her neck flexion/rotation, which contributed to her cervical degeneration.

Starting with the 2005 MVA, counsel reviewed the medical documents. She noted the evidence of muscle spasm and reversal of cervical lordosis, but noted that the Appellant travelled [overseas] within 12 days of the 2005 MVA. Counsel pointed out that the Appellant returned to full-time work duties on March 8, 2005. After the consultations with the neuro-ophthalmologist in April and November 2005, counsel submitted that there is a large gap in documented treatment until October 2006 when the Appellant receives physiotherapy for left sided neck pain, radiating into her upper extremities. The next investigation into radiculopathy symptoms is in June 2008. Counsel argues this absence of documentation and the intermittency of radicular symptoms, supports [MPIC's HCS medical consultant]'s conclusion that there is no causal connection between the 2005 MVA and the Appellant's cervical radiculopathy.

MPIC counsel stressed that the Appellant will seek treatment when needed (as evidenced by her health records). Counsel submitted that it is noteworthy that there is no documentation evidencing neck treatment, particularly in light of the fact that the Appellant increased her work hours by approximately 20-30 hours per week after the 2005 MVA, and she completed her Masters and PhD degrees. Counsel submitted that these facts are not indicative of a progressive neck deterioration with a corresponding loss of function dating from the 2005 MVA and, therefore, submits that there is no temporal relationship between the MVA and the neck radiculopathy.

Counsel reviewed [MPIC's HCS medical consultant]'s testimony and report that states the 2008 cervical spine MRI shows multi-level structural changes and osteophytes that are significant and not normal for the Appellant's age group (i.e. [age]). [MPIC's HCS medical consultant] maintained that these changes indicated a long-standing process rather than the result of one event. Counsel again emphasized the underlying facts that the Appellant suffered a cervical sprain that improved with no impact on function and then an increase in function. [MPIC's HCS medical consultant] testified that functional consequences matter when determining causation.

MPIC disagreed with the position that the Appellant did not suffer from a pre-existing neck issue. The report of the neuro-ophthalmologist recorded the Appellant's past history of C3 on C4 subluxation, and the primary health care report immediately following the 2005 MVA documented "on and off" neck treatment in the 5 years prior to the MVA. Counsel submitted that the forensic review of documents by [MPIC's HCS medical consultant] looks at the whole picture including the history. This picture indicated something other than a neck strain probably contributed to the overall degenerative process.

Finally, the 2009 MVAs were minor collisions that led to cervical and finger strain. Further, the finger strain restricted the Appellant's ability to work. There is no radicular neck pain reported for approximately 5 years between 2009 and 2014 despite numerous medical reports that deal with occupational therapy assessments of the finger strain. Counsel submitted that in the Appellant's 2012 and 2013 Level of Function (LOF) forms, she did not mention radiculopathy neck issues. Therefore, the facts support [MPIC's HCS medical consultant]'s conclusion that the 2009 MVAs had an insignificant impact on the Appellant's neck issues.

MPIC counsel submitted that both experts point out the difficulty of pinpointing the etiology of the Appellant's degenerative cervical spine. [Neurosurgeon #2] testified that correlating the spondylosis with the workplace suffered the same problem as correlating the spondylosis with the traumatic event. [Neurosurgeon #2]'s temporal relationship relied heavily on the Appellant's reported history, which did not include the reported C3-

C4 subluxations. The Appellant reported her history to [neurosurgeon #2] 10 years after the 2005 MVA. Therefore, she argued that the forensic historical document review of [MPIC's HCS medical consultant] is more complete, more relevant and should be preferred over [neurosurgeon #2] for determining causation.

MPIC counsel submitted that the appeal should be dismissed and the December 1, 2016 IRD be upheld.

Legislation:

Section 70(1) of the MPIC Act provides as follows:

70(1) In this Part,

“bodily injury caused by an automobile” means any bodily injury caused by an automobile, by the use of an automobile, or by a load, including bodily injury caused by a trailer used with an automobile, but not including bodily injury caused

- (a) by the autonomous act of an animal that is part of the load, or
- (b) because of an action performed by the victim in connection with the maintenance, repair, alteration or improvement of an automobile;

Credibility and Reliability:

The Appellant

The Appellant testified in a clear and straightforward manner. She was honest in disclosing prior neck issues and she conceded facts that were potentially detrimental to her case. Her testimony was consistent with the documentary evidence on file. She did not exaggerate or embellish her testimony. She had very good recall of historical events and readily admitted when she could not recall certain facts. MPIC did not raise any issue, and the panel has no issue with the Appellant's credibility and reliability.

[Neurosurgeon #2] & [MPIC's HCS medical consultant]

Both [neurosurgeon #2] and [MPIC's HCS medical consultant] (the "experts") testified in support of their respective medical reports. Their testimony was fair and objective. Both doctors answered questions clearly and they reasonably conceded when they were unaware of facts relevant to their opinions. The panel has no issue with either doctors' credibility or reliability.

Substantive Issue:

Was the Appellant's February 22, 2016 cervical discectomy and fusion medically required for management of a condition causally connected to the Appellant's MVAs?

Discussion and Findings:

There was no dispute about the dynamics of the 3 MVAs. The experts agreed that they could not categorically state that the MVAs caused the degenerative changes in the Appellant's cervical spine. The burden of proof is of course whether, on a balance of probabilities, the MVAs caused the degenerative changes in the Appellant's cervical spine that led to her surgery.

The experts agreed that interpretations of diagnostic imaging reports can vary based upon the experience of the medical professional reading the image, and that imaging was subject to lighting and positioning variables. The doctors agreed that the Appellant's imaging reports, which showed a change in normal cervical lordosis, represented a structural change to her cervical spine.

They agreed that multiple traumas could speed up degenerative changes. However, [MPIC's HCS medical consultant] qualified his remark with the comment that the level of trauma is a key factor when considering progressive changes over time. Finally, the experts agreed that surgery does not totally alleviate symptoms and therefore the Appellant's returning symptoms post surgery could be remnants of her prior condition.

The experts disagreed on the temporal and therefore on the causal relationship between the 2005 MVA and the Appellant's cervical degeneration and radiculopathy, which culminated in her February 2016 ACDF surgery. [MPIC's HCS medical consultant] concluded that there was no causal relationship because the Appellant recovered from her initial cervical strain and returned to normal functioning. He also premised his conclusion on his belief that the Appellant suffered a pre-existing neck issue. As such, the degenerative structural changes discovered in her September 2008 MRI, after her initial recovery, could not be the result of the 2005 MVA.

The panel accepted the Appellant's testimony that during her pregnancy she experienced a 'locking' sensation in her neck when waking in the morning. This 'locking' only occurred while the Appellant was nursing her daughter. She attributed the 'locking' sensation to tendon laxity caused by hormonal changes. The panel accepted that the Appellant never experienced this locking or stiffness after she stopped nursing in 2001, at least three years prior to her 2005 MVA.

The Appellant consulted a colleague at her clinic who investigated her neck and told the Appellant that her C3-C4 vertebrae were involved. There is no evidence that the Appellant missed any time off work for neck issues between 1996 when she started her clinic, and January 2005 when her first MVA occurred. Her Manitoba Health billing records do not show any attendances for neck issues.

The Appellant used the word 'subluxation' when she reported her neck locking symptoms to the neuro-ophthalmologist. The neuro-ophthalmologist therefore recorded as follows: a "past history of neck problems with subluxation of C3 on C4", which caused the Appellant's "symptoms of her head becoming 'locked' while turning in bed, but has never caused her dizziness".

The panel accepted the Appellant's testimony that the locking sensation was nothing like the pain and muscle spasm that she experienced in her neck after the 2005 MVA. The muscle spasm was severe enough that it structurally altered her normal lordotic neck

curvature. She had nosebleeds. Her head felt like it no longer sat properly on her shoulders.

Although [neurosurgeon #2] was not aware of the apparent C3-C4 subluxation stated in the neuro-ophthalmologist report, he nonetheless addressed this in his cross-examination. He found the comment bizarre and commented on the severity of such a condition, which surely would have shown up on imaging. Since it did not, he did not find this information to be relevant. [Neurosurgeon #2] maintained his opinion that there was a temporal and therefore a causal relationship between the 2005 MVA and the Appellant's ultimate cervical spine condition, which required her February 2016 surgery. The panel found that this missing 'subluxation' information did not undermine [neurosurgeon #2]'s opinion.

The panel accepted the testimony of [neurosurgeon #2] that the Appellant's prior reference to neck stiffness was incidental, a 'one off', was unrelated to the 2005 MVA cervical strain diagnosis, and may be disregarded as irrelevant. The panel also found that the Appellant's prior neck stiffness was qualitatively different from the neck pain and spasm she experienced after her 2005 MVA. The panel found that the Appellant's prior neck issue had resolved at least three years prior to her 2005 MVA. The panel therefore found that the Appellant did not have a neck condition that pre-existed her 2005 MVA.

[MPIC's HCS medical consultant] premised his conclusion that the 2005 MVA did not lead to the February 2016 ACDF surgery on his understanding that the Appellant fully recovered her normal functioning at work. The Appellant testified that her neck muscles never fully relaxed. Despite her vigilance at working on her posture to alleviate the muscle spasm, she was never without neck pain after the 2005 MVA. The Appellant testified that her neck pain always affected her work and activities of daily living. She did not return to her full functioning at work but rather she modified her work habits to accommodate her neck pain. As examples, the Appellant placed a pillow under her arm to support her while she conducted examinations, she sat on the side of the bed so that she did not have to

turn her neck and torso as much, and she took breaks in a private treatment room and requested assistance to apply heat or acupuncture treatment.

The panel accepted the Appellant's testimony and found that her neck muscle tightness and sensation of lopsided head balance never resolved from the time of her 2005 MVA, until her ACDF surgery in February 2016. While the Appellant may have increased her hours and completed her Masters and PhD, she accomplished this because she persevered with the advantage of self-employment as well as her particular therapeutic training, all of which allowed her to tailor and modify her work schedule to her neck pain. After the 2009 MVAs, the Appellant testified that she focused on therapy for her finger. Nonetheless, the Appellant's 2012 and 2013 LOF reports documented her ongoing restricted neck range of motion, and neck pain and stiffness, which continued to require her to alter or adjust her posture and biomechanics at work, to accommodate her neck.

The panel accepted the testimony of [neurosurgeon #2] that the number of hours worked by the Appellant was not indicative of her functioning. The panel found that the Appellant's self-employment and treatment by colleagues explained the lack of medical documentation referred to by [MPIC's HCS medical consultant] and MPIC counsel. The panel further found that the Appellant did not return to full functioning at work after the 2005 MVA.

The panel found that the above factors undermined [MPIC's HCS medical consultant]'s conclusion that the MVAs were not causally connected to the Appellant's cervical spondylosis and radiculopathy, which led to her surgery. Firstly, [MPIC's HCS medical consultant] incorrectly understood that the Appellant did not seek treatment for neck pain and therefore she fully recovered from the 2005 MVA. Secondly, [MPIC's HCS medical consultant] understood that the Appellant resumed normal functioning both at work and in her activities of daily living, which the panel also found was not correct. Thirdly, [MPIC's HCS medical consultant] testified that there was no real documentation of persistent deterioration.

The panel accepted the Appellant's testimony of her persistent neck pain, persistent muscle tension, and persistent head imbalance since the 2005 MVA. The panel also accepted the Appellant's testimony that described her gradual increase in radicular symptoms such as neck referral pain, arm pain and arm tingling sensation. The panel found that these symptoms, together with the 2008 and later cervical spine imaging are evidence of the Appellant's persistent deteriorating condition. This is not a criticism of [MPIC's HCS medical consultant] but simply an acknowledgement that [MPIC's HCS medical consultant] did not have the full factual foundation for his conclusion. [MPIC's HCS medical consultant] also did not have [neurosurgeon #2]'s advantage of examining the Appellant.

Finally, the panel noted the written comment from the [clinic] that raised the possibility that the Appellant suffered a prior hyperflexion cervical sprain, despite not knowing about the Appellant's MVA history. The panel also noted [MPIC's HCS medical consultant]'s comment that there was a "very, very low probability" that the 2009 MVAs had an impact on the Appellant's 2015 MRI and her radiculopathy. The panel finds that a very, very low probability is still a probability.

The panel noted [neurosurgeon #2]'s years of experience in the specific practice of spinal pathology and spinal surgical management. This factor and well as the underlying facts therefore led the panel to prefer the opinion of [neurosurgeon #2]. The panel found that there is a temporal and therefore a causal relationship between the 2005 MVA and the Appellant's deteriorating cervical condition and radiculopathy. The panel also found that the 2009 MVAs exacerbated the Appellant's cervical spine condition and radiculopathy caused by the 2005 MVA, all of which led to her ACDF surgery in February 2016.

Disposition:

The panel found that the Appellant's February 22, 2016 cervical spine surgery was medically required in the management of her cervical condition because her MVAs caused her cervical spine condition and radiculopathy. The panel therefore rescinds the Internal Review Decision of December 1, 2016 and refers this matter back to the

Appellant's Case Manager to determine any benefits that may flow from our finding of causation.

Dated at Winnipeg this 24th day of March, 2021.

PAMELA REILLY

JANET FROHLICH

BRIAN HUNT