Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-19-159

PANEL:	**Laura Diamond, Chairperson** **Linda Newton** **Paul Taillefer**
APPEARANCES:	**The Appellant, [text deleted], appeared on his own behalf; Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Andrew Robertson.**
HEARING DATE:	**July 20, 2021 and July 21, 2021**
ISSUE(S):	**Whether the Appellant's IRI benefits were correctly reduced for the period of June 6, 2018 - September 21, 2018, on the basis that the Appellant was capable of performing 25% of his job duties;** **Whether the Appellant's IRI benefits were correctly reduced for the period of September 22, 2018 - April 24, 2019, on the basis that the Appellant was capable of performing 96.5% of his job duties;** **Whether the Appellant's IRI benefits were correctly ended on April 25, 2019.** **Whether the Appellant is entitled to further Personal Care Assistance (PCA) benefits.**
RELEVANT SECTIONS:	**Sections 110(1)(a) and 131(1) of The Manitoba Public Insurance Corporation Act ('MPIC Act') and Section 2(3) of Manitoba Regulation 40/94.**

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 October 13, 2017. At the time of the MVA, he was self-employed as the owner/operator of a [text deleted] and [text deleted] company.

Following the MVA, he received Personal Care Assistance (PCA) and Income Replacement Indemnity (IRI) benefits from MPIC.

He continued to receive physiotherapy and treatment from his doctors.

Following re-assessments by occupational therapy, the Appellant's PCA benefits were reduced over time, on the basis of his progress in recovery.

An Occupational Therapist (OT) was also engaged to assess the Appellant's ability to perform his job. This included a Percentage of Duties (POD) assessment which identified which duties he had difficulty with. The conclusion was that the Appellant could perform 42% of his total job duties, and a case manager reduced his IRI benefits accordingly, on January 25, 2018.

His physiotherapist (PT) reported that his clinical condition resulted in an inability to perform the required tasks of his occupation.

His file was reviewed by MPIC's Health Care Service Traumatic Brain Injury (TBI) and medical consultants. Further x-rays were taken. Another PCA assessment was undertaken by the OT, and a POD Addendum report was also submitted. The Appellant continued to complain of severe migraines and investigation and therapies continued for this complaint.

MPIC engaged [rehabilitation centre] to complete a Multi-Disciplinary Assessment (MDA).

The Appellant sought internal review of the case manager's decision that he could perform 42% of his duties and on April 11, 2018 an Internal Review Officer (IRO) issued an Internal Review Decision (IRD) overturning that case manager's decision by finding that the assessment of substantial PCA needs was not consistent with an ability to work that much. The Appellant's continuing headaches were noted by the IRO, along with a resultant difficulty sleeping. (This IRD is not the subject of the appeals before the Commission).

[Rehabilitation centre] provided its MDA on April 12, 2018 noting his headaches and other diagnosis, but concluding that he had a "Light work capacity" and would be medically cleared to resume all of his usual home and work activities. Some further treatment was recommended.

There was a temporary suspension of the Appellant's benefits related to document authorization. When this was resolved, the case manager advised that she would arrange a reconditioning program and the Appellant selected his preferred gym, where a PT performed and provided an assessment. A gym and therapy plan was recommended.

Another OT (selected by the Appellant) submitted a Job Demands Analysis (JDA) for the Appellant's job on May 17, 2018. She reported that his job duties would fall mainly within the Limited (Sedentary) strength demand level (with two exceptions). She also submitted a POD report dated May 29, 2018, which concluded he was capable of completing at least 96.5 % of his job duties.

Finally, the OT provided a PCA assessment dated April 19, 2018 which gave the Appellant a score of 1.5 on the assessment tool, which did not meet the minimum score of 9 required for entitlement to PCA expenses.

Although the Appellant's benefits were re-instated, on June 6, 2018 the case manager reduced his IRI benefits based on his ability to perform 96.5 % of his duties. The Appellant disagreed and sought an internal review of the decision.

The Appellant continued to seek treatment for his headaches, including physiotherapy treatment, treatment from [text deleted], a sports medicine physician specializing in the area, and treatment from [text deleted], a headache neurologist. Their diagnosis was of "post concussion syndrome with headaches and WAD IIB" and "post traumatic migraines".

The IRO referred his file back to the case manager to investigate his IRI entitlement based upon the new information provided regarding his headaches.

The PT continued to recommend and provide treatment and reports and the sports medicine doctor and headache neurologist provided reports to MPIC.

These reports were reviewed by MPIC's Health Care Services medical consultant who concluded that the file did not contain evidence indicating that the Appellant suffered from MVA related impairments that would disable him from performing his work duties.

The case manager then ended his IRI entitlements as of April 25, 2019.

The Appellant filed an application for an internal review of this decision. An IRD dated October 23, 2019 upheld the case manager's decision concluding that the medical information on file did not establish that the Appellant has a physical or mental impairment of function as a result of his MVA that would render him entirely or substantially incapable of performing the essential duties of his pre-MVA employment. Because the Appellant was involved in a rehabilitation program which took up a good deal of his time, the IRO varied the decision for the period from June 6, 2018 to September 21, 2018 to account for only a 25% reduction of his IRI during this period.

But after reviewing all of the medical information the IRO concluded that the Appellant was able to return to his job:

> Giving consideration to the totality of the evidence on your file, I agree with the case manager's decision, which is supported by the information provided by [rehabilitation centre], the information provided by the occupational therapist [text deleted]; and the opinion of MPI's medical consultant; and confirm that you regained the functional ability to perform the essential duties of your pre-accident employment. As such, your entitlement to IRI concluded as of April 25, 2019.

In regards to the PCA benefit entitlement which the case manager had ended on June 5, 2018, after considering the new information and medical evidence regarding the headaches, the case manager issued a new decision on April 23, 2020, indicating that since the new information did not support an inability to perform his pre MVA job duties, MPIC would not be extending his PCA benefits.

The Appellant sought an internal review of this decision. By IRD dated September 23, 2020, the IRO upheld the case manager's PCA decision, concluding that, based upon the views of [rehabilitation centre] that he would be medically cleared to resume his usual home and work activities without restrictions, the POD report of the OT assessing his ability to perform 96.5 %

of his duties, and of the Health Care Services medical consultant that there were no objective impairments that might negatively affect his ability to perform his work duties, entitlement to PCA benefits should end.

It is from these two IRDs that the Appellant has now appealed.

A hearing into the appeals was held by videoconference, due to pandemic considerations, and pursuant to s. 183(7) of the MPIC Act which provides:

> **Effect of lack of formality in proceedings**
> 183(7) No proceeding before the commission is invalid by reason only of a defect in form, a technical irregularity or a lack of formality.

Issues before the Commission

The issues before the Commission were:

- Whether the Appellant was capable of performing 25%, then 96.5%, and then all of his job duties and whether his IRI benefits were correctly reduced and then terminated and ;
- Whether the Appellant is entitled to further PCA benefits.

Disposition

The panel has concluded that the Appellant was not capable of performing 25%, 96.5 % or all of his job duties and that he should be entitled to further IRI benefits from MPIC.

However, the panel has also concluded that the Appellant is not entitled to further PCA benefits from MPIC.

Evidence for the Appellant

The Appellant provided medical reports from a variety of caregivers. In particular, he relied upon reports from PT [text deleted], sports medicine specialist [text deleted] and headache neurologist, [text deleted].

The Appellant and his former partner testified at the appeal hearing.

Documentary Evidence

Physiotherapy Reports

Following the MDA report by [rehabilitation centre], which recommended further treatment, the Appellant began physiotherapy treatment with a new PT, [text deleted]. He provided a report dated May 7, 2018 describing complaints of right neck and shoulder decreased range of motion and pain, pain in his left thumb, and loss of sleep due to migraines. These migraines were described as arising two to three times a week, beginning around 1 a.m. and often lasting for several hours. They would diminish with medication after two hours, or after vomiting, leaving the Appellant very tired and unable to focus due to the sleep disturbance.

Following objective testing for range of motion and strength, the PT noted certain painful activities as well as tenderness in myofascial areas of his cervical spine and upper shoulder region on the right side. Exquisite pain was reported with palpation over the left thenar eminence. The assessment was of WAD II and possible left thumb dislocation /strains/sprain (as previously identified) with associated increased scar tissue within the thenar eminence. A physiotherapy exercise plan was recommended over a course of four weeks, with reassessment to follow.

In the weeks which followed, as physiotherapy continued, the OT, [text deleted], provided a further JDA on May 17, 2018, assessing the Appellant at light strength ability. She also provided

a new POD assessment dated May 29, 2018 which indicated that he was capable of performing 96.5% of his job duties.

On June 6, 2018, his IRI benefits were reinstated (following a suspension) but were reduced by 96.5% and a note that he was continuing with a reconditioning program.

On July 6, 2018, [PT] reported again in regard to his program. He indicated that there had been a significant improvement to the range of motion of his neck with some reports of mild stiffness and, a reduction of pain through medication. Some pain with rotation and flexion was still reported and the Appellant felt his neck rotation was still hindering his return to full function. The occasional numbness and tingling had resolved, active movement of his thumb no longer elicited pain and he was modifying his grip to avoid contact with the base of his thumb.

The Appellant continued to report to the PT that migraines and loss of sleep related to migraines were the main concern. These headaches had become less severe but he still could not sleep and suffered from reduced concentration and focus. He demonstrated consistent forward head posture, protracted shoulders, elevated rates shoulder and an increased kyphosis in sitting.

The PT concluded that the Appellant had shown progress in various aspects of his rehabilitation. Range of motion, pain and overall comfort of movement had improved significantly since treatment began. The left thumb continued to be a concern for heavy lifting and migraines continued to be reported throughout the week. Even though migraines were reportedly less intense at times, the Appellant felt that these were his biggest barrier to returning to full duties. Due to the nature of his work, it was difficult to comply with a return to work schedule with reduced hours but the Appellant agreed to attend physiotherapy two to three times per week to

continue building strength, endurance and utilizing manual therapy to treat symptoms. A further four weeks plan was submitted.

The Appellant saw [sports medicine physician] in July 2018.

On July 19, 2018, the PT reported to the Appellant's insurance company indicating:

> [The Appellant] was involved in a motor vehicle accident on October 14, 2017 resulting in recurring migraines, and injury to his thumb and neck.
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> An initial assessment was completed at PA Physiotherapy on May 7, 2018 where a work hardening program was implemented to focus on rebuilding strength and endurance, regaining range of motion and improving physical function.
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> [The Appellant] has attended for physiotherapy services weekly and continues to receive treatment for the above listed complaints. Although [The Appellant] has made progress during the rehabilitation process, he has not worked since October 2017. Based on my experience, it is difficult for [The Appellant] to resume a full work week as a result of his recurring migraines, thumb and neck injury. I continue to work with him on an on-going basis to ensure a successful return to work.

On August 10, 2018, the PT provided another report. He concluded that the Appellant continued to show progress in various aspects of his rehabilitation. Neck range of motion, pain and overall comfort of movement continued to improve since treatment began. His left thumb continued to be a concern for heavy lifting.

The PT noted that the Appellant continued to report migraines throughout the week. Even though less intense at times, they remained his biggest barrier to returning to full duties. A further four week course of physiotherapy was recommended.

[Sports medicine physician] also referred him to [headache neurologist].

Further reports were provided by [sports medicine physician] and [headache neurologist] and the Appellant's case was referred back to his case manager for reconsideration of the new information. At that time, MPIC's Health Care Services team indicated that there was no need for a further Independent Medical Examination (IME).

In November 2018, the case manager advised the PT that the Appellant would no longer be approved for participation in the work hardening program.

The PT provided a discharge report dated February 11, 2019. He continued to emphasize that the Appellant's migraines and related loss of sleep were his main concerns for full recovery. They caused sleep disruptions leading to reduced concentration and focus during the day. Therefore, the Appellant had sought medical care from a sports medicine physician and a neurologist for treatment related to the migraines.

He noted that during the 20 week work hardening program the Appellant appeared motivated to make a full recovery, with an eagerness to return to his work studio. He regularly participated in physiotherapy sessions (two to three times per week) to build strength and endurance. He progressed in various aspects of his rehabilitation, including improvements to pain, range of motion and overall comfort of movement. However, his migraines were the biggest barrier to achieving full recovery and a successful return to work. During the last week of the program, the Appellant had agreed to participate in a one day per week gradual return to work schedule or reduced hours, but this goal was not met before MPIC ended the program. The PT recommended that the Appellant return to physiotherapy for an assessment, to determine how he could further benefit the Appellant through his rehabilitation process.

[Sports medicine physician] Reports

[Sports medicine physician] is a sports medicine physician with experience in the area of headaches. She provided a Primary Health Care Report dated July 11, 2018. She noted that following the collision, the patient sustained a loss of consciousness and abrasion, contusion or laceration. She noted neck pain, headaches and limited neck range of motion. Her clinical diagnosis was one of "post concussion syndrome with headaches and WAD IIB". Stating that the patient was off work, she indicated a targeted return date, once treated, in about eight weeks. She confirmed that the patient's clinical condition resulted in an inability to perform his required tasks, and posed a safety and health risk at work. A return to work would adversely affect the natural history of the clinical condition. She recommended physiotherapy, and referred the Appellant to [headache neurologist], headache neurologist.

[Sports medicine physician] also provided a narrative report dated July 11, 2018. She recounted the Appellant's description of the MVA, noting that he had a loss of consciousness and his first memory was of someone telling him not to move. She described the other injuries he had suffered. She indicated that the Appellant now suffered from chronic headaches three-four times per week that can last over an hour. He is also sensitive to light and noise, and has poor concentration. He cannot concentrate greater than 20 minutes without getting a headache and has difficulty with short term and long term memory, struggling to remember names, times, places, searching for words with delay.

> … Due to these frequent post MVA symptoms, [the Appellant] has not been able to return to work at. He does not have a past history of concussions or head trauma. He does have a prior history of headaches or migraines. Patient was not injured or treating injuries pre-MVA at time just prior to the collision
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> …
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> A: POST CONCUSSION SYNDROME WITH HEADACHES

> P: I reviewed in detail with patient how chronic post concussion symptoms are treated. It was explained to [the Appellant] that extinguishing the frequent headaches was very important and other symptoms usually subside as the headaches subside. Once his headaches dissipate, he should be able (sic) concentrate better and return to work. He was encouraged to practice memory activities and reading for concentration when he does not have a headache. He was also told to go for walks for exercise and wear sunglasses if light sensitive. Vigourous exercise should be avoided until his headaches subside. He declined the medications commonly used to treat chronic headache such as amitriptyline. He also declined headache/migraine abortive medications. I have referred him to [text deleted] (sic), a headache neurologist for assessment.

[Headache Neurologist] Reports

[Sports medicine physician] referred the Appellant to neurologist [text deleted] for his headaches. The neurologist described the patient suffering from chronic headaches, often left-sided and retro-orbital in location, throbbing associated with nausea, vomiting, photophobia and phonophobia. After reviewing the history and examining the patient [headache neurologist] reported on November 6, 2018 that:

> Impression: [The Appellant] presents with a history of posttraumatic chronic migraine. We discussed the option of preventative migraine medication although the patient was not interested at this time. He would prefer to determine the etiology and for purposes of reassurance I will arrange for an MRI of the brain. He can followup (sic) with me thereafter. Good sleep hygiene and adequate hydration were emphasized.

The MRI showed no structural abnormality.

[Headache neurologist] reported again on May 7, 2019. He indicated that the patient was involved in a motor vehicle accident in which his head hit the steering wheel resulting in a nasal fracture. Since that time the patient has been suffering from chronic headaches.

The doctor indicated that the Appellant "had a prior history of only episodic headaches on occasion. He continues to suffer from headaches approximately twice per week. He has been unable to return to work due to these debilitating migraines."

Testimony

Evidence of the Appellant

The Appellant's testimony at the hearing touched not only upon his injuries, symptoms, rehabilitation experience and contact with caregivers, assessors and MPIC, but also provided detailed evidence regarding the nature and demands of his employment.

He described the MVA and his time in hospital which resulted in him being knocked out and suffering a concussion. He was released from hospital with a fractured nose, neck brace and his arm in a sling due to a partial dislocation of his thumb.

He saw his family doctor on January 2018 and described symptoms of memory loss, loss of smell, migraines, nausea, and sore thumb. He was still wearing a neck brace. The doctor prescribed a medication called Cambia for his severe migraine headaches and the cost was covered through reimbursement from his MPIC case manager.

By the time he met with the first OT, [text deleted], his migraines were very severe, occurring at least two or three times a week. He would be in bed, away from the light, for up to eight hours, vomiting with nausea, cold sweats, fevers, loss of appetite and pain. The Appellant explained that he never had these kind of headaches before the MVA. He may have had a few headaches when he was a child, due to dehydration or something, but he never had migraines prior to the MVA.

He got along with [first OT] but there were periods when he could not speak or do anything because of his migraines, so sometimes a planned date or phone call could not be attended, because he was bedridden at the time. He described the consequences that MPIC placed upon him for lack of attendance. He described this as intimidation, which left him feeling angry and stressed. It also led to him attending a rehabilitation due to the threat of losing benefits, even when he was not feeling well. Even when feeling ill, he would drag himself into rehab. He explained his symptoms at the time from severe migraines which restricted his vision, caused sensitivity to light, vomiting, sweating, fever, banging pain in his head. He was unable to operate a motor vehicle and would either take a taxi or have a friend drive.

The Appellant described his meeting with [sports medicine physician], who diagnosed him with post concussion syndrome and headaches, indicating that he could not work until treated, which would take about eight weeks. She also referred him to [text deleted], a headache neurologist.

At that time, he was receiving some IRI (reduced). He described his condition as a “10, as bad as it can be”. It continued to get worse in the coming year. Sometimes the migraines would wake him from his sleep at 4 a.m. and he would not be able to get back to sleep. He would then stay under the sheets feeling ill, and would try to take his medication.

The Appellant described how this affected his work in the studio and with [text deleted]. He explained that an important part of his work was networking, promotion and collaboration, bringing in [text deleted] from all over the world. The hours were long and late. He took promotional and business trips where he would drive to [Province] and work there for days before driving home. It was a very hands-on business service and his mental capacity had to be at

its best. The headaches left him so debilitated that he could not even make eye contact because of pain and the effects on his vision. He couldn't carry on a conversation, make deals, [text deleted] or do [text deleted]. He couldn't go to any of the night venues to attend the promotional events where he makes most of his money. He wasn't able to carry equipment. He couldn't even find words to communicate. The pain in his head was so bad he was not be able to perform any of these job duties.

After waiting for several months he finally had an appointment with [headache neurologist] who also sent him for an MRI. Following this, [headache neurologist] reported that he had chronic migraines. Still his case manager, without even asking him if he could go back to work, concluded that IRI benefits should be stopped. This led him to go back to [headache neurologist] to ask about his work capabilities and [headache neurologist] indicated that he could not work, in his letter of May 7, 2019.

The Appellant indicated that he is still not able to work at this time. He continues to suffer from headaches approximately two to three times per week. When they are full-blown they have the same severity as they did earlier on, leaving him bedridden, sensitive to sound with blurred vision.

In explaining his treatment for this condition he explained that while he was prescribed Nortriptyline, he did not fill the prescription because he could not afford it. The PT had recommended some further muscle strengthening and movements treatment that MPIC had not provided. He explained that he spent a lot of time with the PT, who would be in a good position to recognize the symptoms and difficulties which he was encountering during his rehabilitation. He described the work that they did as physical and not mental. It had nothing to do with his

migraines, but focused on his thumb, with some weight training and treadmill work. This treatment was for his body and he had not received any treatment for migraines or concussion, since the Cambia was prescribed for him in 2018.

He explained that this is different from the mental acuity he needs to show at work. When networking and working with [text deleted] and [text deleted] he has to be sharp and on his game but migraines, nausea, memory loss and communication difficulties still affect him.

When asked if there are any triggers for his headaches, the Appellant indicated that he could not recall any triggers. Before the pain starts, his vision starts to get blurry or he might be sleeping when a migraine wakes him up. [Sports medicine physician] had recommended that he be cautious and not do anything vigorous that might trigger a headache, but he is not able to perform exercise of that kind.

On cross-examination, the Appellant was asked about the MDA report provided by [rehabilitation centre]. While the report touched upon sleep issues, it did not say that he spent much of the day sleeping or describe the vision problems and vomiting issues he had described. The Appellant was asked whether he told [rehabilitation specialist] and his staff about these problems, but he did not remember [rehabilitation specialist] and explained that due to his difficulties at the time, he had trouble recalling much of that time period. He noted that the sleepiness during the day was a side effect from the Cambia, which he stopped taking after a while. Then, he wouldn't be groggy unless he had been up a lot the night before with a migraine.

The Appellant explained that he had migraines about two to three times a week, and that this started becoming a regular pattern around February or March 2018.

He was also asked whether he had self-limited and not completed all of the tests at [rehabilitation centre], but the Appellant said that he never refused to further his rehabilitation or participate in tests, unless he was incapable of performing a particular task.

When asked about the assessment by the OT [text deleted] in April 2018, the Appellant admitted that he declined to do some of the tasks, not to be rude, but because his handicap would not allow him to do so. The injuries to his thumb and hand made it impossible to lay his palms flat upon the surface and apply pressure. Nor did he feel that he could use his non-dominant hand for cooking. He did not recall the strategies for pacing and modifying activities which she had suggested, but did recall that she ordered some devices like special scissors.
In his view, the OTs had their own agenda, coming in and telling you where to stand and what to grab, then recording it and leaving without asking anything about your health or well-being.

When counsel suggested that his periodic migraines had not affected his functioning, the Appellant did not agree. He indicated that when he shows up to work or rehabilitation he wants to give 100% effort and did so even though he was going through something internally. The Appellant admitted that he had a lack of energy secondary to pain from migraines and that his self-esteem had been affected by the process. He felt really low at that point, having been hit by a drunk driver, losing weight, suffering from pain and an inability to do his job.

When not suffering from migraines, it is not normally difficult for him to focus or concentrate.

The Appellant was asked why he declined to take medication such as Amitriptyline or headache abortive medications. He indicated that he had been going through a difficult time because he

lost a friend to an overdose and was very anti- medication at that point in his life. He did research on the medications and was concerned about their side effects.

Evidence of [Appellant's former partner]

[Text deleted] is the Appellant's former partner, who shares an apartment with him and helped with his care after the MVA. She has known the Appellant and lived with him for approximately 20 years. Prior to the MVA, he had never suffered from migraines and she had never seen him bedridden from a migraine. He was the only driver of the household and would help her by taking her to the hospital or doctor's appointments. He helped to take care of her.

She recalled the evening of the MVA when the Appellant was taken to hospital on a stretcher by the ambulance. He was in hospital for two days and she went to visit him. He was wearing a neck brace, in a lot of pain and looked exhausted. He needed help to take care of himself and even to walk out of the hospital. When they got home and he was settled in, she found that he couldn't dress or undress himself and that he needed help with showering and using the bathroom. He couldn't use his hand or neck and couldn't bend down.

Once he started to become physically stronger, the migraines began. Once a migraine started happening it was terrible to see. He would cry from agonizing pain so she would put a hot cloth on his head. His eyes were giving him a lot of pain, and he was rubbing his eyes, so she tried to black out the bedroom from light. This would go on nonstop for between 8-12 hours. He would vomit and shiver with a high temperature and could not even hold down water.

Then, for a few days afterwards, even while not experiencing the full effects of the migraine, the Appellant would be emotionally drained and mentally incapacitated. She described him as not having his thoughts straight and being full of exhaustion.

She noted that sometimes these migraines would be worse after his sessions with the OT's who came by the apartment to conduct tests for MPIC.

After the MVA, the Appellant could no longer help her or drive her to her appointments and this imposed a burden on their household. She expressed frustration dealing with MPIC. The lack of IRI and the Appellant's inability to work caused financial burdens and triggered a lot of upset and anger for them. Many times, they had to go through little battles to get back benefits which MPIC was taking away and they would have to wait for it to be reinstated.

On cross-examination, the witness confirmed that after he got home from the hospital, the Appellant couldn't do anything to help her around the house. While physiotherapy made some improvement in his hand mobility and in his neck, it did not help the migraines. If he had a migraine she confirmed that it could last up to 12 hours. Then he would wake up feeling a bit better but because he had gone through such intense pain, he wouldn't be 100% the next day. He didn't need as much help to go the bathroom etc. but he still needed some kind of help and couldn't do his daily duties.

She confirmed that the migraines gradually got worse. She didn't recall when he stopped taking Cambia, but thought that when his benefits got cut they couldn't afford it. She didn't think the medication helped very much anyways.

Evidence for MPIC

Documentary Evidence

Occupational Therapy Reports

MPIC provided a number of reports from two different OTs, [text deleted] and [text deleted], which generally took the form of JDA and POD assessments.

Assessment of his PCA needs was also conducted, on January 5, 2018, with a score of 38, resulting in the Appellant qualifying for substantial PCA benefits.

In her assessment dated January 11, 2018, [text deleted] assessed the Appellant's work as constituting 5% administrative duties, 15% late/venue work and 80% in-studio demands. Based upon this, along with her assessment of November 8, 2017, she believed he was capable of performing 42% of his duties.

The Appellant's need for PCA was ongoing, but [OT #1], although mentioning the Appellant's migraines in an addendum to the report dated February 24, 2018, continued to be of the view that he was capable of performing 42% of his job duties at that time (this was later overturned by an IRO who felt that an ability to work at 42% was not consistent with a patient who had such high PCA requirements).

The Appellant then requested a new OT, and MPIC provided reports from [text deleted].

On May 17, 2018, she provided a POD report which assessed the Appellant as having light strength capacity.

Her POD assessment dated May 29, 2018 found him to be capable of 96.5% of his job duties.

Her PCA report of April 19, 2018 resulted in a low score of 1.5, which was well below the minimum score of 9 required by MPIC for entitlement to PCA benefits.

ARCC reports

MPIC provided an MDA report from ARCC dated April 10, 2018. This included diagnoses of the conditions resulting from the MVA. It identified the Appellant as having at least a light strength work capacity, and cleared him to resume all home and work activities without restrictions.

> [The Appellant] was pain focused and self limiting, only completing a limited number of the functional tests. The claimant did not complete grip on the left, Leg Left, High Near, Reach Immediate and Reach Overhead right MTMs, the EPIC Lift Capacity Evaluation, Dynamic Carry, Static Back Endurance, Repetitive Sit Up test, and cervical range of motion. He reported these limitations were due to the left thumb, right shoulder and neck pains. With a number of the tasks [The Appellant] completed, it was noted that there was no white knuckling, and limited to no muscle recruitment or body movement. Based upon [The Appellant]'s demonstrated abilities he is currently functioning in the Sedentary strength demand level.
>
> **SUMMARIZED RECOMMENDATIONS**
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> **Diagnostic**
> 1. No further investigations deemed necessary at this time.
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> **Therapeutic**
> 1. [The Appellant] would be medically cleared to resume all of his usual home and work activities without restrictions at this time.
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> 2. He may benefit from some treatment and physical therapy to the neck and shoulder region. …

As a result, MPIC arranged for reconditioning treatment to be provided by PT [text deleted], who submitted an assessment and plan dated May 7, 2018. The Appellant continued to receive some reduced IRI benefits during this time.

Health Care Services Reports

MPIC's TBI consultant reviewed the file on February 13, 2018. He noted that the Appellant had denied headache and nausea at the scene of the MVA but that there was a documented period of time that he did not recall. His family doctor had noted he did not hit his head but did lose consciousness.

The consultant found that the Appellant met the criteria for "permanent impairment entitlement for minor cerebral concussion or contusion; however, there is insufficient evidence to support that he sustained a brain injury. An increase in symptoms and the development of cognitive problems is not consistent with the known trajectory of concussion. No further TBI Review is required."

MPIC's medical consultant reviewed the file on February 26, 2018. He opined that the Appellant had developed the following medical conditions secondary to the MVA:

> …
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> - Minor cerebral concussion;
> - WAD II cervical spine;
> - Left thumb sprain.
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> Presently the claim file does not contain information confirming [The Appellant] dislocated the left thumb, damaged ligaments supporting the cervical spine, fractured the nose or sustained an injury to the right thigh/hip.

A review documented on August 31, 2018 noted the Appellant's consultations with [sports medicine physician] and [headache neurologist]. The consultant confirmed that a non-treating medical examination (NTME) would not be recommended but that pre-MVA clinical notes from the Appellant's doctor would be of benefit to determine if there was a history of migraines and if so to what degree.

After receiving and reviewing further reports, the medical consultant opined again on April 22, 2019. He noted some references in the Appellant's file to headaches prior to the MVA and the increased frequency of headaches/migraines following the incident. Additional investigations into the cause of the headaches/migraines (MRI) did not identify abnormalities that would contribute to the origin of the headaches/migraines. Therefore, the documents did not contain evidence showing that the Appellant developed additional medical conditions secondary to the incident in question. There was a temporal relationship between the MVA and the increased frequency of the reported headaches, and since the evidence showed that the Appellant had sustained a minor cerebral concussion secondary to the incident, it was not unreasonable to assume the concussion contributed to the increase frequency of the headaches or migraines.

However, from an objective standpoint, the evidence indicated that the Appellant did not exhibit physical impairments that would disable him from performing his pre-MVA work duties as an owner/operator of a [text deleted] and [text deleted company, on a full-time basis. [headache neurologist]'s assessment of the Appellant on November 6, 2018 did not reveal objective impairments that might negatively affect his ability to perform his pre-MVA work duties on a full-time basis.

Following receipt of a further medical report from [headache neurologist] dated May 7, 2019, the medical consultant reviewed the file again on June 29, 2020. He concluded that the recent report did not contain information indicating that the Appellant exhibited objective physical impairments, causally related to the incident in question, which would result in a work disability. He noticed that assessments from [sports medicine physician] showed the Appellant had regained full, pain-free cervical range of motion. His neurological assessments were normal. The Appellant participated in a work hardening program during which time he performed numerous

physically challenging exercises. The physical demands of this program exceeded the demands of his employment, in all probability.

The consultant noted that the PT reported that the biggest barrier for the Appellant to achieving full recovery and a successful return to work was his migraines.

> …In other words [The Appellant] did not demonstrate a physical impairment, which would disable him from performing full-time work duties, if he so desired.
>
> Information obtained from [headache neurologist] indicates [The Appellant] continues to experience migraines twice weekly and as a result of the debilitating migraines [The Appellant] is not capable of returning to work. It is probable that if [The Appellant] requested a return to work medical clearance report from [headache neurologist], at any level, [headache neurologist] would provide the report since his objective assessments of [The Appellant] did not identify a medical condition or physical impairment that would render [The Appellant] at greater risk of harm beyond that he would normally be exposed to even before the incident in question. In other words the only reason [The Appellant] has not returned to work, on a full-time basis, is because of symptoms he experiences (i.e., migraines). Tests to objectively validate or quantify
> [The Appellant]'s migraines do not exist since this is a subjective experience. In the absence (sic) physical impairments that can be objectively validated and quantified the issue of work disability rest solely in the hands of [The Appellant].

Submissions

Submission for the Appellant

The Appellant submitted that his IRI and PCA benefits had been prematurely stopped. He felt that he had been subjected to manipulation and intimidation from MPIC. He suffered stress and trauma both as the victim of a drunk driver and as a sole provider whose benefits were taken away. MPIC furthered their own agenda of getting him off benefits by trying to accelerate his rehabilitation and ignoring the opinions of [sports medicine physician] and [headache neurologist]. He could not understand why, if MPIC had any concern about his work capabilities,

they had not inquired further of [headache neurologist] to ask more about whether he was capable of going back to work.

The Appellant noted that along with her original diagnosis in 2018 of post concussion syndrome with headaches, [sports medicine physician] had indicated he would be able to go back to work after about eight weeks, once treated. However, he never received this treatment. He received some medication, such as the Cambia, which was covered by MPIC for a while, but the headaches continued. Both [sports medicine physician] and [headache neurologist] recognized that these frequent post-MVA symptoms had prevented him from returning to work. After the [rehabilitation centre] report, further physiotherapy treatment was recommended, but funding was ended by MPIC before the program goals were reached.

The Appellant objected to the many assumptions which had been made by the health care consultant who had never met or examined him. The consultant made many assumptions about his motivation or ability to work, disregarding his suffering from the migraines, its impact upon his ability to do his job and the opinions of the headache specialist and neurologist. He had disregarded the opinions of these experts as well as the Appellant's inability to work.

He submitted that his ex-partner's evidence confirmed the extent of his suffering, the care that he needed and that he could not have worked during this time due to migraines.

The Appellant submitted that MPIC should be responsible for this neglect and that he should be entitled to full IRI benefits until the present time.

He also submitted that the PCA score upon which MPIC was relying was false and that they had neglected what he was saying. He submitted that his PCA score should be at 34. His PCA and IRI entitlement should go hand-in-hand and entitlement to benefits should be based upon this higher score.

Submission for MPIC

PCA Benefits

Counsel for MPIC explained that PCA benefits are available where, because of his MVA injuries, the claimant is unable to take care of him or herself or perform essential activities of daily living without assistance. According to the regulations, a minimum score of nine on the assessment tool is required in order to qualify for a PCA benefit. The Appellant's PCA benefit entitlement ended after he scored a 1.5 on the April 19, 2018 reassessment.

Accordingly, the onus is on the Appellant to show, on a balance of probabilities, that the assessment was in error when describing his ability to perform the activities of daily living. The PCA assessment tools and score sheets are the best evidence that we have of the Appellant's ability to perform these tasks, along with the evaluation performed by the OT who also reviewed the Appellant's symptom reports.

Earlier PCA assessments and an addendum showed that the Appellant required varying degrees of assistance as he progressed through his rehabilitation. The MDA performed by [rehabilitation centre] and the later assessments of OT [text deleted] found the Appellant to be capable, with proper techniques and pacing strategies, of doing light housekeeping, meals, bathing, showering and other tasks. He could also do some cleaning of countertops and floors. Her review, which included background information, was over two hours long and compared the things the

Appellant said he could or couldn't do, with the actual abilities that were demonstrated through the MDA.

Counsel noted that the reports from [sports medicine physician], [headache neurologist] and the PT [text deleted] had never indicated that the Appellant was not capable of performing activities of daily living.

He submitted that the overall decision to terminate PCA benefits had been based on [OT #2]'s recommendation and the Appellant had failed to show any error in that, on a balance of probabilities. Therefore, the PCA decision of the IRO should be upheld.

In the alternative, if the Commission were to find that the Appellant was entitled to any PCA benefits beyond April 2018, the file should be returned back to the case manager for review and determination of any payable amounts.

IRI Benefits

Counsel identified three different time periods for the question of IRI determination but noted that all were related so he would review them together. He submitted that the important considerations were the JDAs as an assessment of work tasks performed in the Appellant's employment, the [rehabilitation centre] MDA report and [OT #2]'s POD report of May 29, 2018. The issue of migraines had been dealt with by the Health Care Services reports which reviewed the reports of [sports medicine physician] and [headache neurologist].

He noted that both OT's had prepared JDA reports with largely similar conclusions and both found that the majority of the Appellant's duties involved work in his studio. [OT #2]'s report of May 17, 2018 provided a more detailed breakdown of duties. The Appellant had signed this as an accurate representation of the physical demands of the position. While the Appellant claimed that he had been forced to sign this document because of threats of being cut off benefits, there was no indication in the file that the Appellant contacted his case manager to complain about the contents of the POD or JDA reports. He indicated that the Appellant may have misremembered that his benefits were temporarily suspended as a result of conflict around the signing of consent documents and not regarding participation in OT assessments.

Counsel described the [rehabilitation centre] report as comprehensive. It combined testing of the Appellant's capabilities with his history and subjective complaints of headaches and migraines. There was no indication in the report that migraines or headaches were interfering with the Appellant's ability to work. [Rehabilitation centre] staff were aware of the headaches but did not address them, as they were not seen as a barrier to return to work. During [OT #2]'s assessment, the Appellant presented as alert, oriented, and fluid. No issues with drowsiness, grogginess or cognition were noted.

In the OT assessments, the only limitations noted concerned moving or lifting the mixing board. This resulted in the assessment that the Appellant was only capable of doing 96.5% of his work duties.

Counsel acknowledged that migraines clearly were the main issue expressed by the Appellant. He acknowledged that MPIC had accepted that the exacerbation of headaches and migraines was related to the MVA. However, he submitted that while the Appellant has said that his migraines

and headache symptoms render him completely unable to perform his job duties, that is not supported by the evidence on file. More needs to be provided than the Appellant simply stating that he is unable to work. There is little direct support in the evidence, other than some care providers telling us what he has told them about his ability to work. As [MPIC's HCS medical consultant] has stated, this is a question of objective versus subjective symptoms. There are no tests for the subjective experience of headaches and as [MPIC's HCS medical consultant] noted, in the absence of such evidence the issue of work disability rests solely in the hands of the Appellant.

While [headache neurologist] and [sports medicine physician] provided reports and their training must be recognized, counsel urged to the panel to take a balanced approach in determining what weight to attribute to those opinions. Contextual information such as the effect of the Appellant's migraine symptoms upon his functioning should include the important source of confirming the Appellant's complaints with long-standing caregivers to see whether they had observed those symptoms when they were with him. [OT #2] indicated she did not observe issues with grogginess etc. The PT worked with the Appellant on an almost daily basis and had the ability to see the Appellant's symptoms firsthand, but he did not describe seeing him with migraines or it affecting his function when he was in for reconditioning. As one of the case managers noted, the Appellant displayed an ability to attend this demanding reconditioning program. Counsel submitted that this lack of mention of migraine related complaints is consistent with the lack of reporting of migraines having an effect on function.

Both [sports medicine physician] and [headache neurologist], it was submitted, based their opinions upon the Appellant's subjective reporting. While both said that the Appellant has not been able to return to work due to migraines, they did not conduct any review of other reports on

the file such as the [rehabilitation centre] MDA report, the PODs or the PT's reports. In contrast, the Health Care Services reports took the opportunity to correlate various reports on file including those of the OT, treating practitioner and [headache neurologist], in order to compare the subjective complaints to what the objective tests show. While counsel acknowledged that neither the consultant nor case manager had taken the opportunity to ask these questions of [headache neurologist] or [sports medicine physician], and that [MPIC's HCS medical consultant] even went so far as to make certain assumptions about what [headache neurologist] would have said had he been asked, the most important point is [MPIC's HCS medical consultant]'s review of the importance of objective vs subjective factors.

Counsel submitted that, based upon the information before MPIC, the case manager's assessment of the Appellant's ability to perform 25% of his duties at certain points in time and 96.5% at others was reasonable given the rehabilitation schedule and progress of the Appellant. While the Appellant's migraines did exist and were caused or exacerbated by the MVA, they did not at all affect his ability to work after June 6, 2018. By that time, based upon [OT #2]'s report, he was able to do all job tasks except for some limited lifting tasks. After the PT's final report of February 11, 2019 it became clear, from the assessments of strength and ability to lift which were reported, that even this restriction no longer applied.

Counsel submitted that the IRD should be upheld and that the Appellant was not entitled to further IRI benefits.

In the alternative, should the Commission find that the Appellant was entitled to further IRI, counsel submitted that the remedy should be for the Commission to look closely and determine the relevant dates for further IRI to be applied and to refer the calculation of the amount of

benefits back to the case manager for calculation, with the Commission retaining jurisdiction if disputes arise. This would include the period between April 25, 2019 and present time, if the Commission were to find that the Appellant was unable to perform his job duties during this time.

Appellant's Reply

The Appellant submitted that the [rehabilitation centre] report upon which MPIC was relying was confined to physical testing and assessment. It contained no assessment of difficulties with his brain, headaches or cognition. It consisted of push and pull, sit and stand testing, and did not address his migraines or resulting mental difficulties. Then, [OT #2] relied upon this flawed report. She added that he did exhibit headache symptoms over the 2 hours she met with him, but he noted that he was not experiencing a migraine at that time. If he had been, then he would not have been able to sit with her and have a conversation for hours.

The reports upon which MPIC was relying failed to take into account the actual demands of his job as he knew them and had failed to take into account the debilitating nature of his headaches and migraines.

Discussion

The onus is on the Appellant to show, on a balance of probabilities, that as a result of MVA related injuries, he is unable to perform the duties of his job and entitled to further IRI benefits. He also bears the onus of showing that he is unable to perform activities of daily living, entitling him to further PCA benefits.

The MPIC Act and Regulations provide:

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;

Reimbursement of personal assistance expenses

131(1) Subject to the regulations, the corporation shall reimburse a victim for expenses of not more than $3,000. per month relating to personal home assistance where the victim is unable because of the accident to care for himself or herself or to perform the essential activities of everyday life without assistance.

Reimbursement for personal care assistance under Schedules C and D

2(3) Subject to the maximum amount set under section 131 of the Act, the corporation shall reimburse a victim for the actual and proven expenses of personal care assistance in accordance with Schedules C and D if

(a) the personal care assistance meets the minimum score prescribed in Schedule D;

(b) the personal care assistance expenses are the direct result of the victim's bodily injury caused by an automobile for which compensation is provided under Part 2 of the Act; and

(c) the personal care assistance expenses are not covered under The Health Services Insurance Act or any other Act.

PCA

The panel has reviewed the evidence on file, which, as counsel for MPIC noted, consists mainly of OT reports from the OTs [text deleted] and [text deleted]. These reports used the PCA assessment work sheets and tools, which were submitted as the best evidence of the Appellant's abilities. They combined a review of his subjective symptoms with a performance based evaluation by the OT.

The Appellant did not provide additional documentary evidence to support his claim that he required further PCA benefits beyond April 18, 2018.

The reports provided by [sports medicine physician], [headache neurologist] and PT [text deleted] did not address the Appellant's inability to perform tasks involved in the activities of daily living and at home.

The Appellant did call evidence through the testimony of [Appellant's former partner], who provided a picture of the assistance that the Appellant required, and which she provided for him, following the MVA. The panel found her evidence to be thorough and credible. However, most of her evidence related to the period immediately following the MVA, during his post-MVA recovery, when the Appellant was indeed in receipt of PCA benefits form MPIC. Very little, if any, evidence was provided regarding the need for continuing PCA after April 18, 2018.

On the other hand, MPIC's evidence, found in the reports of the OTs, clearly showed that the Appellant, in assessments at that time, failed to meet the minimum score of 9 which is required to qualify for PCA benefits.

Accordingly, the panel finds that the Appellant has failed to meet the onus upon him to establish, on a balance of probabilities, that the IRO erred in finding that the Appellant was no longer entitled to further PCA benefits after April 18, 2018.

The IRD dated September 23, 2020 is hereby upheld and the Appellant's appeal from that IRD is dismissed.

IRI

While reviewing the evidence on the Appellant's file, as well as the testimony, the panel must keep in mind that much of the information concerning headaches may be based upon subjective reporting. In this case, much of the Appellant's presentation was also corroborated by another witness, [Appellant's former partner].

[Sports medicine physician] and [headache neurologist] also relied somewhat upon the Appellant's reporting when they diagnosed the conditions of post concussion syndrome with headaches and post traumatic chronic migraines.

The Appellant indicated that he was highly motivated to cooperate with the assessments and his therapy, both from a fear of losing his benefits and a willingness to do the physical rehabilitation work necessary to recover his physical strength and get better, which he did. However, when it came to the continued headaches and migraines, he still suffered and his function was impaired.

The panel notes that the Appellant suffered from an established and diagnosed condition of migraine headaches, which MPIC recognized and accepted was caused or exacerbated by the MVA. The specialists who diagnosed this condition, [sports medicine physician] and [headache neurologist], as well as his regular treating PT, [text deleted], were of the view that this condition prevented him from performing the duties of his employment.

MPIC did not agree, and relied instead upon [MPIC's HCS medical consultant]'s opinion that the Appellant's headache complaints consisted only of subjective symptoms. [MPIC's HCS medical consultant] focussed instead upon his physical capabilities and rehabilitation to conclude that the Appellant was not prevented from performing his job duties by injuries arising out of the MVA. He read his own interpretation of the Appellant's condition into what [headache

neurologist] had opined, discounting the specialist's opinion by making certain assumptions about what the specialist might have said had he been asked.

The panel does not concur with this approach and has given greater weight to the evidence of the treating specialists, [headache neurologist] and [sports medicine physician], in this case.

The panel also finds that the Appellant's testimony regarding the nature of his job duties was more detailed, thorough and representative of the demands of the job than that of the JDA reports relied on by MPIC. The Appellant's description of the job showed that the JDAs did not reflect the full nature and intensity of his job, especially with regards to its cognitive demands. He was required to work long and late irregular hours in order to network and promote, but this does not seem to have been fully explored by the JDAs. The panel agrees with the Appellant that the symptoms and cognitive effects of his migraine headaches and accompanying sleep disruption presented a substantial impediment to performing these duties.

[Sports medicine physician] did anticipate that, with treatment, the Appellant could improve within 8 weeks. In our review of the evidence, it does not appear that such treatment was provided. Although the PT [text deleted] recommended further rehabilitation treatment, as well as a graduated return to work plan that the Appellant agreed to try, these recommendations were not followed or funded by MPIC.

The panel agrees with the opinion of [sports medicine physician] that the Appellant was, due to his post concussion syndrome with headaches, not capable of work without further treatment for this condition.

We also agree with [headache neurologist], who advised that the Appellant was "unable to return to work due to dibilitating (sic) migraines".

As a result, the Commission finds that the Appellant was not able to perform 25% of his duties between June 6, 2018 and September 21, 2018, 96.5% of his duties between September 22, 2018 and April 24, 2019, or to perform his full duties after April 25, 2019.

The Appellant's appeal is allowed and the IRD dated October 23, 2019, which upheld the reduction and termination of the Appellant's IRI benefits is hereby overturned.

The amount of the IRI benefits to which the Appellant is entitled will be referred back to the case manager for calculation and the Commission will retain jurisdiction in the event that a dispute regarding these amounts arises between the parties.

Dated at Winnipeg this 28th day of September, 2021.

LAURA DIAMOND

LINDA NEWTON

PAUL TAILLEFER