Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-18-006

PANEL:	**Laura Diamond, Chairperson** **Linda Newton** **Sandra Oakley**
APPEARANCES:	**The Appellant, [text deleted], was represented by [text deleted].** **Manitoba Public Insurance Corporation ('MPIC') was represented by Matthew Maslanka.**
HEARING DATE:	**January 24, 2022 and January 25, 2022**
ISSUE(S):	**Whether the Appellant's patellofemoral syndrome is causally related to the MVA of February 6, 2009**
RELEVANT SECTIONS:	**Section 136(1) (a) of The Manitoba Public Insurance Corporation Act ('MPIC Act')**

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

Reasons For Decision

Background

The Appellant was injured in a motor vehicle accident (MVA) on February 6, 2009. She sustained soft tissue injuries to her neck, shoulder and low back and was provided with MPIC funded therapy.

In October 2013, her doctor, [text deleted], prescribed two knee braces for diagnosed patella subluxation related to the MVA. An MPIC Health Care Services (HCS) medical consultant reviewed the file and concluded that the medical information on file did not support the development of a knee condition secondary to the MVA and the knee braces were deemed not medically required by MPIC. Her case manager and internal review officer (IRO) upheld this decision.

The Appellant appealed and the parties proceeded to mediation where it was agreed (in a Memorandum of Agreement) that MPIC would pay for the knee braces on a one-time basis only, without accepting that the knee condition was casually related to the MVA.

[Appellant's family doctor] provided another note dated October 17, 2017, requesting 2 knee braces for patellofemoral syndrome. MPIC declined to provide funding for the knee braces and the Appellant sought an internal review of this decision.

On December 8, 2017, MPIC provided an internal review decision (IRD), finding that there was no entitlement to funding for the knee brace as (based on a report from MPIC's HCS dated September 2, 2015) MPIC was unable to attribute her knee pain to the MVA and the Appellant had not provided additional medical information since then to support the cause of her knee pain as a direct result of the MVA.

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

Issue

The issue before the panel was whether the Appellant's patellofemoral syndrome is causally related to the MVA of February 6, 2009.

Disposition

Upon a consideration of the documentary evidence on file, including the evidence of the Appellant's doctors and testimony and submissions at the hearing, the Commission finds that the Appellant's knee condition was a consequence of her MVA-exacerbated back pain and was causally related to the MVA.

Hearing

Due to pandemic safety consideration, the hearing into the appeal was heard by videoconference.

The Appellant provided direct testimony and was cross-examined by counsel for MPIC. MPIC's HCS medical consultant, [text deleted], also testified and was cross-examined.

The panel also relied upon the documentation contained in the Appellant's indexed file (the Index) which contained various documents relevant to the appeal and was provided to the parties and the panel for review prior to the hearing and consideration at the hearing.

Preliminary Matters

At the outset of the hearing, after some discussion, counsel indicated that although the issue before the IRO (and the panel) was whether the Appellant's knee condition was casually related to the MVA of February 6, 2009, they agreed that the materials before the panel also contained multiple references to an earlier MVA in 2008. Therefore, counsel for MPIC was prepared to

allow the Appellant to address this MVA as well, and to argue that her knee condition related to either the 2008 or 2009 MVAs, or to a combination of both.

Documentary Evidence

[Appellant's family doctor] (Family Practice)

Reports were provided by the Appellant's family doctor, [text deleted]. A certificate dated October 2, 2008 noted neck and lower back strain sustained in the first MVA. A primary health care report after the second MVA, dated February 20, 2009, noted neck pain, headache, back and shoulder pain but did not identify knee or leg pain or limited knee range of motion.

A narrative report from 2014 described the Appellant's continuing issues with her lower back, noting constant pain and increasing pain with walking. He recounted her concerns with pain radiating into the lower back and left knee, and into the inferior knee area, with numb left thigh and numbness in the left heel. These symptoms had been constant since the MVA and he found decreased sensation in the area of left lateral thigh and posterior inferior heel. He stated that she had developed a regional pain syndrome after soft tissue injuries and there was some evidence of subcutaneous skin nerve trauma in the MVA.

Physiotherapy

The Appellant received physiotherapy treatment for her neck and back pain following the MVA and was prescribed a back brace and lumbar sacral support.

MRIs

The panel reviewed an initial lumbar spine MRI report showing some disc protrusions with narrowing and compression and an impression of degenerative changes.

A follow-up MRI to investigate right leg pain following MVA did not find a compression fracture or significant disc protrusion or herniation, except for a left lateral disc protrusion resulting in mild neuro-foramina narrowing at the L2-3 level.

[Neurologist] (Neurology)

A 2007 (pre-MVA) neurological report from [neurologist] described the Appellant's complaints of numbness, history of fibromyalgia and stress fracture of her left lower limb.

A follow-up report noted continuing back pain and numbness in her left leg and heel related to the 2008 and 2009 MVAs.

In 2013, [neurologist] issued a prescription for a knee brace for a diagnosed patella subluxation related the MVA.

He reported to advise that the Tramacet medication she uses for symptoms of pain and numbness related to the MVA would likely be required for the foreseeable future. In follow-up he noted that she was having considerable lower back pain, frequent spasms and numbness related to the MVA. He stated that the MVAs continued to produce intractable neck and lower back pain as well as left knee and leg numbness, with pain, which she did not experience prior to the MVAs.

A subsequent report confirmed that she continued to experience back pain radiating from the lower back to the left knee area, with the left anterior thigh persistently numb and numbness in the left heel. She did not have these symptoms prior to the MVA. Drug therapy was effective and beneficial to control her regional pain syndrome.

He reported in 2015 to describe the Appellant's lower back and knee pain which was constant since the MVAs. She did not have these symptoms prior to the MVAs and manages the pain with local measures including knee braces, which have been effective and beneficial to control her regional pain syndrome. He prescribed 2 TENS units to help reduce oral meds for her pain and noted her need for 2 knee braces and a new back belt. He noted that she had consulted with orthopedic surgeon, [text deleted], regarding her back and knee pain, and [orthopaedic surgeon]'s impression was that she had a pain constellation originating from her lower back with secondary degenerative chondromalacia of the patellofemoral articulation in the left knee (for which he did not think surgery was necessary). Therefore, conservative therapy was needed and she required bilateral knee braces.

In 2016, [neurologist] issued another prescription for a knee brace for diagnosed patella subluxation related to the MVA. He reported again to reiterate [orthopaedic surgeon]'s opinion regarding the diagnosis of pain constellation of the lower back with secondary degenerative chondromalacia of the patellofemoral articulation in the left knee, and the need for bilateral knee braces. [Neurologist] opined that the knee injury was caused by the MVAs of 2008 and 2009 and that the bilateral knee braces are medically required as essential treatment for the Appellant's accident related condition.

He reported again in late 2016 to request a four wheeled walker with seat for the Appellant (for her back pain) and in 2017 to request 2 knee braces for patellofemoral syndrome for the Appellant's permanent injuries for the MVA.

He provided an additional report which stated:

> I believe that the knee braces are medically necessary. Her symptoms have been constant since motor vehicle accidents of Sept 27/08 and Feb 6/09. [text deleted] the orthopedic surgeon and myself concur regarding her back pain and knee pain. We believe that she has a pain constellation originating form her lower back with secondary degenerative chondromalacia of the patellofemoral articulation in the left knee for which he did not believe surgery was necessary. Therefore conservative therapy is needed and she requires bilateral knee braces and this is a permanent disability and therefore a permanent requirement for knee braces.

[Orthopaedic surgeon] (Orthopaedic)

[Neurologist] referred the Appellant to orthopaedic specialist, [text deleted].

He reported following an examination of the Appellant, noting her history of MVAs and fibromyalgia. He diagnosed a pain constellation originating primarily from her back. While there may be some secondary early chondromalacia of the patellofemoral articulation, this was certainly not the primary event. He did not have anything surgical to offer her and discussed with her the possibility of continuing use of the knee brace and medications.

A subsequent report recognized that while there may have been some degenerative wear to the knee, it was asymptomatic prior to the MVAs. On a balance of probabilities, the causative injury leading to the clinical symptoms in the knee was the specific trauma. He described the knee injury as permanent, chronic and progressive, suggesting knee bracing as a sensible and reasonable approach.

[Orthopaedic surgeon]'s final report reiterated his view that it is clearly within the balance of probability that the symptoms from her knees started as a result of the MVA. The onset of her current symptoms was a direct result of the MVA where, at the very least, the symptom onset

should be considered an enhancement of a pre-existing condition. Her back injury affects her knees and her walking, and she requires medical support for her permanent disability.

[Text deleted] (Internal Medicine)

[Internal medicine specialist] reported after a review of the MPIC HCS consultant opinion that there was not a medically probable cause and effect relationship between the MVA and the Appellant's documented knee symptoms.

He stated that after reviewing the documents following the MVA, including a primary health care report that checked the box for knee/leg pain, he believed there is documentation on file which supports her position that there was a knee injury in the MVA. Her neck and back symptoms were more substantial following the MVA and were the focus of subsequent visits but the presence of knee pain was documented. He noted that documentation on file from [orthopaedic surgeon] and others were relevant to her diagnosis and condition.

HCS Reviews

[MPIC's medical director]

A report from MPIC's medical director, [text deleted], in 2014 noted that based upon the current documents on file and references to the Appellant's pre-MVA chronic pain, a cause and effect relationship between the MVA and her chronic neck and back pain could not be substantiated.

[MPIC's HCS medical consltant]

MPIC's HCS medical consultant, [text deleted], reviewed reports from [Appellant's family doctor] and [neurologist] and concluded that the Appellant has a pain condition related to the

MVAs, that her low back pain was a permanent worsening of her pre-existing low back pain, and that medication was medically required to manage this pain.

[MPIC's HCS medical consultant]

MPIC's HCS medical consultant, [MPIC's HCS medical consultant] reviewed the file in 2015 and noted that the Appellant's vehicle was rear ended with minimal damage occurring to the rear portion of the vehicle. This made it medically improbable that she was subjected to a transfer of force that would result in an active knee injury. There was also an absence of medical evidence reporting symptoms of a knee injury after the MVA. He opined that her left patella tendinitis was not temporally or causally related to the MVA.

A subsequent opinion indicated that the medical literature did not support the position that chronic back pain which might alter gait contributes to the development of knee problems. Nor was there evidence based support for the belief that a healthy limb might undergo more rapid degeneration when the symmetrical limb is permanently impaired. He concluded that the reports in the claim file did not contain objective physical evidence to support findings of patella tendinitis and patella subluxation.

[MPIC's HCS medical consultant] later approved funding for a prescribed walker as medically required for the management of the Appellant's MVA related permanent worsening of pre-existing back pain, but continued to be of the view that it was not medically probable that her back symptoms adversely affected her ability to ambulate to the extent it would affect her patella or chondromalacia. The documentation did not demonstrate that an antalgic gait was assessed that might adversely affect the integrity of her knee.

After reviewing [orthopaedic surgeon]'s report, [MPIC's HCS medical consultant] reiterated his views regarding the mechanics of the MVA and his view that if pre-existing asymptomatic chondromalacia had been aggravated or enhanced as a result of the MVA, the symptoms would have commenced shortly after the incident, but the symptoms did not start until 2013.

After reviewing further documentation from the period after the MVA, [MPIC's HCS medical consultant] noted non-specific reference to leg pain but not knee pain and knee problems. There was nothing to indicate the knee was acutely injured on the MVA, resulting in persistent symptoms to the extent a thorough evaluation was required many years later.

[MPIC's HCS medical consultant]'s final report rejected [internal medicine specialist]'s opinion that the notation of knee/leg pain in a February 2009 primary health care report was sufficient evidence supporting the position that the knee was acutely injured during the MVA.

[MPIC's HCS medical consultant] also testified at the hearing into the appeal.

Evidence of the Appellant

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

She described the 2008 MVA, where her car was hit hard and bumped forward and she heard and felt a pop in her lower back. She tried to get out of the car, but couldn't stand and felt excruciating pain down her body. She went to the hospital for injuries and pain in her arm, neck, shoulders, lower back and legs.

She was still not fully recovered and was still wearing her back belt brace when she was hit in a second MVA in 2009. Her foot was on the brake and she felt the shock from there all the way up her body to the back of her neck and head. She described her visits with [Appellant's family doctor] after the MVA and her reports of pain to him.

The Appellant explained that prior to the MVAs she suffered from fibromyalgia, which she described as a very different sort of pain than she discovered after the MVAs. She did not recall having any knee problems from that or prior to the MVA. She described the fibromyalgia pain as more like muscle fatigue and burning.

But since the MVA she has massive pain in her back radiating down to her legs, especially when standing or walking. Her right leg drags, pain radiates down her left leg and she uses a cane. She described this pain as a crushing kind of pain in certain areas. In her back it is a sharp, stabbing pain that radiates down her back. She said that she had never had that pain before the MVA and it was very different from her fibromyalgia pain.

MPIC paid for her first knee braces but they wore out, started causing bruising, digging into her legs and lost their support. MPIC would not pay for replacements so Manitoba Health took over. The Appellant was asked to describe how her gait changes after she has walked for awhile. She explained that she can walk normally for about 10-20 steps, but then start to waddle side to side and the pain starts to go into her knees. The walker givers her something to lean on so that she can walk farther. It helps to stop the waddling a little and support her back and legs, giving her a bit more freedom. She really hadn't wanted to use the walker initially, but gave in when she saw that it was going to help her go further.

On cross-examination the Appellant acknowledged that when reporting her injuries at the time of the MVA she may not have identified an injury to her leg. She explained this was because she felt she had wrenched her whole body.

She indicated that her disability payments had started some years earlier and were related to her fibromyalgia. Prior to that she had been employed as a head photo lab tech for graphic arts and aerial photography but found that with her fibromyalgia she could no longer stand to lift and cut paper or take care of the machines, because her muscles became too fatigued.

She also talked abut the stroke she suffered in July of 2009, after the MVAs, which did not affect her limbs but affected her emotional state and her memory, with some loss of vision. She also discussed her rare condition of arteritis vasculitis, an inflammation of the arteries in the body for which she takes infusions and chemotherapy pills. The condition does not cause symptoms or pain but puts her in danger of heart attack or stroke.

The Appellant maintained that she had not had leg numbness prior to the MVAs. She said it was possible that she complained to [Appellant's family doctor] of lower back pain as she had many trigger points from the fibromyalgia that were sore when touched. But this was different from the MVA pain which was stabbing and sharp, causing her to waddle. The fibromyalgia pain caused more muscle fatigue, with burning if she pushed through it. She said that she can definitely tell the difference in her body between the MVA pain and the fibromyalgia and that she has never reported anything that she has not felt in her body. She confirmed that areas of [Appellant's family doctor]'s chart notes that she had asked be redacted had to do with bad things that happened in her life but nothing whatsoever to do with any physical symptoms.

Evidence of [MPIC's HCS medical consultant]

[MPIC's HCS medical consultant] was qualified as an expert in sports medicine with experience in forensic medical review.

He began his testimony by describing what he looks for and how he approaches a causation analysis by reviewing the claim file (including the vehicular damage information), looking at the transfer of force, at what the health care providers had documented in the early stages and the diagnostic tests performed.

When he saw the prescription for the Appellant's knee braces caused by the MVA, (non-specified patella tendonitis, patella subluxation due to MVA) he first assumed that there must have been a knee injury as a subluxation is not a condition that occurs after a traumatic injury to the knee. So he went back to the file to see when the injury occurred. But the hospital and health care provider reports he reviewed did not document injury to the knee. Most minor rear end collisions do not give rise to much injury and he was not alerted to something significant that could have challenged the Appellant's knee.

Post MVA symptoms of leg/knee pain documented by [Appellant's family doctor] were not very different from his pre-MVA assessment of the Appellant's lower back pain and leg pain and numbness. In his view, a temporal lag of a few days delay in reporting symptoms in the knee might not be unusual, but a 4 year delay was. In addition, knee problems are very common in the general population, making it hard to relate her pain to an event that happened some time before.

[MPIC's HCS medical consultant] went over [orthopaedic surgeon]'s opinion that the knee condition was MVA-related and explained that he focused on the injury, saying that she was asymptomatic before the MVA, so that it must be related to the MVA. But the vast majority of people with knee problems don't ever have information that there was an injury to the knee and don't define an event that caused symptoms to develop. Even if it was an aggravation of a previous condition, she would not be asymptomatic for 4 years after the MVA and [MPIC's HCS medical consultant] could not support [orthopaedic surgeon]'s opinion that the injury was due to the MVA. This may have been based upon what the Appellant had outlined to him and not the historical information and evidence from the claim file.

He opined that the big issue is the Appellant's longstanding and persistent back problems with early degenerative chondromalacia of the patella, but there had not been much concern or attention paid to the knee in examinations post-MVA. The information did not really establish that the back issue caused the knee conditions. Symptoms can develop in the absence of an event.

Although [neurologist], [internal medicine specialist] and [orthopaedic surgeon] all differed from [MPIC's HCS medical consultant]'s opinion, he explained that [[neurologist]] failed to take into account knee symptoms prior to the MVA and [orthopaedic surgeon] based his opinion on the same conclusion, and his impression that she had them ever since. But we know that she had no leg symptoms or documentation of them for 4 years. Non specific examination tenderness around our kneecaps is a common symptom and doesn't reflect a major problem with the knee.

Further, he indicated that [internal medicine specialist]'s opinion had no evidence to support it. She could have had an altered gait and chronic L5 radiculopathy even prior to the MVA which gluteal weakness could have contributed to. This was not a medically probable opinion.

Submissions

Submission for the Appellant

Counsel for the Appellant submitted that the medical evidence on file establishes a causal relationship, albeit an indirect one, between the Appellant's knee problems and the MVAs. MPIC accepted that there had been an enhancement of the Appellant's low back problems as a consequence of the MVAs. [neurologist], [orthopaedic surgeon] and [internal medicine specialist] all opined that her knee problems are a consequence of these low back problems. [orthopaedic surgeon] stated that chondromalacia may have either gradual onset and progression or acute onset related to a specific trauma. He opined, and [[neurologist]] agreed, that the knee problems were a consequence of the low back pain. This pain, counsel submitted, manifested itself in the Appellant's waddling, altered gait, which began to cause pain in her knee joints.

As a neurologist, [text deleted] relied upon [orthopaedic surgeon]'s opinion as an orthopedic surgeon. Both concurred regarding her back and knee pain, which they believed was a pain constellation originating in her lower back, with secondary degenerative chondromalacia of the patellofemoral articulation in the knee. This was caused by the MVAs and conservative therapy was recommended in the form of bilateral knee braces.

[MPIC's HCS medical consultant] took the position that since the Appellant's knee problems did not appear until October 2013, the problem was likely a case of gradual onset and not from the

MVAs. He opined that for the MVA to have caused chondromalacia, it would have to have been by acute trauma.

Counsel pointed out that [orthopaedic surgeon] was aware of the Appellant's pre-existent fibromyalgia, yet the Appellant had not reported any specific generalized low back pain or leg/knee pain preceding the MVAs. An MRI report prescribed due to right leg pain following the MVA examined the lower back. [MPIC's HCS medical consultant] agreed that this MRI would indicate a probable worsening of the low back symptoms following the 2008 MVA. This was supported by the Appellant's testimony that she did not waddle prior to the MVAs and that she experienced a significant increase in her low back pain as well as a change in the nature of that pain following the 2008 MVA.

[Internal medicine specialist] diagnosed a chronic L5 radiculopathy and indicated that the temporal relationship between the MVAs and her symptoms suggested this may be related to the initial MVA, with ongoing symptoms of abnormal gait believed to put stress on her knees. He identified the possibility that weakness in the gluteal musculature may result in abnormal gait mechanics. Although [MPIC's HCS medical consultant] agreed that such weakness could lead to patella femoral pain, he erred in concluding that there was no evidence on file that any such gluteal weakness existed in the Appellant's case.

In summary, counsel submitted that the Appellant's family doctor, [Appellant's family doctor] and 3 specialists (neurologist, orthopaedic surgeon and internist) all agreed that the Appellant's knee problems were caused by the MVAs. All of these doctors had full knowledge of the Appellant's pre-existing fibromyalgia and actually examined her. [orthopaedic surgeon] even noted her pre-existing low back pain. These specialists are more qualified to diagnose the

Appellant's knee problems than [MPIC's HCS medical consultant], who had even agreed that gluteal muscle weakness could cause knee problems.

Therefore, counsel asked the panel to give more weight to the opinions of the caregivers than to the opinions of [MPIC's HCS medical consultant] and accept that the Appellant's knee problems are causally related to the MVA.

Submission for MPIC

Counsel for MPIC reviewed the 2008 MVA which caused soft tissue injuries to the Appellant's back. He reviewed the circumstances of the 2009 MVA and the injuries reported in the aftermath, which included sore neck, right side, back, left and right leg, tailbone, groin and right ankle. He noted that the evidence of [[neurologist]], [orthopaedic surgeon] and the MRI mostly related to the left knee, and addressed the question of whether the diagnosis of degenerative chondromalacia is causally related to the MVAs. He submitted that causation had not been established on a balance of probabilities and that the appeal should be dismissed.

In this regard, counsel relied upon the reports and testimony of [MPIC's HCS medical consultant]. [MPIC's HCS medical consultant] explained what he looks for when reviewing a file for causation, including what happened, the circumstances of the MVA, the force to which the victim was exposed, the potential for injury, the history and documentation around the time of the MVA and following. He looks for a temporal connection between the injury and the MVA.

In reviewing [Appellant's family doctor]'s initial request for a knee brace for non-specific tendinitis, [MPIC's HCS medical consultant] looked at the minor rear-end collision MVAs

(which do not normally result in musculoskeletal injuries), and the mechanism of injury with no documentation of injury to the knees. Based on this information and the lack of reporting of symptoms or physical findings suggestive of an acute knee injury (reports indicated she aggravated previous back symptoms) he concluded that the evidence did not support acute knee injury as a result of the MVAs.

Although the Appellant had at least 16 visits with [Appellant's family doctor] between the time of the 2009 MVA and the reporting of knee symptoms in October 2013 the evidence indicated, and the Appellant agreed, that there did not seem to be a knee problem until October 2013. [MPIC's HCS medical consultant] would have expected her to have noted symptoms such as pain and swelling immediately following or in the week following the MVA.

[MPIC's HCS medical consultant] explained his opinion that the reports of the other doctors were based upon their erroneous belief that her knee problems began at the tine of the MVAs, which is false. They did not explain the 4 year gap or whether they were aware of it. [[neurologist]]'s numerous reports set out the erroneous conclusion that the Appellant did not have back pain prior to the MVAs and his belief that her knee pain was constant from the time of the MVAs. [orthopaedic surgeon] indicated that the knee pain was constant and this was the basis for his conclusions, perhaps without seeing [Appellant's family doctor]'s chart notes from the time of the MVA. [internal medicine specialist], although he had access to this reporting, also relied on information that the knee pain began at the time of the MVA, stating that the temporal relationship between the MVA and symptoms sounded as though it might be related to the MVA. Therefore, counsel submitted that little reliance should be placed upon their opinions and the opinion of [MPIC's HCS medical consultant] should be preferred.

[MPIC's HCS medical consultant] testified that the sole early notation of left leg/knee pain was not sufficient, as it was unclear what it related to and the corresponding box for range of motion was not checked off. Chondromalacia occurs in most cases in the absence of a single event and there was no evidence to support worsening of the condition from the MVA. Nor was it medically probable that her back symptoms adversely affected her ability to ambulate, and there was no indication that she demonstrated an antalgic gait or gait pattern. Further, [MPIC's HCS medical consultant] did not see any material to support the doctors' conclusions that the Appellant's back was causing her knee problems or evaluating weakness in the glutes. He was not aware of any medical literature suggesting that chronic back pain could alter gait to the extent that the knee would require prescription bracing.

Therefore, counsel submitted that [MPIC's HCS medical consultant]'s forthright evidence and helpful manner withstood cross-examination and that the Appellant had not successfully challenged his reliable opinion regarding causation.

The IRD should be upheld and the appeal dismissed.

Discussion

The MPIC Act provides:

> **Reimbursement of victim for various expenses**
>
> 136(1) Subject to the regulations, the victim is entitled, to the extent that he or she is not entitled to reimbursement under *The Health Services Insurance Act* or any other Act, to the reimbursement of expenses incurred by the victim because of the accident for any of the following:
>
> (a) medical and paramedical care, including transportation and lodging for the purpose of receiving the care;

The onus is on the Appellant to show, on a balance of probabilities, that the IRO erred in concluding that her knee condition was not causally related to the MVA.

The panel has reviewed the documents before us, the testimony of the Appellant and [MPIC's HCS medical consultant], and the submissions of the parties. We have weighed the evidence of the Appellant and the medical evidence in the documents and testimony before us.

The panel found that the Appellant delivered her evidence in a clear and consistent manner. Her description of her past medical symptoms and history and the change in her pain after the MVA was detailed, articulate and not varied upon cross-examination.

She described her pre-existing fibromyalgia pain as having a quality of muscle ache, burning and fatigue, and contrasted this with the more crushing, sharp, stabbing pain radiating down her back and into her leg after the MVAs. We found her description to be credible and consistent with her documented report to her case manager on November 21, 2013 that because of her back injury she walks funny and it is causing knee problems. Her explanation that the change in her pain post-MVA led to difficulties walking and gait changes (which she described as waddling) was also provided in a forthright, direct manner in both her direct evidence and upon cross-examination.

We have also carefully compared the conflicting expert opinion evidence of [MPIC's HCS medical consultant] and four of the Appellant's doctors, [text deleted].

Counsel for MPIC submitted that we should prefer the evidence of [MPIC's HCS medical consultant] to the four doctors who believed there was a connection between the Appellant's

knee condition and the MVAs. In support of this position he argued that none of these doctors had taken into account the Appellant's pre-existing back and body pain from her fibromyalgia.

However, the panel's review of the doctors' reports does not support this position.

[Orthopaedic surgeon]'s report to [neurologist] of September 14, 2015 noted her significant health history for fibromyalgia and the medications she takes for it.

[Orthopaedic surgeon]'s subsequent report of November 3, 2019 recounted a significant past history of Takayasu's arthritis, hypertension and fibromyalgia, with pre-existent low back pain.

[Internal medicine specialist]'s report of June 23, 2021 attached documentation which refers to her history of both fibromyalgia and Takayasu arthritis.

Accordingly the panel finds that, in forming their opinions, these caregivers were fully aware that the Appellant suffered from body pain due to pre-existing fibromyalgia and that there is no reason to believe that they did not take it into account in forming their expert opinions.

We have also reviewed the reports of these specialists to determine if, as argued by MPIC, they incorrectly relied upon the existence of reports of knee pain following the MVA and prior to 2013.

As [MPIC's HCS medical consultant] and counsel for MPIC noted, [orthopaedic surgeon] did seem to be of the opinion that the Appellant's knee was injured in the MVA. He made reference

to a lack of back pain prior to the MVA and pain in the knee in the period following it, which do not seem to be supported by the documentary evidence reviewed by the panel.

The panel recognizes that [orthopaedic surgeon] is not a back specialist, as he indicated in his report of November 2, 2018, and did not want to comment upon her pre-existing condition or whether the MVA caused her low back pain. His comments were limited to the potential for one diseased joint to hasten the deterioration of an adjacent segment.

This concept was reiterated in his report of November 3, 2019 which stated that her back injury affects her knees and walking, with her symptom onset described as a direct result of the MVA or an MVA-related enhancement of a pre-existing condition.

The panel prefers the evidence of [neurologist] and [internal medicine specialist], who both explained how the Appellant's knee condition resulted from the effects of the Appellant's back condition. We find this to be consistent with the Appellant's description of the nature of her back pain after the MVAs, as distinct from the nature of her fibromyalgia pain in the years prior. Her knee pain then arose and increased as she encountered more and more back pain and associated difficulty walking.

The panel agrees that there is some lack of clarity in [neurologist]'s earliest brief reports. For example, in prescriptions dated October 28, 2013 and April 21, 2015 he simply refers to patella subluxation related to MVA. In a report dated November 9, 2014 he states that the MVAs continue to produce intractable neck and lower back pain as well as left knee and leg numbness.

These reports lack detail regarding the mechanism of injury and source of symptoms.

But his other reports specifically address the Appellant's intractable lower back pain, or considerable lower back pain and frequent back spasms. [Appellant's family doctor] reported on her lower back strain from the first MVA as early as October 2, 2008, reiterated on September 15, 2011. The lower back pain led to MPIC's acceptance of an enhancement of her back condition resulting from the MVA and funding of a back brace prescribed by him for lumbosacral strain related to the MVA.

Later reports from [neurologist] took a more holistic view of the Appellant's condition. [Appellant's family doctor] had described the Appellant as having "maintained a consistent pattern for treatment of her regional pain syndrome". [Neurologist]'s report of June 12, 2015 referred to her lower back and knee pain as a regional pain syndrome. He acknowledged the impact of her back problem upon her knee, often reporting on back pain and spasm, leg numbness and knee pain together. In reviewing [orthopaedic surgeon]'s opinion and in his own later reports, [neurologist] described that connection as a "pain constellation originating from her lower back with secondary degenerative chondromalacia of the patellofemoral articulation in the left knee".

[Internal medicine specialist]'s report also included reference to documented nerve injury, which could create gluteal weakness, strain walking, and symptoms of abnormal gait, putting strain on her knees.

These considerations have led the panel to place greater weight upon the evidence of these caregivers, and particularly of [neurologist] and [internal medicine specialist], and to some degree of [Appellant's family doctor] and [orthopaedic surgeon] who met with, interviewed, examined, assessed and treated the Appellant. Their conclusions were consistent with the

credible testimony of the Appellant regarding the change to the nature of her pain after the MVA, her lower back pain and difficulties walking, the gait changes she experienced and the emergence of her knee symptoms.

Overall, the evidence had led us to find, as her caregivers did, that the Appellant's knee condition was a consequence of the MVA-related exacerbation of her back pain and causally related to the MVA.

The Commission therefore upholds the Appellant's appeal and overturns the decision of the IRO which concluded that because her knee condition was not causally related to the MVA, she was not entitled to funding for knee braces.

The Commission finds that the Appellant's knee condition was causally related to the MVAs and that the Appellant is entitled to funding from MPIC for her knee braces.

Dated at Winnipeg this 11th day of April, 2022.

LAURA DIAMOND

LINDA NEWTON

SANDRA OAKLEY