

**Automobile Injury Compensation Appeal Commission**

**IN THE MATTER OF an Appeal by C. B. A.  
AICAC File No.: AC-05-80**

**PANEL:** Ms Yvonne Tavares, Chairperson  
Dr. Patrick Doyle  
Mr. Antoine Frechette

**APPEARANCES:** The Appellant, C. B. A., was represented by Mr. Donald Granatstein;  
Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Morley Hoffman.

**HEARING DATE:** June 13, 2006

**ISSUE(S):** 1. Entitlement to psychotherapy treatment benefits; and  
2. Entitlement to funding for additional pain management therapy, occupational therapy and physiotherapy.

**RELEVANT SECTIONS:** Section 136(1)(a) of The Manitoba Public Insurance Corporation Act (the 'Act') and Section 5 of Manitoba Regulation 40/94

**MAIC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE PERSONAL HEALTH INFORMATION OF INDIVIDUALS BY REMOVING PERSONAL IDENTIFIERS AND OTHER IDENTIFYING INFORMATION.**

**Reasons For Decision**

The Appellant, C.B.A., was involved in a motor vehicle accident on June 7, 1997. As a result of the motor vehicle accident, the Appellant sustained soft tissue injuries to her neck and back. Due to the bodily injuries which the Appellant sustained in this accident, she became entitled to Personal Injury Protection Plan ("PIPP") benefits pursuant to Part 2 of the Act.

The Appellant is appealing two (2) separate internal review decisions, dated September 2, 2004 and March 10, 2005. The Internal Review Officer in her decision dated September 2, 2004, determined that the totality of the medical information on the Appellant's file did not provide objective substantiation that her current symptoms and subsequent need for pain management therapy, occupational therapy or physiotherapy was causally related to the motor vehicle accident or medically required pursuant to s. 5 of Manitoba Regulation 40/94.

In her decision dated March 10, 2005, the Internal Review Officer determined that the need for additional psychotherapy sessions was not medically required for conditions relating to the motor vehicle accident. The Internal Review Officer found that the medical information on the Appellant's file did not support a causal relationship between her psychological problems and the motor vehicle accident in question.

The issues which require determination in this appeal are:

1. Whether the Appellant's ongoing problems are causally related to the motor vehicle accident of June 7, 1997; and
2. Whether pain management therapy, occupational therapy or physiotherapy are "medically required" within the meaning of Manitoba Regulation 40/94.

Due to the Appellant's ongoing post-traumatic symptoms, a neurological assessment was undertaken on February 5, 2002 with Dr. Levitan, a neurologist. In his report dated March 21, 2002, Dr. Levitan noted that the Appellant's neurological examination was normal, but that she had significant affective symptoms as a result of her injuries sustained in the motor vehicle accident. As a result, he recommended that the Appellant undergo a psychiatric examination.

Subsequently, the Appellant underwent an independent psychiatric examination with Dr. R. van Reekum on March 5, 2003. In his report dated April 9, 2003, Dr. van Reekum opines as follows:

It would appear to me to be most likely that [C.B.A.] suffered MSK injuries in the MVA which may have been superimposed on a vulnerable cervical spine. She has developed a pain disorder due to both the MSK injuries (according to Dr. Levitan) and to psychological factors, some of which are accident related (e.g. the losses and some of her stresses). Out of this pain disorder has arisen Major Depression and Generalized Anxiety Disorder (the former is in partial remission on venlafaxine at present). Also due apparently to the pain is a sleep disturbance (cannot rule out the possibility of primary sleep disorder) and resultant anergia (lack of energy or fatigue). She is also exhibiting both irritability and the apathy syndrome, both of which are common in TBI, and can also be caused by Depression, chronic pain, anergia and metabolic disturbance. As mentioned above, she has complaints of progressive cognitive decline since the MVA, and indeed cognitive impairment was observed in interview (including problems with word finding, poor recall, repetitiveness, and visual-spatial constructive abilities). She has not yet had cognitive testing. Finally, as with most similar cases, we cannot rule-out the possibility of malingering and drug seeking behaviour.

All of the above listed problems and impairments are potentially at least in large part due to the MVA. As mentioned, and as is outside my area of expertise, her pain and MSK problems may be in part related to pre-MVA factors, however I would note that she did not appear to require treatment for pain immediately pre-MVA, and was apparently functioning normally. As such it would appear to me that the MVA-related MSK injuries were at least a significant contributing factor to her post-MVA pain. As best I can tell [C.B.A.] did not suffer with Depression pre-MVA, and nor with Generalized Anxiety Disorder, sleep disturbance, irritability or apathy, and as such all of these problems would appear to be accident related. As discussed above, the cognitive complaints may be indirectly due to some of the accident-related problems she has had, however we also cannot rule-out the possibility of non-accident related factors.

Dr. van Reekum recommended that the Appellant undergo an MRI of the brain as well as neuropsychological testing to help determine the cause of the cognitive impairment. He also recommended that the Appellant attend a pain specialist and a psychiatrist and/or psychologist to address her depression and anxiety concerns.

Consequently, the Appellant underwent a neuropsychological evaluation by Dr. Joanna Hamilton to investigate the nature of her cognitive difficulties. In her report dated November 20, 2003, Dr. Hamilton noted the following:

There is no evidence, in the medical record, that she was exhibiting depression prior to the accident and nor was she experiencing significant levels of pain. As a result, her levels of psychological distress and her chronic pain condition are thought to be a result of the accident. However, it must be noted that [C.B.A.] may have been vulnerable to the development of increased depression following a stressful situation. Prior to the accident she was involved in an abusive marriage with her second husband and her first husband left her. Although she stated that she experienced some levels of depression following the break-up of the first marriage, no functional changes were reported. It is thought that [C.B.A.] used her activity level and work to assist her in coping with stressful situations. Following the accident, her pain limited her ability to engage in typical ways of coping and she developed more levels of psychological distress. The removal of this coping strategy (e.g., work and activity) increased the probability of the development of significant psychological distress, including depression and anxiety. As her pain has continued, further psychological distress occurred.

...

At present, [C.B.A.'s] most pressing rehabilitation concern is related to her pain and psychological distress. These challenges are related to the effects of the accident. [C.B.A.] has not received any psychological treatment for her pain and, as a result, the psychological impact of this is thought to be chronic and permanent in nature at this time. [C.B.A.] will benefit from implementation of a pain management program. Although, ideally, this program should be an inpatient pain management program, access to these programs is extremely limited in [C.B.A.'s] geographical area. As a result, a referral to a pain management specialist (from a medical perspective) is recommended to evaluate issues related to medication. In addition, a referral to a psychologist specializing in pain management would be appropriate. I would recommend Dr. Susan Beckett in this regard. Comprehensive pain management should also include both occupational therapy and physiotherapy to assist in the development of a physical activity program, as well as the development of pacing techniques.

Based upon Dr. Hamilton's report, MPIC approved a psychological intervention program to assist the Appellant with pain management. Dr. Langewisch assessed the Appellant for potential treatment of chronic pain management. In his report, dated February 13, 2004, Dr. Langewisch concluded that:

[C.B.A.] presents as a very pleasant and interpersonal woman who is visibly suffering a considerable amount of physical and psychological pain. Her current symptom complex is congruent with moderate to severe depression and anxiety, related to changes in her life that have occurred as a result of injuries sustained in an MVA seven years ago. The constant physical pain that she suffers from has led to feelings of helplessness, hopelessness, depressed mood, and considerably anxiety. The

coinciding changes in her ability to function on a daily basis have only served to exacerbate her depression, despite considerable support from her family. It is recommended that [C.B.A.] receive 8 to 12 sessions of individual psychotherapy to treat symptoms of clinical depression, and to attempt to assist her in managing her daily anxiety and pain. It is also recommended that [C.B.A.] consider speaking with her physician about the benefits of anti-anxiety medication.

The Appellant's file was also referred to MPIC's Health Care Services Team to determine whether funding for a pain management specialist, occupational therapy and physiotherapy assessments was medically required in relation to injuries sustained in the motor vehicle accident. In his report dated March 5, 2004, Dr. Craton concluded that:

I am unable to link this patient's current psychosocial and psychological distress to the event in question. It is difficult to link her entire clinical syndrome to the accident of 1997 based on the information I see on this file. The patient does not appear to have had a brain injury. It is possible that she could have chronic Whiplash Associated Disorder pain. The most probable source of Whiplash Associated Disorder pain would be the z-joint. I would therefore suggest a clinical encounter with a medical doctor who is an expert in z-joint medial blocks and subsequent neurotomies. At this point, I do not see physiotherapy having a medical requirement in this case. At this point, I do not see occupational therapy being a medical requirement related to the event in question. It is difficult to link the patient's overall clinical condition, at this point in time, to the whiplash she sustained several years ago.

In a letter dated April 28, 2004, MPIC's case manager informed the Appellant that MPIC would not fund additional pain management therapy, occupational therapy or physiotherapy. An Internal Review was sought with respect to this decision, which resulted in the Internal Review decision dated September 2, 2004, confirming the case manager's decision.

Subsequently, Dr. Langewisch wrote to MPIC providing an update on his treatment sessions with the Appellant. He noted that the Appellant had made good progress in therapy and reported improvement in her sleep, energy level, mood, stress levels, anxiety and interpersonal relationships. However, he advised that she continued to suffer with depressive

symptomatology, frustration and lack of motivation. As a result, Dr. Langewisch requested a further eight (8) treatments sessions in order to help the Appellant work through her fears and sadness.

In a decision dated July 12, 2004, MPIC's case manager denied the Appellant's request for additional psychotherapy. An Internal Review was sought with respect to this decision, which resulted in the Internal Review decision dated March 10, 2005 confirming the case manager's decision.

A further opinion was then sought from Dr. Hamilton requesting her comments on Dr. Craton's report of March 5, 2004. In her report dated September 15, 2004, Dr. Hamilton concluded that:

As a result, after review of the file, I believe that it is incorrect to assume (as it appears that Drs. Craton and Rallo have) that all of her presentation following the motor vehicle accident is a direct result of pre-accident stress and depression. Terms such as reactive depression, stress reaction, and anxiety state may all be used to refer to the same underlying condition or presentation and, as a result, I believe it is probably most appropriate to identify that [C.B.A.] had pre-existing difficulties reflecting anxiety. This appears to be what Dr. Theodore refers to as her "anxiety state." It further appears that [C.B.A.'s] condition has worsened following the motor vehicle accident. Although [C.B.A.] was taking medication for anxiety prior to the accident, she was not seen for psychological therapy. Her pre-existing anxiety state would predispose her to having greater difficulties coping with additional stressors (such as these experienced following the motor vehicle accident). As I reported on page 14 of my report, [C.B.A.] was thought to have been vulnerable to the development of increased depression following a stressful situation. It also appears, based on her history, that she utilized her activity level and work as a way of coping with pre-accident stressful situations (as mentioned in my report) and that this coping method was eventually eliminated for her following the accident, although she did attempt to return to work. As this was not successful, she developed increased psychological distress. As a result, I continue to believe that she requires psychological treatment for her current presentation and that the accident has, at minimum contributed to her present state. I do not believe that there is enough information in the record to indicate that [C.B.A.'s] pre-accident status was as severe as it is at present. Prior to the accident, and in spite of anxiety, she was employed and managing her psychological issues through the use of medication. She continues to require psychological intervention at present as her state has worsened.

...

In summary, although the medical record does document some pre-existing issues (which were mentioned in my report – see pages 2, 3, and 13) I do not believe that [C.B.A.] was experiencing the levels of depression that she was reporting at the time I saw her for evaluation. In my opinion, her pre-existing anxiety left her vulnerable to being able to cope effectively with any additional stressor (e.g., the accident) and would heighten her psychological distress. Her pain experience also worsened since the accident. She attended frequently at the hospital in regards to her neck pain and headaches following the accident and this would appear to be an increase in the amount of medical attention sought for these symptoms when compared to prior to the accident. Given that it appears that there was an increase in her psychological distress and pain experience following the accident, it seems reasonable to conclude that, despite her pre-existing anxiety, [C.B.A.’s] presentation is a result of injuries sustained in the accident. Her pre-existing issues served to make her vulnerable to the development of a pain disorder with both organic and psychological features following the accident.

An additional report was also requested from Dr. van Reekum, in light of Dr. Craton’s assessment of March 5, 2004. In his report dated January 19, 2005, Dr. van Reekum disagrees with many of the conclusions reached by Dr. Craton and concludes as follows:

In summary, the additional evidence you have provided me with for the most part confirms my earlier opinions. I do need to revise one conclusion as follows. It would appear that [C.B.A.] was suffering with some anxiety (related to Adjustment Difficulties and made chronic at least in part due to inappropriate treatment with chronic doses of lorazepam) prior to and at the time of the MVA. As such, her post-MVA GAD may be related, in part to her pre-MVA anxiety. It is likely, though, that the pain and loss/stress associated with her MVA-related injury(s) have also contributed significantly to the development of her post-MVA GAD.

Counsel for the Appellant submits that while the Appellant may have had a pre-existing anxiety disorder and the occasional migraine, she did not have pain in her neck and she did not have Major Depressive Episodes (MDE). The motor vehicle accident also contributed significantly to the development of her post-MVA General Anxiety Disorder (GAD) and exacerbated the frequency and severity of her migraines. In support of his submission, counsel for the Appellant relies on the case *Athey v. Leonati*, 1963 SCR 458, where the Supreme Court of Canada found that where an accident “materially contributed” to the occurrence of an injury, causation is established. Counsel for the Appellant argues that, according to that case, a contributing factor is

material, if it falls outside the *de minimis* range. He notes that the law does not excuse a defendant from liability merely because other causal factors for which he is not responsible also help to produce the harms. It is sufficient if the defendant's negligence was a cause of the harm. The pre-existing disposition may have aggravated the injuries, but the defendant must take the plaintiff as he finds him. If the defendant's negligence exacerbated the existing condition and caused it to manifest in a disc herniation, then the defendant is the cause of the disc herniation and is fully liable. Counsel for the Appellant therefore concludes that, since the Appellant's condition was at least contributed to by the motor vehicle accident, then MPIC is responsible for treatment of her injuries.

Counsel for the Appellant also notes that pain management therapy, occupational therapy and physiotherapy were all recommended by the Appellant's treating physicians. The report of Dr. Langewisch dated June 21, 2004, indicated improvement in the Appellant's sleep, energy level, mood, stress levels, anxiety and interpersonal relationships. Therefore, counsel for the Appellant concludes that pain management therapy has been demonstrated to improve her condition and therefore she should continue to receive this treatment. He submits that the Appellant should have a current assessment in order to determine whether occupational therapy and further physiotherapy are still medically required.

Counsel for MPIC submits that the Internal Review decisions should be confirmed. He notes that the Appellant had long standing problems before the motor vehicle accident. He maintains that the difficulties which the Appellant developed after the motor vehicle accident are related to those pre-existing conditions and not to the motor vehicle accident. Counsel for MPIC further submits that the Supreme Court of Canada decision in *Athey v Leonati* is not applicable in this case, because that case dealt with tort issues and causation and the Defendant's liability for

injuries caused or contributed by his negligence. In his submission, counsel for MPIC contends that:

Principles concerning causation in tort are founded on considerations of fault. This does not apply to the no fault system in PIPP. In tort there also is an element of punishment. As well, in tort there is an element of moral judgment implicit in findings regarding damages falling on the guilty rather than the innocent party.

The “thin skull” rule is designed to circumvent normal understandings of foreseeability and remoteness and is conditioned by ideas of fault and guilt. It has no part to play in PIPP.

Tort also has “material cause” elements where one event is plucked out of a complex of causes operating simultaneously so that the tortfeasor becomes responsible for everything. For the purposes of deciding where the loss falls, what is merely an occasion, is treated as a cause.

The tort techniques for manipulating causation often defy common sense.

The tort techniques have nothing to do with no fault disability insurance schemes. Tort applies concepts of future contingencies to awards which is foreign to no fault schemes. Moreover, the tort concept of limiting responsibility for aggravation of damages has no use in no fault. This is a technique used to limit responsibility of the tortfeasors where they would otherwise have unlimited responsibility and would outrage sense of fairness.

For all these reasons, it is our submission that *Athey* has no application to this case or any case at AICAC, for that matter.

### **Decision**

Upon a review of all of the evidence made available to it, both oral and documentary, the Commission finds that the Appellant’s current condition is causally related to the motor vehicle accident of June 7, 1997. As a result, she is entitled to continuation of her psychotherapy treatment sessions. We also find that a current assessment should be undertaken in order to determine whether occupational therapy or physiotherapy are presently medically required for the Appellant.

The Commission accepts Dr. van Reekum’s opinion with respect to the Appellant’s psychological condition, and the development of that condition. We find that Dr. van Reekum,

having assessed the Appellant and having reviewed the Appellant's medical history, is in the best position to comment on the Appellant's psychological condition. We accept Dr. van Reekum's opinion that the pain and loss/stress associated with the Appellant's motor vehicle accident-related injuries have contributed significantly to the development of her post-MVA Generalized Anxiety Disorder.

In these circumstances, we find that the comments and observations made by Dr. van Reekum, a consultant and clinical investigator in neuropsychiatry, who had the benefit of personally observing the Appellant, must be preferred to those of Dr. Craton, who did not have the opportunity to personally assess the Appellant. As a result, we find that the Appellant's current condition is causally related to the motor vehicle accident and accordingly, she is entitled to continuation of her psychotherapy treatments and/or pain management therapy.

Dated at Winnipeg this 25<sup>th</sup> day of September, 2006.

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**YVONNE TAVARES**

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**DR. PATRICK DOYLE**

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**ANTOINE FRECHETTE**