Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by R.J.R.
AICAC File No.: AC-04-205

PANEL:	**Ms Yvonne Tavares, Chairperson** **Ms Mary Lynn Brooks** **Mr. Paul Johnston**
APPEARANCES:	**The Appellant, R.J.R., appeared on his own behalf; Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Morley Hoffman.**
HEARING DATE:	**June 27, 2006**
ISSUE(S):	**1. Entitlement to reimbursement of the cost of medications;** **2. Entitlement to Income Replacement Indemnity benefits beyond November 30, 2004.**
RELEVANT SECTIONS:	**Sections 110(1)(a) and 136(1)(d) of The Manitoba Public Insurance Corporation Act (the "MPIC Act") and Section 38 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, R. J. R., was involved in a motor vehicle accident on May 8, 1999. As a result of this motor vehicle accident, the Appellant sustained injuries to his right shoulder, back, right wrist and left knee. Due to the bodily injuries which the Appellant sustained in this accident, he became entitled to Personal Injury Protection Plan ('PIPP') benefits pursuant to Part 2 of the MPIC Act.

The Appellant is appealing two (2) separate Internal Review decisions, dated November 17, 2004 and February 10, 2005, with respect to the following issues:

1. Entitlement to reimbursement of the cost of medications; and
2. Entitlement to Income Replacement Indemnity benefits beyond November 30, 2004.

1. Entitlement to reimbursement of the cost of medications

The case manager's decision, dated September 17, 2004, determined that the Appellant's requirement for the current amount of narcotic analgesia, Oxycontin and/or Codeine Contin was unrelated to the motor vehicle accident of May 8, 1999. The decision set out a weaning regimen from September 22, 2004 to March 16, 2005, at which point the Appellant's narcotic usage would be equal to his pre-motor vehicle accident narcotic usage. Upon a review of that decision, the Internal Review Officer confirmed the case manager's decision and dismissed the Appellant's Application for Review. The Appellant has now appealed to this Commission.

The issue which requires determination in this appeal is whether the Appellant's ongoing requirement for medication, and specifically narcotic analgesia, is causally related to the motor vehicle accident of May 8, 1999.

The relevant sections of the MPIC Act and Regulations are as follows:

Section 136(1)(d) of the MPIC Act provides that:

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:
. . . .
(d) such other expenses as may be prescribed by regulation.

Section 38 of Manitoba Regulation 40/94 provides that:

Medication, dressings and other medical supplies
38 The corporation shall pay an expense incurred by a victim for the purchase of medication, dressings and other medical supplies required for a medical reason resulting from the accident.

The Appellant submits that his ongoing requirement for pain control medication is related to the motor vehicle accident of May 8, 1999 and, accordingly, the costs of these medications should be covered by MPIC. He maintains that he has not recovered to his pre-motor vehicle accident status. He requires the medications in order to manage his pain, as no other interventions have helped him. Accordingly, the Appellant argues that since his ongoing pain is related to the motor vehicle accident, the cost of pain control medication should continue to be covered by MPIC.

Counsel for MPIC submits that there is a lack of medical evidence to establish an ongoing requirement for the pain control medication. He argues that the case manager followed the recommendations set out by Dr. Hoeschen, an expert in this area, and there is no medical evidence that the medication regime set out by Dr. Hoeschen was wrong or should not be followed. Counsel for MPIC also notes that there is no medical evidence as to why the medications continue to be prescribed and no evidence that the medications are necessary or required because of the motor vehicle accident. Counsel for MPIC therefore concludes that the Appellant has not established that the ongoing requirement for pain medications is necessary, or related to the motor vehicle accident of May 8, 1999. As a result, he maintains that the Internal Review decision dated November 17, 2004 should be confirmed and the Appellant's appeal dismissed.

After a careful review of all of the evidence before us, both oral and documentary, we find that the Appellant has failed to establish, on a balance of probabilities, that his ongoing requirement for pain control medication is related to the motor vehicle accident of May 8, 1999, or that his usage of narcotic analgesia should continue at the level he was at in September 2004. There was no medical evidence presented to the Commission to refute the recommendations set out by Dr. Hoeschen, or to establish that the weaning regimen proposed by Dr. Hoeschen was inappropriate. As a result, we find that MPIC properly terminated reimbursement to the Appellant of his medication expenses. Therefore, the Appellant's appeal is dismissed and the Internal Review decision dated November 17, 2004 is hereby confirmed.

2. Entitlement to Income Replacement Indemnity benefits beyond November 30, 2004

In a decision dated November 26, 2003, MPIC's case manager advised the Appellant that his IRI benefits would cease effective November 30, 2004. In her decision, the case manager noted the following reasons for the termination of IRI benefits:

> Based on the available medical information, the cervical symptoms and low back pain which you experience do not, on a balance of probability, relate directly to the motor vehicle accident. In addition no limitations have been identified which would prevent you from participating in a sedentary occupation utilizing the same restrictions following your retraining with the WCB.
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> You are now capable of returning to your pre-accident employment, however, your position is no longer available to you. Based on the Manitoba Public Insurance Corporation Act Section 110(2)(d) (attached), you will be provided with IRI benefits for one year beginning December 1, 2003 and ending November 30, 2004.

The Appellant sought an Internal Review of that decision. In a decision dated February 10, 2005, the Internal Review Officer found that:

> After the motor vehicle accident, there were four areas of concern for you which included the left knee, the wrists, the lumbar spine and the cervical spine. As stated above, Dr. Casey found that the right wrist sprain and left knee sprain have resolved without issue. With respect to your cervical symptoms, although it was reported immediately following the motor vehicle collision, it was not medically documented again until March 2001, 22 months post-accident. On this basis, Dr. Shrom concludes on a balance of probability that your cervical symptoms do not relate directly to the motor vehicle accident of 1999. In support of Dr. Schrom's opinion, is Dr. Huebert's examination of July 2001 which noted decreased cervical range of motion based on an "unwillingness to move in any direction" with the cervical spine x-ray report as "perfectly normal". As well, there is Dr. Casey's most recent examination of March 2003 which showed discordance between cervical movement when directly tested and when observed when distracted. I do not see any relation of your cervical spine symptoms to your motor vehicle accident of May of 1999.
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> As well, your low back pain symptoms existed prior to your motor vehicle accident. In fact, you were provided re-training by WCB which was based on an evaluation by Dr. H. Lesiuk in July of 1996 that stated it would be unlikely that you would be able to continue at medium to heavy work. You were re-trained into a light duty occupation and with the incorporation of mini-stretch breaks during the workday, it would be attainable at that time in 1996. I can see no information that would convince me that your lower back pain is related to the motor vehicle accident of 1999 and any symptoms that you may have in your lower back would not be preventing you from returning to a sedentary occupation which you were re-trained for.

As a result, the Internal Review Officer confirmed the case manager's decision and dismissed the Appellant's Application for Review

The Appellant has now appealed from that Internal Review decision to this Commission. The issue which requires determination in this appeal is whether the Appellant was capable of returning to his pre-accident employment as of November 30, 2003, so as to justify a termination of his IRI benefits. Additionally, in order to establish an ongoing entitlement to IRI benefits, the Appellant must establish that:

1. he has a medical condition which renders him "entirely or substantially unable to perform the essential duties" of his employment; and,

2. the condition is causally related to a motor vehicle accident.

The Appellant had a previous appeal with this Commission, dealing with the termination of his IRI benefits. In the Reasons for Decision arising from that appeal (*R.J.R.* AC-00-25), the Commission noted the following at page 17:

> Patently, the task of this Commission is made much more difficult in the present case by [R.J.R.'s] several pre-accident back injuries. Even now, there is minimal compelling evidence to establish, one way or the other, whether the problems that seem to have plagued [R.J.R.] since May 8th, 1999, are causally related to his accident of that date, or whether the injuries he sustained in May 1999 have long since healed and his continuing pains are sequelae from his earlier accidents. It may well be that the magnetic resonance imaging that Dr. Huebert has requisitioned for [R.J.R.] will give the Appellant's care-givers a clearer answer to that vexed question. There is an even stronger probability that the experts at the Pain Clinic, even if unable to effect a permanent cure, will be able to restore [R.J.R.] to a condition in which he can return to his former employment. Pending those two events, we find from the evidence available to us to date that, on a balance of probabilities, the organic basis for [R.J.R.'s] complaints in his lower thoracic and lumbar spine, with possible radiation of pain from there, has its origins in his motor vehicle accident of May 8th, 1999.
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> We base that finding upon two factors in particular:
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> - The opinion of Dr. Huebert expressed in his letter of May 12th, 2000—an opinion which he may wish to vary once he has the results of the MRI but which, until then, should be adopted;
> - [R.J.R.'s] work history. This is a man who, with a mere grade [text deleted] education, appears to have worked diligently for all of his life since leaving school, doing so in physically demanding situations until his first, serious accident. Even after that four-storey fall, [R.J.R.] did not lie back on his oars; rather, he returned to his workplace as soon as it was physically practicable for him to do so. He later completed the retraining offered him by The Workers Compensation Board, qualifying for full-time employment in work demanding a high level of attention to detail. He obviously impressed his employer with his dedication. In sum, we find his evidence credible and, whatever may have been the cause of his continued pain, we find his complaints genuine and the opinions of his current care-givers valid.
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> This, in our respectful view, is clearly one of those cases to which Mr. Hayles, in his text quoted above, made reference. From the evidence before us, we find that the pain experienced by [R.J.R.] since he was last employed has prevented him from performing work to the standard reasonably required by his employer, and that his incapacity was exacerbated by the analgesics that he has been taking to help him deal with that pain. It

> is, we hope and believe, probable that his present care-givers and the specialists at the Pain Clinic will enable him to return to work within a reasonable time. Until then, or until Dr. Huebert is able, upon the basis of MRI or other diagnostic reports, is able to express the view that the fractures described above pre-dated the Appellant's motor vehicle accident of May 8th, 1999, [R.J.R.'s] Income Replacement Indemnity will be restored.

Subsequently, Dr. Huebert did provide a report, dated May 9, 2002, wherein he concluded that the compression fractures at T11 and T12 would not be due to an injury of May 8, 1999, but more likely occurred with the Appellant's Worker's Compensation Board injury of 1987. There have also been several other significant medical reports received by the Commission since the Appellant's previous appeal which should be noted.

Dr. Thomas:

As part of the Appellant's ongoing case management/treatment planning, he underwent a psychological assessment and DSM-IV diagnosis with Dr. Thomas in May and June 2002. In his report, Dr. Thomas concludes the following with respect to the Appellant's psychological assessment:

> [R.J.R.'s] responses to the psychological assessment materials suggest that he responded in a somewhat defensive manner to the various psychological questionnaires. However, his responses strongly indicate that he has experienced a marked negative change in level of physical functioning. [R.J.R.'s] psychological profile further indicated that he has likely experienced an associated disturbance in sleep his pattern, a decrease in energy and level of sexual interest as well.
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> Psychological assessment is useful for assessing the extent to which chronic pain and physical limitations in functioning are a central concern in an individual's life. It is important to recognize that people with very similar physical conditions can differ drastically in their reactions to the condition. [R.J.R.] psychological profile suggest that at times his physical symptoms may be presented in a dramatic manner that suggests more serious pathology than actually exists. His psychological profile is consistent with those profiles frequently obtained by individuals who are expressing excessive concern about the functioning of their bodies and worry excessively about somatic symptoms. [R.J.R.] reports feeling tired much the time and does not wake up fresh and rested most mornings. These are symptoms of mild to moderate depression.

[R.J.R.] self reported history indicates an emotionally unstable childhood and family environment. His childhood situation was further complicated by manifestations of a conduct disorder during adolescence and clinical depression as a young adult. This background likely have contributed to poor psychologically adaptive behaviors in his social relationships related to impulsivity, anger management problems with authority figures and a lack of compliance with social conventions both during adolescence and adulthood. [R.J.R.] likely uses indirect, passive means of expressing his anger as he tends to feel insecure in close relationships. His psychological profile indicates that he may be vulnerable to abuse substances/medications when experiencing ongoing stress. As well, at time's [R.J.R.] if feeling overwhelmed could be vulnerable to clinical depression and associated suicidal ideation.

R.J.R.'s] psychological profile suggests he is dissatisfied with his current life situation, demanding of emotional attention, complaining in regards to his current health status and generally negative and pessimistic in his expectations for the future. Secondary gain (sympathetic attention) may influence at times his presentation of the frequency and severity of his chronic pain symptoms. Medical treatment for his pain and disability symptoms from his injuries may only produce short-lived improvements from his perspective as full medical recovery is problematic/unlikely. However, [R.J.R.'s] dissatisfaction with his life situation is likely chronic and a constant personality feature at this time, although he may only be aware of limited emotional distress due to the long standing nature of his unhappiness. Given this likelihood it is not surprising that he tends not to analyze his or others' behavior. This feature of his personality would complicate most psychological interventions aimed at increasing his insight regarding his focus on pain and somatic concerns. Short-term, medical interventions that focus primarily on his physical symptoms will likely be most effective. [R.J.R.'s] MPI profile of scores suggests that his primary psychological coping strategy at present is to involve himself socially as much as he can to distract his awareness of his pain and disability.

Based on the currently available information the DSM-IV-TR diagnosis most consistent with [R.J.R.'s] medical symptom presentation, psychological functioning, and personal history is:

Axis I - 307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition
Axis 11 - 301.9 Personality Disorder NOS (features primarily from Cluster B)

Individuals with the above DSM-IV-TR diagnoses will report that their daily functioning has been compromised by physical problems. They will further report somatic symptoms, pain complaints, and physical disability, often accompanied by chronic feelings of unhappiness and bitterness about their health condition. Given [R.J.R.'s] psychological profile he appears to be coping effectively at present given that he has limited emotional resources to cope with the stress associated with his current health status.

Dr. Shrom:

A thorough review of the Appellant's medical history was undertaken by Dr. Jerry Shrom, Medical Consultant to MPIC's Health Care Services Team. In an Inter-departmental Memorandum dated September 17, 2002, Dr. Shrom commented as follows:

> **COMMENTS**
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> Review of the available medical information notes recurring, preexisting episodes of low back pain. The information notes a significant initial injury occurring in 1987 when the claimant fell from a height, striking the mid portion of his spine against the centre point of a pile of rubble. Following convalescence over a period of several months, the claimant continued to report frequent exacerbations of low back pain. The information notes significant exacerbation in June of 1993 (following a lift at work) and September 1994 (also following a lift at work). Following the September 1994 injury, symptoms persisted despite active treatment, with a CT scan of February 1995 noting central disc prominence at the L4-5 and L5-S1 levels. Persistent symptoms lead to a rheumatologic assessment in May 1995, wherein the claimant's presentation was seen to be multifactorial in nature. On and off back pain persisted through July 1996 at which time, a WCB examination noted ongoing symptomatology appearing to relate to multifactorial factors, including lumbosacral degenerative disc disease, sacroiliac joint complex origin pain and muscular origin pain at the trunk and buttock musculature. In view of longterm/permanent restrictions having been assigned by WCB, the claimant was retrained as a computer draftsman. Subsequent clinical notes of October 1996, July 1997, November 1997 and August 1998 note exacerbation of low back pain. It is in this setting of chronic and recurring back pain that the claimant was involved in the motorbike accident of May 8, 1999.
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> There are several issues requiring clarification:
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> ♦ Subsequent to the current motor vehicle accident, the claimant has continued with report of lower back pain. The passage of time and various types of physiotherapy support have not resulted in any substantial improvement in pain symptoms or function. The issue of compression fractures noted at the T11 and T 12 levels has been addressed by orthopedic consultants, Dr. D. Balageorge and Dr. H. Huebert. Dr. Balageorge provided opinion in 2000 that based on his review of x-ray and tomographic examinations, the end plate fractures of T11 and T12 were felt to be old in etiology. A diagnosis of mechanical low back pain was advanced. Upon reviewing the bone scan report of November 3, 1999, Dr. Huebert has recently changed his earlier opinion with respect to the vertebral compression fractures, noting that these fractures would not be due to the injury of May 8, 1999, as it would "probably take between one and two years for the bone scan to become negative". Dr. Huebert further noted that it was, therefore, more likely that the compression fractures had occurred as a result of the 1987

fall. Dr. Lesiuk's examination notes of July 9, 1996 advances the presence of multifactorial back pain, also noting the past history which injury in 1987 having resulted in multiple compression fractures, which "appear to have been thoracic".

Based on the foregoing, the opinions of Dr. Balageorge, Dr. Huebert and Dr. Lesiuk are supported in that the T11 and T12 compression fractures do not, in all probability, relate to the motor vehicle accident of May 8, 1999.

The ongoing report of low back pain appears to be in keeping with the preexisting multifactorial factors presented, with imaging studies noting some progression of the degenerative disc component.

With respect to the report of cervical pain, as best as can be established from review of the available medical information, it is noted that cervical pain was identified at the time of the initial assessment immediately following the motor vehicle accident. Subsequent to this evaluation, there was no mention of cervical symptoms in the medical information reviewed until March 2001. At this time, the claimant was attending ARCC for a rehabilitation program. On March 12, 2001, the claimant reported neck pain being worse than low back pain, which he felt was due to the testing performed at the facility. Dr. Huebert's evaluation of July 23, 2001 noted report of neck and low back discomfort, with pain in the neck "going all the way down to the toes". Dr. Huebert's examination noted decreased cervical range based on unwillingness to move in any direction, with a cervical spine x-ray reported as "perfectly normal". Dr. Huebert noted a working clinical diagnosis as psychogenic overlay with regard to neck and low back symptoms, indicating he was unable to ascribe the symptoms to any demonstrable pathology. With respect to cervical symptoms, Dr. M. Shing noted report of cervical pain at the time of her November 22, 2001 evaluation. CT scan of the cervical spine of February 4, 2002 noted only minor degenerative changes. The plan was to consider medial branch block at the right C3-4, C4-5 and C5-6 levels bilaterally as both a diagnostic and therapeutic measure.

- ♦ No specific anatomical diagnosis has been assigned to the cervical symptoms. Although cervical pain was reported in March 2001, there has been no ongoing objective and/or medical substantiation as to a specific diagnosis. If medial branch block has proceeded, the response to same could be reviewed at this time. Based on review of the available medical information, the cervical symptoms currently being experienced do not, on a balance of probabilities, relate directly to the motor vehicle accident.

With respect to rehabilitation recommendations to assist the claimant in improving function, it is felt that pain management strategies would be worth tapping in this situation. Having reviewed Dr. M. Thomas' psychological evaluation, it is felt that psychological work to address pain issues, expectations and function could be beneficial. This will be discussed with the Case Manager.

Dr. Casey:

The Appellant also underwent an independent medical examination with Dr. Allan Casey in order to provide recommendations for treatment and opinions regarding diagnosis and work restrictions. In his report, Dr. Casey comments as follows:

> The entirety of the submitted MPIC file was reviewed as well as the WCB files for [R.J.R.'s] current and previous claims. In terms of review of the submitted materials, I have little additional to add that has not been well addressed by Dr. J. Shroms' September 17, 2002 review. Dr. Shrom addresses the fact that imaging has been completely non-contributory, with no changes on bone scan activity either from before the collision or after; and with no changes on anatomical imaging (CT, MRI) either from before the collision or after. From my review of the WCB file, it does appear that additional times off work and job changes were required in 1992, 1993, 1994 and 1995. [R.J.R.] also noted a previous distant WCB-BC claim related to a right forearm injury that required skin grafting. No diagnosis other than chronic pain related to the incident injury of 1987 had ever been firmly reached during [R.J.R.'s] recurrent interactions with the WCB. Again, to reinforce Dr. Shrom's opinion, the majority of medical evidence immediately and shortly after the May 8, 1999 collision was in reference to the left knee injury, which, by all accounts, including [R.J.R.'s] at this point, has resolved without sequelae. Prescription review suggests that [R.J.R.] stopped the amitriptyline in the fall of 2002. Dr. Thomas' last notes do not suggest a change in psychiatric diagnoses of axes I (Pain Disorder associated with a psychological condition and general medical factors) and II (personality disorder NOS (features primarily cluster B)). No sustained benefit was felt to be feasible following three sessions, and these were terminated.
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> **Interpretation:**
> 1. **Diagnosis**:
> The interview and examination were not able to add substantially to his diagnoses. There is however no evidence of lumbar nerve root irritation, or of sacroiliac dysfunction whatsoever. There is no evidence of cervical nerve root irritation or shoulder dysfunction as cause/contributor to his neck pain complex. There are the known lower thoracic compression fracture-associated injuries, outstanding, which historically at least had been worsened by several workplace injuries, and frequent pain exacerbations. The recent DSM-IV psychological diagnoses seem quite appropriate to even a relatively untrained eye as myself. No other co-morbid psychiatric features, such as depression, were evident. No classically addiction issues were acknowledged, although the slow increment in narcotic use is somewhat worrisome.
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> The previous documented collision-related injuries - the right wrist sprain, the left MCL grade II sprain - have resolved without issue.

There may be additional evidence from the Pain Clinic (Dr. Intrater) in relation to perceived outcomes of the medial branch blocks. As you are aware, facet syndrome is a common sequelae to whiplash injuries, and accounts for a high proportion of post-traumatic injuries. [R.J.R.'s] pain relief and atypical adverse effects would suggest to me however that the posterior elements of the spine are not a primary contributor to his pain complex. As such, further injections are not indicated. I do not think that they would have benefit regardless, due to the diffuse nature of his pain complaints here. There is no clinical evidence of myofascial pain or a sensitized segment, suggesting these forms of treatment would not be helpful. I do not think sclerosing treatments such as prolotherapy either would be indicated, especially in the case of spine pain post-compression fracture often, the problem is the loss of mobility and limiting it more is less likely to help. No surgical options are open for this diffuse pain. Even implanted stimulators would have fairly low yield due to the widespread nature here. Intrathecal morphine could be considered, but he seems to be coping somewhat on oral narcotics, and this should be optimized as much as possible first.

As a result residual diagnoses remain chronic pain syndrome, with presumed mechanical low back pain and presumed mechanical neck pain NYD.

2. Investigations:

Further specifics are not feasible given that examination, which was so limited by him. He displayed at least four of five Waddell signs. Overreaction to simulated maneuvers and improvement with distraction was often noted as described above, as well as diffuse non-anatomic tenderness. No regional sensory changes were evident other than to the perispinal tissues. He may benefit from nerve conduction tests for a non-compensable, non-related median neuropathy, if his nocturnal hand parestheisae increase.

[R.J.R.'s] documented assessments - both medical and functional - have all been largely similar. Yet, his self-descriptions of his functional capabilities are discordant with each other and with observed, especially when he states his leisure activities. If he is as capable at a sedentary position for thirty hours a week, he could have returned to work long ago. It is somewhat unclear as to why he could not return to a sedentary capacity, utilizing the same restrictions as imposed in 1999 by the WCB, even at present. At this point, I would suggest considering surveillance. When there is significant discordance of a person's claims of abilities and observed abilities, often paying more attention can help sort out what true impairments exist.

3. Treatments:

In terms of treatment, again, without tissue-specific diagnosis, it can be challenging. As found by Dr. Thomas, a pain psychological paradigm is not likely successful. A tertiary pain centre may therefore also not be helpful. He still is noting moderate side effects wit (sic) the Oxycontin despite doubling the dose without pain control. He may be a better candidate for a Fentanyl patch, which is more challenging to `pop' ad lib. For him, he would begin at 50 mcg/hr, and likely need a later change to 75 mcg/hr. Fewer G.I. and G.U. effects are usually found. If he were still persisting with the Pain Clinic,

> it would be worth finding out their plans and ideas to date. I would check serum levels of amitriptyline, discover if they are in fact above 0, and then titrate to near therapeutic serum levels. Addition of other antidepressants is not going to be additive. For these "spasms", it may be worth a two-week trial of Zanaflex, 4-8 mg po OD hs for sleep effect and anti- "spasm" effect. Similarly, at times, for paraplegic persons with that description of electrical shock type pains, I have used lamotrigine (Lamictal) with some benefit with titrating up to 150 mg po BID at times. I have never used it for other non-neuropahy pain states, and would only do so if he persisted in that pain description. Effect usually is in twelve to sixteen weeks with slow weekly titrations, meaning to trial it means a commitment. Given his utter lack of response to gabapentin, I have low hopes for success, as with any oral treatments. I would not advocate inhaled marijuana for [R.J.R.], due to the concomitant health problems of smoking.

Discussion:

Upon a careful consideration and review of all of the evidence made available to it, both oral and documentary, the Commission finds that, on a balance of probabilities, the Appellant's ongoing chronic pain complaints are most likely related to the cumulative effects of his earlier accidents, and the injuries sustained by the Appellant in the motor vehicle accident of May 8, 1999 are no longer a contributing factor to his chronic pain presentation.

We base these findings on the medical reports received by the Commission since the Commission's earlier decision dated August 1, 2000 and referred to above. Of note, Dr. Huebert's opinion, expressed in his correspondence of May 9, 2002 that the compression fracture at T11 and T12, would not be due to an injury of May 8, 1999. We also had the assistance of the very thorough file reviews conducted by Dr. Jerry Shrom and the reports of Dr. Thomas and Dr. Casey. Based upon those reports, we find that:

1. the Appellant had a long standing chronic pain condition at the time of the motor vehicle accident;
2. the majority of medical evidence immediately and shortly after the May 8, 1999

collision was in reference to the left knee injury, which has resolved without sequelae; and

3. the Appellant should be able to do sedentary work, according to the opinions of Dr. Balageorge, Dr. Huebert, Dr. Shrom and Dr. Casey.

In view of the totality of the foregoing, we find that the Appellant's ongoing chronic pain complaints are, on a balance of probabilities, attributable to the pre-motor vehicle accident incidents. As a result, we find that the Appellant's appeal should be dismissed, and the Internal Review Decision dated February 10, 2005 is therefore confirmed.

Dated at Winnipeg this 5th day of December, 2006.

YVONNE TAVARES

MARY LYNN BROOKS

PAUL JOHNSTON