Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-17-068

PANEL:	**Jacqueline Freedman, Chair** **Linda Newton** **Sandra Oakley**
APPEARANCES:	**[Text deleted] (the "Appellant") was represented by [Text deleted];** **Manitoba Public Insurance Corporation ("MPIC") was represented by Andrew Robertson.**
HEARING DATES:	**July 5, 6, 7 and 8, 2021** **Additional Submission from the Appellant received October 22, 2021** **Additional Submission from MPIC received in reply November 4, 2021** **Additional Submission from the Appellant received in response November 10, 2021**
ISSUES:	**Whether the Appellant's low back condition was caused by the MVA.** **Whether the Appellant suffered a relapse of the MVA injury.** **If the Appellant suffered a relapse, whether that relapse entirely or substantially prevented the Appellant from performing the essential duties of his employment as a [text deleted]**
RELEVANT SECTIONS:	**Subsections 70(1), 81(1) and 117(3) of The Manitoba Public Insurance Corporation Act (the "MPIC Act") and section 8 of Manitoba Regulation 37/94.**

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

Reasons For Decision

Background:

The Appellant was injured while driving a motorcycle on September 12, 1996 (the "MVA"). He suffered injuries as a result of the MVA, including fractures to both ankles. He received treatments pursuant to the Personal Injury Protection Plan ("PIPP") provisions of the MPIC Act, including Income Replacement Indemnity ("IRI") benefits.

At the time of the MVA, the Appellant was employed as a [text deleted]. After a period of being unable to work following the MVA (and receiving IRI benefits), the Appellant eventually regained the ability to perform that employment. He resumed work as a [text deleted], and worked in that position until December 7, 2005, when he suffered a relapse of his MVA injuries. MPIC then reinstated his IRI benefits. Subsequently, MPIC provided training to the Appellant. In 2007, MPIC determined an employment for him (Residual Capacity Determination, or "RCD") of Insurance Agent/Broker, a job with fewer physical demands than his [text deleted] job. However, the income that the Appellant earned from the RCD employment as an insurance agent was less than the income that he had previously earned from his employment as a [text deleted]. Therefore, the Appellant received top-up IRI benefits from MPIC.

In March, 2009, the Appellant began new employment, as a [text deleted]. By May, 2011, his income from that employment was high enough that the IRI top-up benefits that he had been receiving from MPIC were terminated.

In November, 2016, the Appellant contacted MPIC and requested reinstatement of his IRI benefits, explaining that he was required to reduce his work hours and duties due to his MVA injuries. He also

requested physiotherapy treatment. The case manager considered the request of the Appellant, and the medical information was reviewed by MPIC's Health Care Services ("HCS") consultant. The case manager issued a decision dated February 15, 2017, which states, in part, as follows:

> The information on file indicates that your inability to continue the employment held at the time of the reported relapse is due to a low back condition.
>
> […]
>
> There is no entitlement to IRI beyond May 26, 2011.
>
> In addition, there is no entitlement to PIPP with respect to the low back condition. This includes IRI and physiotherapy treatment.

The Appellant disagreed with the decision of the case manager and filed an Application for Review. The Internal Review Officer ("IRO") considered the decision of the case manager. In looking at the issue of IRI benefits, the IRO was of the view that because the Appellant's last entitlement to IRI had been based on the RCD of Insurance Agent/Broker, therefore any IRI entitlement following a relapse would need to be based on the Appellant's ability to hold that determined employment. The IRO also considered the issue of causation of the Appellant's low back condition. The Internal Review decision, dated May 23, 2017, provides, in part, as follows:

> In order for you to succeed on this review, I have to be satisfied, on the balance of probabilities, that the evidence supports you sustained a "relapse" of your initial injury that would render you "entirely or substantially" incapable of performing the essential duties of your determined employment of an [text deleted], beyond May 26, 2011. In my opinion, that has not been demonstrated.
>
> Giving consideration to all the information on your file, I agree with the case manager's decision of February 15, 2017 which is supported by the opinion provided by MPI's Medical Consultant. As such, you are not entitled to Income Replacement Indemnity ("IRI") benefits beyond May 26, 2011.
>
> […]
>
> Although it may be possible that you sustained a low back injury in this motor vehicle accident, I am not prepared to go so far as to concur that your current low back complaints continue to relate to your motor vehicle accident of 20 years ago. Based on the evidence on file, I concur with MPI's medical consultant that your lower back symptoms are not causally related to the motor vehicle accident, on the balance of probability.

> Giving consideration to all the information on file, I agree with the case manager's decision of February 15, 2017. I am therefore confirming the decision and dismissing your Application for Review.

The Appellant disagreed with the decision of the IRO and filed this appeal with the Commission.

As discussed below, the parties agreed that if the Appellant suffered a relapse, then any entitlement of the Appellant to IRI as a consequence of that relapse would involve a consideration of the Appellant's ability to perform the duties of his employment as a [text deleted], rather than a consideration of his ability to perform the duties of his determined employment as an insurance agent/broker.

Issues:

The issues which require determination on this appeal are as follows:

1. Whether the Appellant's low back condition was caused by the MVA;
2. Whether the Appellant suffered a relapse of the MVA injury; and
3. If the Appellant suffered a relapse, whether that relapse entirely or substantially prevented the Appellant from performing the essential duties of his employment as a [text deleted].

Decision:

Following a review of the documentary evidence on file, the testimony of the witnesses and the submissions of the parties, and for the reasons set out below, the panel finds as follows:

1. That the Appellant has met the onus to establish, on a balance of probabilities, that his low back condition was caused by the MVA;
2. That the Appellant has met the onus to establish, on a balance of probabilities, that he suffered a relapse of the MVA injury; and

3. That the Appellant has met the onus to establish, on a balance of probabilities, that the relapse entirely or substantially prevented him from performing the essential duties of his employment as a [text deleted].

Preliminary and Procedural Matters:

This hearing was held during the COVID-19 pandemic, and took place entirely by videoconference, with the consent of the parties.

In advance of the appeal hearing, on June 28, 2021, a Case Conference was held with the parties, to clarify the issues under appeal. One matter discussed related to a case manager's decision, dated June 15, 2017, reinstating IRI benefits to the Appellant. The parties indicated that although the decision reinstated certain IRI top-up benefits, these represented only a portion of the total IRI benefits that the Appellant is seeking in the current appeal, and so this remained a live issue between the parties.

Also discussed at the Case Conference of June 28, 2021, was subsection 117(3) of the MPIC Act, which provides for a victim's entitlement to IRI after a relapse (as set out below). The Commission noted that under subsection 117(3), where there is a relapse, if it occurs more than two years after the victim's last entitlement to IRI, then the victim is entitled to IRI as if the relapse were a second accident. The Commission noted that the Appellant had not received IRI benefits since 2011, and raised with the parties whether the interpretation of subsection 117(3) might require a consideration of the employment that the Appellant was performing at the time that he complained to MPIC of a relapse, which here appeared to be his employment as a [text deleted]. The parties did not agree at that Case Conference, and noted that the IRO had considered the Appellant's ability to perform the determined employment as an insurance agent/broker. Therefore, at the Case Conference of June 28, 2021, the parties agreed that, in addition to a consideration of causation of the Appellant's low back

condition, the Commission should consider the following issues in this appeal: whether there was a relapse, and, if so, whether that relapse prevented the Appellant from performing the essential duties of his determined employment.

At the outset of the hearing, the chair raised this issue again with the parties. They expressed that they would like to have the Commission consider the issue that had been considered by the IRO. Therefore, the hearing proceeded on that basis.

In the course of the hearing, the parties agreed that if the Appellant had suffered a relapse, the effective date of that relapse was November 25, 2016. That is the date of [orthopaedic surgeon]'s report (referred to below), in which there was the first reporting of the Appellant's back symptoms and their connection to the MVA, as well as their effect on his ability to work.

Following the conclusion of the hearing that was held on July 5 through 8, 2021, the panel convened to consider its decision in this matter and determined that additional information was required from the parties. In particular, the panel noted that the parties had agreed at the hearing that if the Appellant had suffered a relapse, the date that the relapse occurred was November 25, 2016. On that date, according to the evidence, the Appellant's employment was his job as a [text deleted] with [text deleted]. In the circumstances, the panel required additional information in order to assist it in considering the Appellant's entitlement to benefits under subsection 117(3) of the MPIC Act. A further Case Conference was held with the parties on September 23, 2021, at which the parties agreed that they would provide written submissions to address the following issue:

> If the Appellant suffered a relapse, whether that relapse entirely or substantially prevented the Appellant from performing the essential duties of his employment as a [text deleted].

Once those submissions were received, the panel convened again, and a decision was reached in this matter.

As indicated above, the parties provided submissions at the hearing on the issue of the Appellant's ability to perform the essential duties of his employment as an insurance agent/broker, as of November 25, 2016, the agreed relapse date, which was not an employment that he held on that date. Given that the parties subsequently agreed that the interpretation of subsection 117(3) of the MPIC Act requires a consideration of the Appellant's ability to perform the duties of his employment as a [text deleted] on that date, rather than a consideration of his ability to perform the duties of his determined employment as an insurance agent/broker, we have not included their submissions on that specific point herein, nor have we made any finding on that point, as it is not relevant to the Appellant's entitlement to IRI benefits.

Legislation:

The relevant provisions of the MPIC Act are as follows:

> **Definitions**
> **70(1)** In this Part,
>
> **"accident"** means any event in which bodily injury is caused by an automobile;
>
> **"bodily injury"** means any physical or mental injury, including permanent physical or mental impairment and death;
>
> **"bodily injury caused by an automobile"** means any bodily injury caused by an automobile, by the use of an automobile, or by a load, including bodily injury caused by a trailer used with an automobile [...];
>
> **Entitlement to I.R.I.**
>
> **81(1)** A full-time earner is entitled to an income replacement indemnity if any of the following occurs as a result of the accident:
>
> (a) he or she is unable to continue the full-time employment; […]

Entitlement to I.R.I. after relapse

117(1) If a victim suffers a relapse of the bodily injury within two years

(a) after the end of the last period for which the victim received an income replacement indemnity, other than an income replacement indemnity under section 115 or 116; or

(b) if he or she was not entitled to an income replacement indemnity before the relapse, after the day of the accident;

the victim is entitled to an income replacement indemnity from the day of the relapse as though the victim had been entitled to an income replacement indemnity from the day of the accident to the day of the relapse.

[…]

Relapse after more than two years

117(3) A victim who suffers a relapse more than two years after the times referred to in clauses (1)(a) and (b) is entitled to compensation as if the relapse were a second accident.

Effect of lack of formality in proceedings

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

Manitoba Regulation 37/94 provides, in part, as follows:

Meaning of unable to hold employment

8 A victim is unable to hold employment when a physical or mental injury that was caused by the accident renders the victim entirely or substantially unable to perform the essential duties of the employment that were performed by the victim at the time of the accident or that the victim would have performed but for the accident.

Evidence for the Appellant:

The Appellant provided numerous medical reports from his health care providers in support of his appeal. He also testified at the hearing, along with his treating spinal surgeon, [text deleted].

The Appellant:

As indicated, the Appellant testified and was cross-examined at the hearing of his appeal.

He described the MVA, which occurred when he was almost [text deleted] age in September, 1996. He had been riding motorcycles since the age of [text deleted] and that evening he was riding a powerful motorcycle and unfortunately lost control of the bike. He flipped off the bike and slid a long way. He suffered fractures to both ankles, and had surgery on his right ankle, which was injured severely. He was in hospital for two weeks, and then he was released to the care of his parents. He was in a wheelchair and was bedridden for several months. The Appellant said that the MVA was very difficult for him both physically and emotionally.

Eventually, the Appellant was able to walk with the aid of crutches, and he went for physiotherapy in [text deleted] with [physiotherapist]. MPIC also provided funding for a gym membership, which helped him to keep the rest of his body in shape. This was particularly helpful going into future surgeries. His right ankle eventually required fusion surgery, which was done in [text deleted]. He also had another surgery, which was done by arthroscopy, to take out bone chips. [Physiotherapist] was a big part of his recovery, although he did caution him that he would face future physical problems, such as back problems.

At the time of the MVA, the Appellant had been working as a [text deleted] at [text deleted] in [text deleted]. That work involved being on his feet. The initial consensus of his health care providers, following the MVA, was that the Appellant should be considering sedentary work, due to the ankle fusion surgery. He took some courses at [university], which had a satellite campus in [text deleted]. However, he also wanted to work, and so he undertook a work hardening program at [rehabilitation centre] as suggested by MPIC. By late 2001, the Appellant returned to work at [text deleted] as a [text deleted]. However, that return to work eventually failed. He suffered swelling and pain in his ankle, and he was also getting a lot of mid-thoracic pain, with a dull tightness in his low back.

In December, 2005, the Appellant stopped working as a [text deleted] at [text deleted], and MPIC assisted him in training in the insurance field, in order that he could find employment in that industry. In May, 2007, the Appellant began work as an insurance agent at [insurance agency]. That job was one where he would be minimally on his feet, although it also involved going into people's homes and taking pictures. When he was working in that job, it reduced the swelling and worsening of arthritis in his ankle. However, the Appellant explained that in the years since the MVA, he had married and had a family, and he was not able to stay in the insurance industry due to the acrimonious breakdown of his marriage. Unfortunately, in late 2008, the Appellant's estranged wife made allegations of fraud against him, which caused his employer, [insurance agency], to question his integrity. Rather than risk termination, the Appellant quit his job while awaiting the results of the investigation that was being conducted by the [council]. That investigation, which found that there was no evidence of any contravention of the Insurance Act by the Appellant, took seven months to complete.

While the insurance investigation was ongoing, the Appellant needed to find another job. He said he looked for the most sedentary position he could find. A friend offered him a position as a [text deleted] at [text deleted], which would involve sitting at a desk and sending out quotes, which he viewed to be no different than his previous insurance job. He would also have to go to homes and take measurements, which was similar to what he did at [insurance agency], and he felt that the jobs would be very similar. The Appellant said he was concerned about the future, and so he called MPIC, and they reassured him. He was never told that he should not take the [text deleted] job. He started working at [text deleted] in March, 2009.

As the years progressed, the Appellant tried to do the best he could at [text deleted] to develop his clientele and build up a higher income. However, he continued to have a dull tightness in his back and in addition he developed a clicking in his back, and significant sciatic pain running down his back and leg. He tried to deal with the increasing pain by taking painkillers, and changing mattresses in his bed at home. He sought out chiropractic treatment and massage therapy. He had coverage for that treatment through his employee benefits at [text deleted]. However, he developed a synovial cyst, and the back condition became so bad, the Appellant could not continue to work. He contacted MPIC to ask for income replacement benefits, and provided MPIC with a job description prepared by his employer. His health care providers attributed his back problems to the MVA. He was eventually able to see [spinal surgeon], who performed surgery to remove the cyst and also performed a lumbar fusion. Subsequent to the surgery, the Appellant does have less mid-thoracic pain, but some tightness is permanent. The sciatica remains present. [Spinal surgeon] expects that a future surgery may be necessary. Presently, the Appellant is employed with a different company, working part-time, four days a week, in a position where he sometimes sits at his desk and sometimes drives to see clients. The employer understands his physical limitations.

The cross-examination of the Appellant dealt with whether he had been diagnosed with a back injury, or had reported back pain, following the MVA. The Appellant agreed that he was not diagnosed with a back injury at the time of the MVA, but he pointed out that [doctor] noted that he had tender trigger points in his back when he examined him in July, 1997. When questioned as to whether he reported back pain to his physiotherapist in the initial assessment on November 21, 1996, the Appellant said that he talked about pain to his whole body, which was banged up due to the bad fall he had taken onto the pavement. He said that his ankle was his worst injury and that was the focus during medical appointments. There were no physiotherapy treatments specifically directed to his back in the first few months following the MVA. The Appellant did not get the trigger point needling and stretching

treatment recommended by [doctor]. When questioned as to why he did not follow up about that, he said that there was a lot happening at that time; he was fairly young and he was relying on his doctors to guide him.

The Appellant said that he did experience back pain throughout the period from 2002 to 2015, although at some times it was worse than others. When asked specifically regarding the first time he spoke about it to [doctor #2], the Appellant did not recall precisely, but said that he did not focus on his back until his ankle had been dealt with. The Appellant recalled that he did specifically speak to [doctor #2] about problems in his low and mid back in October of 2007. When counsel pointed out that the doctor recorded problems in the Appellant's upper back, but not his lower back, the Appellant said that his lower back is where he was having problems, and that is what he would have talked about. He said that he would have spoken with [doctor #2] about his back pain in follow-up, and he was not aware of any reason why the doctor would not have recorded it in his chart notes. The Appellant did not agree with counsel's suggestion that he did not complain to his medical providers of low back pain from 2002 to 2015; rather, he said that he didn't make enough of an issue of it. He didn't want to keep going back to doctors, because he was trying to get his life back. Counsel questioned the Appellant about a file note dated April 24, 2012, in which the case manager recorded that he asked the Appellant what issues were ongoing for him at that time, and the Appellant did not mention back pain. The Appellant said that in that call, they were talking about orthotics and physiotherapy, which were needed for both his ankle and his back.

Counsel also questioned the Appellant regarding more recent reports from his health care providers. The Appellant noted that he had gone for massage and chiropractic treatments as soon as he had coverage as an employee with [text deleted], beginning in 2009, until January 2017. He thought that chart notes from those treatments would have been available to MPIC, which had full access to his

medical file. In the week prior to the appeal hearing, when he realized those chart notes were not part of the appeal file, he tried to obtain them, but couldn't do so in time. The Appellant did not agree with [doctor #2]'s notation in his January 8, 2015, report that his lower back pain had only a one year history; he thought that [doctor #2] could have been referring to the clicking sensation in his back. The Appellant was uncertain as to why [doctor #2] had not recorded references to back pain in his more recent chart notes, as he was certain that he had raised it; however, he pointed out that for many years, the ankle remained the focus of their medical appointments. On redirect, the Appellant confirmed that none of his health care providers discussed their chart notes with him.

Cross-examination also addressed the question of whether the Appellant's limp and back pain were aggravated by the work that he did. The Appellant said that when he initially returned to his job at [text deleted], he was dragging his foot around. As he moved around more, his ankle pain and swelling increased, and his limp became worse. When asked whether his back symptoms were made worse by the job at [text deleted], the Appellant said that he would think that they were, being on his feet that much. Counsel pointed out that [doctor #2]'s letter of December 6, 2005, reporting that the Appellant was unable to work, didn't mention back problems, and asked whether the Appellant told [doctor #2] that his back was part of the reason that he couldn't work. The Appellant said that he would not have said it that way; [doctor #2] knew how bad his ankle was, and that was the main concern, although [doctor #2] was aware of his back problems.

The Appellant was asked about his duties at [insurance agency]. He described taking information from MPIC customers as they came in, going to customer's homes to take on-site pictures, going to farms or commercial establishments, as well as office duties. When asked whether there were any physical elements to the job, the Appellant said that there were no substantial physical components;

it was a sedentary position and he was able to do all of the duties. None of his doctors ever had said he wasn't able to perform that job.

The Appellant was asked about his sales position at [text deleted], which he said was more sedentary than his sales position at [text deleted]. When asked whether it was more physically demanding than his position as an insurance agent, the Appellant said the positions were similar. He was asked about his comments in an email that he sent to MPIC's case manager on January 12, 2017, in which he said that before he had to stop working at [text deleted], he had to eliminate physical duties. He said he had trouble bending, and couldn't lift sample boards to show to customers, which were found throughout the showroom. They were approximately 10 pounds each, and lifting them often involved awkward movements. As his back got bad, he sat at his desk a lot more, because he couldn't stand and talk to customers. He also had to reduce his hours before he stopped work.

The Appellant was asked about a meeting with the case manager on December 7, 2016. The case manager recorded in a file note on that date that in the meeting, the Appellant described various duties, including covering duties in the warehouse, and that he said that there was a 70/30 split between physical and desk duties. The Appellant said that he recalled the meeting, but that was not an accurate description of his duties. He did load a pallet once or twice a month, but never by hand. He would not consider the walking and standing to be extensive. Some of his work was done at his desk, and there were sample tables for the designer products. The Appellant said that to clear up the confusion regarding his duties, he asked his manager to provide a letter regarding the duties of the sales representative position. On redirect, he confirmed that the case manager never discussed with him the notes that were taken at meetings.

Counsel for MPIC questioned the Appellant regarding the advice he received from his doctors in late 2016, shortly before he stopped working, that he change to a more sedentary position. The Appellant said that he didn't think he would have been able to do that, given his back pain at that time. When questioned regarding his email of January 12, 2017, to the case manager, advising that he was in talks with two insurance companies and had sent resumes to them, the Appellant said that he did not specifically recall whether he had sent resumes, but he did recall talking to the owner of one of the insurance companies, whom he knew, and it would have been easy to send a resume to him. He had been "hassled" by MPIC for working outside his determined position, and that is why he contacted the insurance company. He was looking to the future, and considered a return to the insurance industry as a possibility for when his back got better.

[Spinal surgeon]:

[Text deleted] is the Appellant's treating spinal surgeon. In addition to his testimony at the appeal hearing, he provided a report dated February 20, 2019.

He has been a neurosurgeon for over 25 years, having trained in [text deleted] and [text deleted]. He came to Canada in 2001, and works at the [hospital] in [text deleted], as well as at the [hospital #2]. He is the Medical Director of the [text deleted] of the [text deleted] and is the Section Head of [text deleted] at the [text deleted]. [Spinal surgeon] performed surgery on the Appellant, which he described as spinal fusion and lumbar decompression, to decompress the nerve roots at L4-5. He said that the goal of the surgery was to provide stabilization of that segment, to decompress the nerves and alleviate the sciatica.

The doctor said that at the time of presentation in 2018, the Appellant was experiencing symptoms of low back pain, and he complained of sciatica radiating down his left leg to his foot. On examination, the Appellant had a profound limp. He also had nerve tension signs, and lifting his leg elicited buttock pain. He had tried massage and numerous medications which had not helped. An MRI done in 2017 confirmed facet arthropathy and a synovial cyst, causing the bulging of the nerve root, and therefore it was decided to proceed with spinal fusion.

[Spinal surgeon] explained that the type of damage to the Appellant's back generally is a product of time and wear, and would take time to develop, as it is degenerative in nature. However, the Appellant was young for this type of degenerative disc disease ("DDD"). Although he does see it in patients across a range of ages, typically this is a condition for people in their sixth or seventh decade. He also discussed the impact of the Appellant's antalgic gait on his condition. The Appellant limps quite profoundly. He is a big, tall person, and the limp results in quite a "waddle" on the spine. While acknowledging that this may be impossible to conclusively prove or disprove, [spinal surgeon] was of the view that this waddle resulted in accelerating arthritic change (such as is seen in scoliosis). Constantly tipping the weight to one side results in straining one side more, which results in premature degenerative change. He said that when writing his report, he was asked if the Appellant's limp could be the cause of the degeneration to his back, and he said yes.

[Spinal surgeon] noted that the Appellant faces some difficulties in the future. He will eventually need to have the hardware from the fusion removed. Someone with a spinal fusion is somewhat limited in terms of occupation, and so [spinal surgeon] suggested that the Appellant seek more sedentary work as opposed to labour-intensive work. He also noted that the Appellant may be vulnerable to increased loads, and as well some patients develop problems on adjacent segments. He

pointed out that the Appellant still limps, he's going to get older, and he still has the same collagen makeup.

On cross-examination, [spinal surgeon] was questioned regarding the difficulties that he had in determining causation in this case. He said that it is difficult in any case, because there is no radiological test to determine causality. He said that DDD affects everyone by age 70. Here, there was someone presenting at a very young age, [text deleted], with very obvious mechanical problems, walking with a profound limp, and it is unusual to develop facet arthropathy at that age. He said he was asked if it was more likely than not that the facet arthropathy was caused by the MVA. [Spinal surgeon] said that in his mind, it was more likely than not that it was caused by the MVA, which in his view, was not an unreasonable conclusion to come to.

[Spinal surgeon] was asked regarding the comment in his report that it was impossible to separate the impact of the MVA from the impact of the arthrodesis (ankle fusion) on the Appellant's back. He noted that the MVA was the primary source of injury to the Appellant. If the Appellant's back pain is attributed to the MVA, there would be a fracture. If it is attributed to the arthrodesis, this resulted in a limp. It could have been the trauma of the MVA that caused the back condition, or it could have been the limp, or it could have been both. But in his view, it is not possible to separate them, and it does not affect the treatment of the Appellant, it only affects proceedings like this appeal. [Spinal surgeon] also noted that his staff physiotherapist took an extensive history from the Appellant, who said he had a long history of lower back pain over many years, with a more recent onset of left gluteal pain, in May, 2017.

The doctor acknowledged that he has encountered younger patients who have developed problems like this. He said it is fairly unusual, but like any problem, there is a distribution across age groups.

DDD is a product of time and wear. The risk factors are age, body habits and sedentary lifestyle, as well as other factors like scoliosis or leg shortening. The vast majority of people affected are obese and smokers. There is a genetic component, collagen, which affects the structure of the discs. [Spinal surgeon] agreed that some cases of DDD have no clear causative factors. As well, the fact that a person has been in an accident does not necessarily mean that they will develop the condition.

[Spinal surgeon] was asked about the impact of the Appellant's antalgic gait. He said that the Appellant has an orthopedic problem. He can't run. Walking puts a mechanical strain on his foot, and this is a risk factor that can't be removed, which probably contributes to his problem. When asked whether everyone who has an antalgic gait develops DDD, [spinal surgeon] said no, but many people do. Many people with a limp present with back problems, and a limp is an important driver in altering the dynamics of the spine. Duration of the limp is one risk factor that determines whether a limp will cause DDD. When asked whether there was any way to determine whether someone developed DDD due to a limp, as opposed to due to some other reason, [spinal surgeon] said that there was no categorical way to determine that. He was of the view that it was likely that the Appellant's DDD was caused by his limp. When asked whether it is possible that something else could have contributed to the Appellant's back problems other than his limp, [spinal surgeon] said that there would be no way of knowing, but the limp is a powerful mechanical driver here. He said "there is no such thing as always or never in medicine".

When asked whether a person with DDD would experience increasing symptoms over time, [spinal surgeon] said not necessarily. The Appellant developed nerve compression, and the nerve symptoms resulting from that would have happened all at once, like a toothache. The back problems tend to be more progressive, although symptoms can vary greatly. When asked whether back symptoms caused by gait issues would increase over time, [spinal surgeon] said not necessarily, although they might,

to the point where the patient seeks help. [Spinal surgeon] was not aware as to whether or not there was evidence in the file of any reports by the Appellant of lower back pain to his health care providers between 2002 and 2015. When asked whether, in his opinion, the lack of reported symptoms would make it less likely that back problems were caused by the MVA, [spinal surgeon] said no, because DDD is a product of time; the wear and tear of DDD takes time, which could even mean a period of 13 years. He did not agree with the opinion of [orthopaedic surgeon] that the Appellant's facet arthropathy was symmetrical; he said it was absolutely asymmetrical. [Spinal surgeon] noted that [orthopaedic surgeon]'s opinion was based on a CT scan, which did not appreciate the synovial cyst. [Spinal surgeon] was of the view that this was not the standard of care, and said that [orthopaedic surgeon] should have done an MRI.

Evidence for MPIC:

In addition to numerous HCS medical reports and case managers' notes on the Appellant's file, MPIC called as a witness one of its HCS consultants, [text deleted].

[MPIC's HCS medical consultant]:

[Text deleted] is a medical consultant for MPIC's HCS team. He reviewed the Appellant's file and provided reports dated July 21, 2002, January 30, 2017, May 8, 2017, May 10, 2017 and July 24, 2019. He testified at the appeal hearing and was qualified as an expert in sports medicine.

He described his education and training in sports medicine, which is a form of family practice, and includes the review of musculoskeletal and neurologic systems, with the emphasis on trying to promote treatment and recovery. He has been a consultant with MPIC since 1996. Since that time, he has conducted many forensic file reviews. In preparing his opinions, he reviews the medical reports in the claim file, and considers the examinations done by the professionals involved in the Appellant's

care and the results of the treatment, because they are a true reflection of his condition at the time he was assessed and his health at the time. He does not examine the Appellant personally. He does not believe that he is at a disadvantage for not having assessed the Appellant personally, particularly in this case, because many years have elapsed since the MVA. In [MPIC's HCS medical consultant]'s view, the most important information was how the Appellant presented shortly after the MVA, and what followed thereafter.

In his report dated January 30, 2017, [MPIC's HCS medical consultant] noted that facet joint degeneration can occur in the absence of a traumatic event. He explained that degeneration can be caused by things such as age, weight or inactivity. Most often, his patients cannot recall a particular event, or what brought on their symptoms. Sometimes, a person has injured their back, for example by falling out of a tree or getting injured in a hockey game, and then there are degenerative changes associated with that trauma that would show up on a CT scan, but this is rare. [MPIC's HCS medical consultant] did not agree with [orthopaedic surgeon] that the Appellant's facet degeneration was secondary to the MVA. There was no evidence that the Appellant suffered trauma to his back in the MVA, which would have led to clinical findings that would have supported [orthopaedic surgeon]'s opinion. Forty percent of people have degenerative changes in their back at [age], and it is not reasonable to opine that the Appellant's DDD was caused by the MVA.

[MPIC's HCS medical consultant] reviewed his report dated May 10, 2017, in which he noted that myofascial symptoms and physical findings are common in the population that has not been exposed to a traumatic event. He referred to [doctor]'s July 7, 1997, report which documented mid-thoracic pain and bilateral lumbar pain. He was of the view that these symptoms were not associated with the MVA. [MPIC's HCS medical consultant] said that these findings were nonspecific, and clinical findings are not necessarily reflective of an injury. Further, he did not see a link between the later

development of DDD and the earlier myofascial pain reported by [doctor]. Lumbar DDD is something that [MPIC's HCS medical consultant] deals with in his practice as a sports medicine expert. He said he has been seeing quite a lot of it recently, during the pandemic, because although younger people's sports injuries are down, the older population still has lower back conditions.

In his report dated July 24, 2019, [MPIC's HCS medical consultant] stated that a medically probable cause and effect relationship could not be established between medical conditions arising from the MVA and the degenerative changes affecting the Appellant's spine. He said that degenerative changes can occur in the population not exposed to a traumatic event, and not exposed to limping, and so he could not connect these changes to an MVA that occurred 19 years earlier. He did not agree with [spinal surgeon] that, on a balance of probabilities, it was reasonable to state that the MVA was the cause of the Appellant's medical condition. He said that in his thirty years of experience practising sports medicine, he very often sees complaints that are not connected with a traumatic event. Here, there was no clinical evidence of a back injury. Sometimes, there may be something that happens in the MVA, where the back decompensates. However, here, there was no evidence of progressive deterioration. It is hard to state that back symptoms many years after the fact were caused by the MVA. The more probable explanation is that the Appellant developed back problems over time, as we all do, rather than that these problems were caused by an MVA which did not actually injure his back.

In the July 24, 2019, report, [MPIC's HCS medical consultant] had noted that there are many examples of individuals developing DDD in their thirties and forties who have never experienced a traumatic injury. He was asked whether it was common or rare to have DDD to the point of needing fusion. He noted that the degeneration was common, although how it affects the nerves, and the radicular pain, varies, as do the requests for surgery. Patients who have underlying degeneration are

more prone to having sciatica and other problems, and may not get better with conservative treatment. A small percentage need surgery. Here, the need for surgery was not due to the MVA. Regarding the link between antalgic gait, or limping, and DDD, [MPIC's HCS medical consultant] said it is necessary to look at the risk factors for developing facet arthritis and DDD, and the severity of the alteration of gait. Very few patients with DDD present with altered gait. He was of the view that limping, by itself, is not a risk factor. In the literature, other factors are genetics, weight, lifestyle, history of trauma, smoking, and anatomical alignment.

In [MPIC's HCS medical consultant]'s view, the evidence on the file does not support that the Appellant's DDD was accelerated by his antalgic gait. It appears that the onset of back pain occurred in about 2014. From then until 2019, he had back symptoms. Reviewing the notes from his family doctor and [orthopaedic surgeon], neither of them comment that his back pain was caused by his limp or altered gait. The Appellant appears to have been active during this time, at work and recreation. This may also have contributed to further development of his back condition. [MPIC's HCS medical consultant] did not agree with [spinal surgeon] regarding the impact of the absence of reporting of back pain by the Appellant to his health care providers from 2002 to 2015. In [MPIC's HCS medical consultant]'s view, the absence of reports of back pain during this time frame makes it less likely that the Appellant's back condition was caused by the MVA. This was one reason why he came to his opinion on the absence of a causal connection between the Appellant's back condition and the MVA.

Counsel for the Appellant asked only one question of [MPIC's HCS medical consultant] on cross-examination, who confirmed that he did not physically examine the Appellant.

Submission for the Appellant:

As indicated above, counsel for the Appellant provided oral argument at the hearing, and also provided further written submissions at the panel's request, which was appreciated.

Counsel for the Appellant submitted that the Appellant's MVA-related injuries, specifically his ankle fusion (arthrodesis), caused his limp. This limp led to the Appellant's back condition, specifically the DDD and the synovial cyst. Therefore, the Appellant's back condition was caused by the MVA, as was the relapse. The Appellant is entitled to IRI benefits as a consequence of the relapse that he suffered due to his MVA injuries, because he was not able to perform the duties of his employment as a [text deleted].

The Appellant suffered significant injuries to both of his ankles in the MVA. In his testimony he described the numerous surgeries he underwent. He had right ankle fusion surgery in February, 1999. [Text deleted], an orthopedic surgeon, discussed the upcoming fusion and noted in his report dated November 24, 1997, that the Appellant would always have some disability and limitation with regard to walking because of the fusion. The Appellant was also noted to have back pain within several months following the MVA. In his report dated July 7, 1997, [doctor] noted that the Appellant had pain in the mid-thoracic region in the midline as well as right and left lumbar. He also had tender trigger points in the thoracic and lumbar regions. [Rehabilitation centre], in their report dated June 15, 2001, noted complaints of low back and hip pain bilaterally, which was made worse with walking or standing, and which the Appellant associated with his ankle fusion. The Appellant testified regarding his experience with back pain, which he said was ongoing. The Appellant did note that ultimately, his focus, when he was with his physicians, remained on his ankles, as those were his most significant injuries.

Counsel pointed out that beginning in 2015, the Appellant began to experience increasing back pain, to the extent that it impacted his ability to work. He referred the panel to several reports contained in documentary evidence which reflected this increase in back pain, including the following:

- [Doctor #2], in his report dated January 8, 2015, noted that the Appellant had lower back pain with a clicking sensation, especially when standing. He referred the Appellant for physiotherapy.

- An x-ray of the Appellant's lumbar spine dated January 14, 2015, identified very slight narrowing of the L4-5 disc. Aphopyhseal joint degenerative change was also suspected at L4-5.

- A discharge summary dated March 25, 2015, from [physiotherapy and sports injury clinic] records that after six treatments, the Appellant received only temporary relief of his lumbar spine signs and symptoms.

- A CT scan dated June 16, 2015, identified degenerative changes of the lumbar spine, with severe facet arthropathy at L4-5.

- In [doctor #2]'s chart note of a visit on July 14, 2016, he recorded that the Appellant's lower back pain was getting worse. He stated: "It may have to do with his past MVA, and/or right ankle fusion". Physiotherapy had not helped. He referred the Appellant for consultation to an orthopedic surgeon, [text deleted].

- [Orthopaedic surgeon] provided a report dated November 25, 2016. He opined that the Appellant's presenting symptoms were secondary to his facet arthropathy, and secondary to the MVA. He recommended reducing the Appellant's hours of work.

- [Doctor #2], in a report dated December 5, 2016, also recommended that the Appellant reduce his hours of work, as a consequence of his chronic lower back pain and chronic right ankle pain, sequelae from his MVA.

- Physiotherapist [text deleted] assessed the Appellant on December 14, 2016, and diagnosed him with lumbar DDD.

- Chiropractor [text deleted] provided a report dated January 23, 2017. He recommended custom orthotics in order to reduce pain in the Appellant's right ankle, leg and low back. He stated "due to his fused right ankle, the patient's mobility is greatly reduced and therefore his body (mainly right leg and low back) compensates".

- [Orthopaedic surgeon] provided a report dated March 10, 2017, in which he confirmed his view that the Appellant's lumbar spine osteoarthritis was caused by the MVA.

[Spinal surgeon] was of the opinion that the Appellant's back condition was caused by the MVA. In his report dated February 20, 2019, [spinal surgeon] noted that the Appellant had severe degenerative

changes at a young age. He also noted the Appellant's profound limp, and stated that without the MVA, which led to the ankle fusion, the Appellant would probably not have developed the degenerative changes and synovial cyst. Counsel pointed out that [spinal surgeon] concluded his report by stating that it would seem reasonable that the MVA is the source of the Appellant's problems. In his testimony, he reiterated that the Appellant's degeneration was more typical of older patients, usually in their sixties and seventies. The Appellant walks with a limp, which creates a waddle on the spine. This constant strain accelerated degenerative changes. In his view, on a balance of probabilities, the Appellant's limp was the significant driver of his back condition, particularly given its duration.

[Spinal surgeon] noted that DDD is a product of time and wear; however, there would not necessarily be an increase in back pain symptoms over time. His conclusion on causation was not impacted by the fact that the Appellant did not report symptoms of back pain to his health care providers between 2002 and 2015. He noted that a patient may not seek help until the pain gets worse. [MPIC's HCS medical consultant] was of the view that DDD could develop in the absence of a traumatic event, but here there was a traumatic event, an MVA, as well as multiple surgeries. Counsel submitted that [spinal surgeon]'s opinion should be given more weight than that of [MPIC's HCS medical consultant], based on [spinal surgeon]'s expertise and experience in spinal pathology and surgery. On the basis of [spinal surgeon]'s opinion, counsel submitted that the Appellant's back condition was caused by the MVA.

Counsel further submitted that because the Appellant's back condition was caused by the MVA, he falls within the relapse provisions of the MPIC Act, specifically subsection 117(3). The agreed-upon date of the relapse is November 25, 2016. Counsel submitted that the Appellant is entitled to IRI

benefits, because the relapse substantially prevented the Appellant from performing the essential duties of his employment as a [text deleted].

The duties of the Appellant's employment as a [text deleted] are outlined in a letter from the store manager at [text deleted]. These duties included hosting customers in the showroom, assisting in product selections, placing orders by email and phone, and occasional site visits. Due to his back condition, the Appellant was having difficulty performing the duties of his employment at the time of the relapse. As noted above, both [orthopaedic surgeon] and [doctor #2], in their reports, recommended that the Appellant reduce his working hours. On December 7, 2016, the Appellant met with the case manager, and advised her that his doctor had instructed him to reduce his hours, his duties and the amount of days he worked per week. He also advised that his employer was not able to accommodate these restrictions and would need to replace him as soon as possible. On January 12, 2017, the Appellant advised the case manager by email that he was still at work, because he had a family to provide for and he needed an income, but he had eliminated any physical duties in order not to make things any worse than they already were. His last day of work at [text deleted] was February 11, 2017.

Counsel submitted that the Appellant has established, through his testimony and through the medical and other documentary evidence, that he was entirely or substantially unable to perform the essential duties of his employment as a [text deleted] as a consequence of the relapse.

Submission for MPIC:

As indicated above, counsel for MPIC provided oral argument at the hearing, and also provided a further written submission at the panel's request, which was appreciated.

Counsel for MPIC noted that there are essentially two issues under appeal. The first relates to the Appellant's back condition, and whether it was caused by the MVA, thus resulting in a relapse. The second issue arises if there was a relapse, and relates to the Appellant's ability to perform the duties of the employment he held at the time of the relapse, his [text deleted] job.

MPIC acknowledges that by 2016, it was clear that the Appellant was suffering from a back condition. The question is whether that condition was causally related to the MVA. It is MPIC's position that it was not. There is no evidence that the Appellant suffered a direct injury to his back in the MVA. The attending physician who examined him the day following the MVA at the [hospital] noted severe ankle injuries, but "no head injury or any other injuries". Similarly, the Initial Physiotherapy Report of [physiotherapist] dated November 21, 1996, did not note any back symptoms. Although [doctor], in his report dated July 7, 1997, noted back pain, there is no evidence of an objective anatomical injury that led to this pain. As [MPIC's HCS medical consultant] noted, back pain is very common, and doesn't necessarily reflect that there has been an injury to the back. Similarly, although the Appellant did report back pain during his assessment at [rehabilitation centre], as reflected in their report of June 15, 2001, there is no indication of a back injury. Further, there are other medical reports from 2001 which contain no mention of back pain; notably, the [rehabilitation centre] discharge report dated November 27, 2001, states that "lumbar spine ranges of motion were essentially normal and unremarkable", and that the Appellant did not have any lumbosacral specific pain.

It is MPIC's position that it is not reasonable to link the limited reports of back pain to the development of the Appellant's condition of DDD years later, particularly where they are inconsistent with the many other medical reports on file which do not contain reports of back pain. Counsel submitted that the Appellant's lack of reporting of any back pain between 2002 and 2015 is not consistent with the Appellant's position that his back condition was caused by his altered gait, which

caused damage to his spine slowly, over time, with wear. Counsel referred to several medical reports from 2005 and 2007, when the Appellant reported an increase in ankle pain, and noted that there was no mention in those reports of back pain. In a file note dated April 24, 2012, the case manager recorded that he asked the Appellant what issues were ongoing for him at that time. The Appellant referred to his left ankle, orthotics, physiotherapy and travel expenses, but did not mention back pain. Counsel argued that if the Appellant's back was worsening over time, it would be reasonable to expect that he would have reported it to his health care providers and to the case manager.

[MPIC's HCS medical consultant] noted that the absence of reporting of back pain by the Appellant from 2002 to 2015 was part of the reason that he came to his conclusion that there was no causal connection between the Appellant's back condition and the MVA. Counsel submitted that this is a reasonable conclusion, given [spinal surgeon]'s evidence that the Appellant's back condition was a product of time and wear. Although [spinal surgeon] said that the Appellant may not have had pain the entire time, and that he was not necessarily expecting increasing reports of pain, counsel submitted that if the Appellant suffered degeneration over time due to his antalgic gait, it is not reasonable that he had no pain during the period from 2002 through 2015, or at least none recorded in his health care providers' notes. Counsel acknowledged that for radicular symptoms, such as sciatica, the nerve may suddenly become pinched and nerve symptoms may develop on a short-term basis, but that is not the case for the kind of degeneration that is not solely nerve-based.

Counsel also argued that the medical reports in which there are reports of back pain, starting in 2015, are not sufficient to support the Appellant's position of causation. For example, although [doctor #2], in his report dated January 8, 2015, referred to a one-year history of lower back pain, this history is not reflected in his chart notes. Counsel also submitted that although [orthopaedic surgeon], in his reports dated November 25, 2016 and March 10, 2017, expressed the opinion that the

Appellant's facet arthropathy is secondary to the MVA, he did not give sufficient reasoning for this conclusion.

Although the Appellant had severe degenerative changes at a young age, in his report dated February 20, 2019, [spinal surgeon] acknowledged that DDD and spinal stenosis are "extraordinarily common". He acknowledged that the determination of causation in cases such as this is quite difficult. [MPIC's HCS medical consultant] testified that 40% of people at [age] would have degenerative changes, and based on his clinical work as a sports medicine physician, he was not prepared to conclude, on a balance of probabilities, that the Appellant's back condition was caused by the MVA. [MPIC's HCS medical consultant] said that often there is no cause for the degeneration, so it is not necessarily the case that the Appellant's limp must be the cause of his DDD. In his report dated July 24, 2019, [MPIC's HCS medical consultant] noted that degenerative changes can occur in individuals in their thirties and forties, and to people who have never experienced a traumatic injury to the affected region. Counsel submitted that overall, the evidence does not support the conclusion that the Appellant's back condition was caused by the MVA or its sequelae.

Given MPIC's position on causation, it is also MPIC's position that the Appellant did not suffer a relapse. In order for a condition to be considered a relapse within the meaning of section 117 of the MPIC Act, that relapse must be causally connected to the MVA.

However, in the event that the Commission should find that the Appellant's back condition was caused by the MVA, and that the Appellant did suffer a relapse, it is MPIC's position that the Appellant's relapse did not prevent him from performing the essential duties of his employment as a [text deleted].

Counsel submitted that there was some dispute, both in the documentary evidence and at the hearing, regarding the essential duties of the [text deleted] position. The Appellant testified that his position at [text deleted] was similar to his position at [insurance agency], which was a sedentary position. In his Application for Review, he said that the work was "comparatively the same as my duties when I worked in insurance". He also submitted a letter from the manager of [text deleted] outlining the duties of his position, in support of this. However, a case manager's file note dated December 7, 2016, records a conversation with the Appellant, in which the Appellant described his duties. The file note indicates that the duties were split 70/30 between physical and desk work.

Counsel argued that if it is accepted that the [text deleted] job was a sedentary position, with similar physical duties to the [insurance agency] position (as was testified to by the Appellant), then it must be noted there are no medical providers that said that the Appellant was unable to perform sedentary work.

[Orthopaedic surgeon], in his report dated November 25, 2016, did not indicate that the Appellant was unable to work, but simply recommended that the Appellant would benefit from part-time work. Similarly, [doctor #2], in his report dated December 5, 2016, said that the Appellant should work only three days a week, with physically light duties only. On January 12, 2017, the Appellant emailed the case manager to advise that he continued to work, but eliminated any physical duties. In that same email, he noted that he was in talks with two insurance companies, and had sent resumes to them, because he wanted to make the transition without being off work. Counsel submitted that although, in cross-examination, the Appellant said he was looking to the future, the email said that the resumes were already sent. This suggests the actions of a person who feels he is capable of performing a sedentary occupation, since he was seeking that position at that time. [Spinal surgeon] said that the

Appellant should not engage in manual labour, but there was no indication in his report that the Appellant was disabled from sedentary work.

The Appellant said that the [text deleted] position was sedentary, and there is no medical report which substantiates an inability on his part to do sedentary work. Counsel submitted that if there was a relapse, there is insufficient medical information to demonstrate that the Appellant was unable to perform the duties of his position at [text deleted] as of the relapse date.

Discussion:

The onus is on the Appellant to establish, on a balance of probabilities, the following:

1. That his low back condition was caused by the MVA;
2. That he suffered a relapse of the MVA injury; and
3. That the relapse entirely or substantially prevented him from performing the essential duties of his employment as a [text deleted].

In making our decision, as set out below, the panel has carefully reviewed all of the documentary evidence filed in connection with this appeal. We have given careful consideration to the testimony of the witnesses and to the submissions of counsel for the Appellant and counsel for MPIC. We have also taken into account the provisions of the relevant legislation and the applicable case law.

Causation

The first issue to consider is causation of the Appellant's low back condition.

Pursuant to subsection 70(1) of the MPIC Act (as set out above), in order to be entitled to PIPP benefits, the Appellant needs to show that his low back condition was caused by the MVA. There is

no dispute that the Appellant was ultimately diagnosed with, and had surgery for, a low back condition, including DDD, facet arthropathy, and a synovial cyst, as reported by [spinal surgeon] in his report dated February 20, 2019. The dispute is whether this condition was caused by the MVA.

The Appellant suffered fractures to both of his ankles in the MVA, with the right ankle requiring fusion surgery. He did not assert that he injured his back directly in the MVA. He testified as follows regarding his back pain:

- it arose shortly after the MVA;
- it was present over the years, but it was worse at certain times than at other times; and
- he complained about it to his health care providers over the years, but he did not make a big issue of it, because his main concern at medical appointments was his ankle.

The Appellant's explanation, that he was more concerned with his ankle at medical appointments than with his back pain, is borne out in the documentary evidence. As indicated above, there are some early notations in the records of the Appellant's health care providers regarding complaints of back pain ([doctor]'s report dated July 7, 1997, and the ARCC report dated June 15, 2001). Apart from one notation in [doctor #2]'s chart note from October, 2007, which records that the Appellant complained of pain in his upper back, there are no other notations in the documentary evidence regarding the Appellant's complaints of back pain until 2015.

Beginning in 2015, the Appellant's increasing back pain is reflected in the reports of his health care providers, including the reports of [doctor #2] and [orthopaedic surgeon], noted above, who both attributed his back condition to the MVA.

[MPIC's HCS medical consultant] said that the absence of reports of back pain from 2002 to 2015 was part of the reason that he came to his conclusion that there was no causal connection between the Appellant's back condition and the MVA. [MPIC's HCS medical consultant] further said that

degenerative changes can occur in individuals in their thirties and forties, and to people who have never experienced a traumatic injury to the affected region. Often there is no cause for the degeneration, so it is not necessarily the case that the Appellant's limp must be the cause of his DDD. In his report dated July 24, 2019, he stated as follows:

> […] I'm not aware of evidence-based medicine that establishes a causal connection between limping and the development of lumbar degenerative disc disease. The actual impact limping might have on the spine cannot be determined. Degenerative disc disease and spinal stenosis are very common, as noted by [spinal surgeon], and the vast majority of cases develop in the absence of an altered gait. I'm not aware of evidence-based medicine supporting the position that an altered gait will accelerate a degenerative process affecting the spine.

Based on his clinical work as a sports medicine physician, he was not prepared to conclude, on a balance of probabilities, that the Appellant's back condition was caused by the MVA.

In contrast, [spinal surgeon] was of the opinion that the Appellant's back condition was caused by the MVA. In his view, the Appellant had severe degenerative changes at a young age, which was unusual. [Spinal surgeon] testified that due to his ankle fusion surgery (the arthrodesis), the Appellant walked with a profound limp, which created a waddle on the spine. In his opinion, this constant strain accelerated degenerative changes, which was more typical of older patients, usually in their sixties and seventies. The Appellant's limp was a significant driver of his back condition, particularly given its duration. In his report dated February 20, 2019, [spinal surgeon] stated as follows:

> […] I do understand the patient has been walking with a limp and you are wondering whether or not the limp per se could have resulted in the degenerative change noted at L4-L5.
>
> There is no categorical way of establishing this. […]
>
> Whether or not it is the motor vehicle per se or the arthrodesis or the combination thereof, it is almost impossible to determine, but the fact remains without the accident, he would not have had the arthrodesis and without the issue of a poorly united fracture and the need for a fusion, he would probably not have developed the issues you have highlighted above. The source of the synovial cyst is simply that of degenerative change of the facet joint itself and thus the answer to the question is exactly as above.

> […]
>
> As a counterpoint, degenerative disc disease and spinal stenosis is extraordinarily common. I would, however, emphasize that [the Appellant] has developed his change at a young age and therefore if you regard balance of probabilities as your test, then it would seem reasonable that the accident is the source of this patient's problem.

In his testimony, [spinal surgeon] said that it was more likely than not that the Appellant's facet arthropathy was caused by the MVA, and that it was also likely that the Appellant's DDD was caused by his limp, although he could not prove that conclusively. He also said that although DDD is a product of time and wear, there would not necessarily be an increase in back pain symptoms over time. He said that his conclusion on causation was therefore not impacted by the fact that the Appellant did not report symptoms of back pain to his health care providers between 2002 and 2015. He noted that the patient may not seek help until the pain gets worse.

[Spinal surgeon] is a neurosurgeon and spine specialist at the [hospital]. He is the Medical Director of the [text deleted] for the [text deleted]. The panel has weighed his evidence against [MPIC's HCS medical consultant]'s forensic assessment. [MPIC's HCS medical consultant]'s area of expertise is sports medicine. Although [MPIC's HCS medical consultant] said that he deals with lumbar DDD in his practice, [spinal surgeon] is a specialist in this area, and he had the opportunity of personally examining the Appellant, obtaining his medical history and assessing his credibility, and we have therefore given greater weight to the evidence of [spinal surgeon] than to that of [MPIC's HCS medical consultant].

As indicated, [spinal surgeon], who examined and performed surgery on the Appellant's back, was clear in stating that it is more likely than not that the Appellant's facet arthropathy was caused by the MVA. [Spinal surgeon] was also consistent in stating that it was likely that the Appellant's DDD was

caused by his limp, although he said that it was not possible to conclusively prove that, stating that "there is no always or never in medicine".

We acknowledge [spinal surgeon]'s proviso, that although it was likely that the Appellant's DDD was caused by his limp, he is not able to conclusively prove that. The panel notes, however, that the Commission is not required to determine causation with scientific certainty. In this regard, we have noted the comments of the Supreme Court of Canada in *Athey v. Leonati*, [1996] 3 SCR 458, where the Court confirmed its earlier decision in *Snell v. Farrell*, [1990] 2 SCR 311. The Court in *Athey*, referring to its earlier decision, stated at paragraph 16:

> The causation test is not to be applied too rigidly. Causation need not be determined by scientific precision; … and as was quoted by Sopinka J. at p. 328, it is "essentially a practical question of fact which can best be answered by ordinary common sense".

Applying the threshold test of a balance of probabilities, rather than a test of scientific certainty, the panel finds, based on the Appellant's evidence and the evidence of [spinal surgeon], that the Appellant has met the onus upon him to establish a causal connection between the MVA and his low back condition. Consequently, we find that the Appellant is entitled to PIPP benefits in respect of his low back condition.

Relapse

The next issue to consider is whether the Appellant suffered a relapse of the MVA injury.

The term "relapse" does not seem to appear anywhere in the MPIC Act other than in section 117, nor is it defined in the MPIC Act. In AC-06-143, the Commission noted that:

> […] there are a number of slightly varying definitions for relapse, including:
>
> *Concise Oxford Dictionary*, 10th ed., *s.v.* "Relapse": 1) Deteriorate after a period of improvement 2) deterioration in health after a temporary improvement.

> Hensyl, William R., *Stedman's Medical Dictionary*, 25th ed., (Baltimore, MD: Williams & Wilkins, 1990) *s.v.* "Relapse": Recurrence; return of the manifestations of a disease after an interval of improvement.
>
> Schmidt, M.D., *Schmidt's Attorneys' Dictionary of Medicine*, 25th ed., (New York, NY: Matthew Bender and Company, 1995) *s.v.* "Relapse": The aggravation of a disease after a period of improvement. Also, the return of a disease after it has all but disappeared, or after it has actually disappeared.
>
> *Webster's New World College Dictionary*, 4th ed., *s.v.* "Relapse": To slip or slide back into a former condition, esp. after improvement or seeming improvement.

In the Internal Review decision dated May 23, 2017, the IRO provided a similar definition, stating as follows (at page 11):

> The term '*relapse*' is not defined anywhere in the *Act* or the regulations, however, the common usage of the term (based on dictionary definitions) suggests that its use in Section 117 is intended to convey a recurrence of, or return to, a previous state of injury, presumably after some period of recovery (partial or complete).
>
> In broad terms a *relapse* is defined as "*a recurrence of a disabling condition which is directly related to an initial injury sustained as a result of an automobile accident* […]".

We note that the IRO's definition of the term "relapse" contains a proviso not included in the excerpt quoted above, which addresses the entitlement to IRI ("and for which I.R.I. compensation is payable"). However, this proviso suggested by the IRO is not supported by the dictionary definitions above, as quoted from AC-06-143. In fact, the first paragraph quoted directly above from the Internal Review decision is in accord with the dictionary definitions.

We therefore conclude that the entitlement to IRI in respect of a relapse is a separate issue from the issue of whether, in fact, there was a relapse. The parties also treated these issues separately. The Appellant's entitlement to IRI is addressed further below.

Here, the parties were in agreement that if the Appellant's back condition was found to have been caused by the MVA, then that would mean that he would have suffered a relapse within the meaning of section 117 of the MPIC Act. In other words, in the context of the definitions set out above, after a period of improvement, the Appellant had deteriorated or returned to a state of injury (low back condition), which was caused by the MVA.

The parties also agreed that if the Appellant suffered a relapse, then the effective date of that relapse was November 25, 2016. As noted above, this is the date of [orthopaedic surgeon]'s report, in which there was the first reporting of the Appellant's back symptoms and their connection to the MVA, as well as their effect on his ability to work.

Accordingly, given that we have found that the Appellant's back condition was caused by the MVA, we therefore find that the Appellant has established, on a balance of probabilities, that he suffered a relapse, caused by the MVA, effective November 25, 2016.

Ability to Perform Duties of [text deleted] Position

The final issue to consider is the Appellant's entitlement to IRI benefits.

As noted above, in looking at the issue of the Appellant's entitlement to IRI benefits, the IRO was of the view that because the Appellant's last entitlement to IRI had been based on the RCD of Insurance Agent/Broker, therefore any IRI entitlement following a relapse would need to be based on the Appellant's ability to hold that determined employment.

However, with respect (and as discussed above), we have concluded that this view was based on an incorrect interpretation of subsection 117(3) of the MPIC Act. That subsection provides that "A

victim who suffers a relapse more than two years after [he has last received IRI] is entitled to compensation as if the relapse were a second accident" [emphasis added]. Although the phrase "second accident" is not defined, the panel is of the view that the only reasonable interpretation of this phrase, in this context, is that any relapse would be treated as a fresh accident. On this basis, under subsection 117(3), IRI entitlement, if applicable, would arise from, and be determined as of, the date of the relapse, as would be the case with any other accident under the IRI provisions of the MPIC Act.

Here, the agreed date of the relapse is November 25, 2016, which was more than two years after the Appellant's last receipt of IRI benefits. Subsection 117(3) of the MPIC Act applies to treat this relapse as if it were a second accident; therefore, for IRI purposes, the Appellant's entitlement to IRI would be determined by looking at the employment that he held on the date of the relapse (second accident). On that date, the Appellant was a full-time employee, holding the position of [text deleted] with [text deleted]. His entitlement to IRI is governed by the IRI provisions applicable to full-time employees, specifically subsection 81(1) of the MPIC Act and section 8 of Manitoba Regulation 37/94 (as set out above). As noted above, the parties agreed with this interpretation.

In order to be entitled to IRI benefits, the Appellant must therefore establish that his relapse (low back condition) entirely or substantially prevented him from performing the essential duties of his employment as a [text deleted]. Accordingly, he must establish, on a balance of probabilities:

a) The duties of his [text deleted] employment; and

b) That he was entirely or substantially unable to perform those duties due to the relapse.

a) The Duties of the Appellant's Employment

An analysis of the duties of the Appellant's employment as a [text deleted] requires an examination of the prescribed duties of the position, as well as the actual duties performed by the Appellant.

The Appellant provided an undated letter from the store manager at [text deleted], [text deleted]. This letter, which noted that the total area of the showroom is approximately 3600 ft.^{2}, outlined the duties of a "[text deleted]" at [text deleted], as follows:

- Hosting customers in showroom and assisting in product selections;
- Showroom organization as needed;
- Placing orders by email and phone;
- Preparing quotes and orders at workstation; and
- Managing installation projects via phone and email with occasional site visits [as] required.

The Appellant also testified regarding his position at [text deleted]. Counsel for MPIC noted that in the course of his testimony, the Appellant referred to his [text deleted] position as "sedentary". We do not consider the use of the word "sedentary" by the Appellant, a layperson, to be determinative of the duties of the position. The Appellant testified specifically regarding the duties that he performed as a [text deleted], as follows:

- walking, standing and talking to customers;
- showing products to customers;
- handling sample boards which weighed on average 10 pounds each;
- going to homes to take measurements;
- sitting at a desk and sending out quotes; and
- loading pallets once or twice a month, by machine.

Counsel for MPIC noted that in his Application for Review, the Appellant referred to the letter from [Appellant's employer], and said that his duties were "comparatively the same as my duties when I worked in insurance". In his testimony, the Appellant identified that the duties which were similar to those from his insurance job were sitting at a desk and sending out quotes, and going to homes to

take measurements. In his Application for Review, the Appellant also said that he would estimate that his position at [text deleted] required standing and walking "approximately 40%" of the time.

There is one further document which addresses the Appellant's [text deleted] job duties. As noted above, in a file note dated December 7, 2016, the case manager recorded that she met the Appellant, and he described his duties as follows:

- in-home measurements and estimates, including flooring, backsplash and exterior;
- covering duties in the warehouse, including loading and unloading rolls of carpets, and loading pallets by hand and by equipment;
- extensive walking and standing; and
- computer work.

When asked about the file note during cross-examination, the Appellant said that it was not an accurate description of his duties, and he asked his store manager to provide the above-noted letter in order to clear up the confusion. The Appellant said that he would not consider the walking and standing to be "extensive". He also disagreed with the point regarding the duties that he did in the warehouse, stating, as noted above, that he loaded pallets once or twice a month, but only by machine. In that regard, we note that the letter provided by [Appellant's employer] does not refer to any warehouse duties of the position. In any event, the case manager's note identifies that the Appellant would only be "covering" duties in the warehouse, and so we do not consider any warehouse duties to be essential duties of the [text deleted] position.

Apart from warehouse duties, which we have found not to be essential duties of the position, we note that the remaining duties recorded by the case manager, specifically walking and standing, in-home measurements, and computer work, are duties which are also found in the letter provided by [Appellant's employer] (hosting customers in showroom; site visits; and placing orders and preparing quotes), and are also duties which were described by the Appellant in his testimony (walking,

standing and talking to customers; going to homes to take measurements; and sitting at a desk and sending out quotes).

We therefore accept the Appellant's testimony regarding the specific duties of his [text deleted] position at [text deleted], and find the essential duties of that position to be as follows:

- walking, standing and talking to customers;
- showing products to customers;
- handling sample boards which weighed on average 10 pounds each;
- going to homes to take measurements; and
- sitting at a desk and sending out quotes.

b) The Appellant's Ability to Perform the Duties

The issue that then arises is whether the Appellant was entirely or substantially unable to perform the essential duties of his [text deleted] position, as identified above, as a consequence of the relapse.

The Appellant testified that due to his back condition, he had to reduce his duties and his hours at work. He said that as his back got bad, he sat at his desk a lot more because he couldn't stand and talk to customers. He had trouble bending, and couldn't lift sample boards to show to customers, which were found throughout the showroom.

[Orthopaedic surgeon], in his report dated November 25, 2016, stated as follows:

> [The Appellant] is a [age] gentleman who presented to my clinic with history of low back pain. […] This affects his daily living activities. He walks maximally a mile on good days but on bad days he cannot walk at all. Sitting is only for an hour and a half until he has to change his position. Standing for 15 minutes. […]
>
> […]
>
> […] Also, this is a long term problem and this affects his daily living activities. He will benefit from part-time work (three days working and two days off).

[Doctor #2], in his report dated December 5, 2016, stated as follows: “the above named is fit to work only 3 days a week, and physically light duties only, due to his chronic lower back pain”.

The Appellant met with the case manager on December 7, 2016, and advised her that his employer was not able to accommodate the restrictions imposed by his doctors. The case manager’s file note provides as follows:

> [The Appellant] advised that due to the injuries sustained in the accident, he is no longer able to continue working his employment at [text deleted]. The doctor had instructed him to reduce his hours, his duties and the amount of days per week. [The Appellant] advised that his employer is not able to accommodate these restrictions and need[s] to replace him. He will no longer be able to work – end date at this time is unknown but the employer has indicated that they want to replace him as quickly as possible.

The Appellant’s last day of work was February 11, 2017.

As noted, [doctor #2] said in his report that the Appellant was “fit to work” only three days per week, physically light duties only. While [orthopaedic surgeon] was less directive in his wording, stating that the Appellant “will benefit from” working three days per week, he noted in his report that the Appellant suffered from physical limitations which affected his activities of daily living. These limitations included that the Appellant could only walk maximally a mile on good days, while on bad days, he could not walk at all, and standing was limited to 15 minutes. [Orthopaedic surgeon] also noted that this was a long-term problem.

As indicated, the Appellant testified that these restrictions and limitations identified by [orthopaedic surgeon] and [doctor #2] affected his ability to perform his job duties, in particular the following:

- walking, standing and talking to customers;
- showing products to customers; and
- handling sample boards which weighed on average 10 pounds each.

The above-noted duties are essential duties of the Appellant's full-time employment with [text deleted]. As indicated, the Appellant was restricted from working full-time in that position. Further, the Appellant's employer advised him that his work restrictions could not be accommodated, and his employment was terminated at [text deleted] approximately two months after [orthopaedic surgeon] and [doctor #2] issued their reports.

Based on the testimony of the Appellant, and the reports of [orthopaedic surgeon] and [doctor #2], we find that the Appellant has established, on a balance of probabilities, that the relapse entirely or substantially prevented him from performing the essential duties of his employment as a [text deleted]. Consequently, we find that the Appellant is entitled to IRI benefits in connection with his relapse of November 25, 2016.

Conclusion

As indicated above, the panel finds as follows:

1. That the Appellant has met the onus to establish, on a balance of probabilities, that his low back condition was caused by the MVA;
2. That the Appellant has met the onus to establish, on a balance of probabilities, that he suffered a relapse of the MVA injury; and
3. That the Appellant has met the onus to establish, on a balance of probabilities, that the relapse entirely or substantially prevented him from performing the essential duties of his employment as a [text deleted].

Disposition:

Accordingly, the Appellant's appeal is allowed and the Internal Review Decision dated May 23, 2017, is therefore rescinded.

The Appellant shall therefore be entitled to PIPP benefits with respect to his low back condition in connection with the MVA of September 12, 1996.

The Appellant shall therefore also be entitled to IRI benefits in connection with his relapse of November 25, 2016.

The matter is hereby returned to MPIC's case manager, for a determination as to the amount of those benefits.

The Appellant shall be entitled to interest upon the monies due to him by reason of the foregoing decision, in accordance with section 163 of the MPIC Act.

The Commission shall retain jurisdiction in this matter and if the parties are unable to agree on the amount of compensation, either party may refer this issue back to the Commission for final determination.

Dated at Winnipeg this 15th day of December, 2021.

JACQUELINE FREEDMAN

LINDA NEWTON

SANDRA OAKLEY