

**Automobile Injury Appeal Commission
Province of Saskatchewan**

Citation: *E.V. v. Saskatchewan Government
Insurance, 2006 SKAIA 098*
Date: 20061221
File: 109 of 2005

BETWEEN

E.V., Applicant

and

Saskatchewan Government Insurance, Respondent

Appearances:
E.V., Applicant
Dale Brown, for the Respondent

Before: **Joy Dobko, Chair**
Stephanie Pfefferle, Commission Member
Carol Olson, Commission Member

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

Heard at Saskatoon, Saskatchewan
April 26, 2006

DECISION

[1] This is an appeal by the Appellant, E.V., of a decision made by Saskatchewan Government Insurance (“SGI”) dated October 20, 2004, which provided the Appellant with a 20% apportionment of benefits for medical rehabilitation and income replacement relating to surgery on his left shoulder and for the period of post-operative recovery relating to that surgery.

PRELIMINARY MATTERS:

[2] At the outset of the appeal, Mr. Brown, legal counsel for SGI advised the Commission that he was prepared to reimburse the Appellant 100% of his income replacement benefits, his living assistance benefits, babysitting costs and any other rehabilitation expenses for the period of time that the Appellant was off work due to the shoulder surgery, which was a six week period following the surgery on January 10, 2005. Mr. Brown advised the panel that he was not in a position to withdraw the decision letter nor could he consent to setting it aside, however, it was his submission that where there are conflicting medical opinions on causation, it is more appropriate to retain an independent medical exam to resolve the issue. Mr. Brown further advised the panel that he was prepared to pay 100% of the expenses and income replacement benefits associated with the Appellant’s post-operative recovery from his surgery regardless of the opinion of the independent medical examiner and that the purpose of the report would be used to determine any entitlement the Appellant may have to future benefits with respect to his left shoulder, specifically permanent impairment benefits. The Appellant did not wish to proceed with the independent medical exam.

[3] In light of Mr. Brown’s offer to pay 100% of the expenses and income replacement benefits associated with surgery regardless of our decision, the decision rendered by this Commission will only be relevant for purposes of determining future entitlement to benefits. The real issue is whether or not the Appellant will be entitled to 20% or 100% of any future benefits; specifically, but not limited to, permanent impairment benefits.

[4] The second issue which arose was whether or not the Appellant was proceeding with the same action in the Court of Queen's Bench. We are satisfied that the Appellant's action in the Court of Queen's Bench is not related to his shoulder injury and does not involve a claim for benefits arising out of his shoulder injury, therefore we are in a position to proceed with the Appellant's appeal without barring or prejudicing his Court of Queen's Bench action.

FACTS:

[5] The Appellant was involved in a motor vehicle accident on December 29, 2001 (the "accident") when he was struck on the driver's side of his minivan by another vehicle. The Appellant was the driver of his minivan at the time of the accident. The emergency hospital records note that the Appellant complained of pain to the left side of his body. The Appellant also complained of pain in the scapular region, which increased with movement and palpation. The Appellant reported hitting his head on the side window upon impact.

[6] The Nursing Assessment Progress Records note complaints by the Appellant of pain in his neck, left shoulder and left side of body. Dr. Mah examined the Appellant on January 2, 2002 and completed a practitioner's report in which he diagnosed the Appellant with an injury to his left shoulder. He also prescribed Vioxx. On January 3, 2002, x-rays were taken of the Appellant's left ribs, left shoulder and pelvis. The X-rays showed no fractures visible in the ribs, the left shoulder was normal and the pelvis showed signs of advanced degenerative joint disease in both hips. There was no evidence of osteoarthritis in the shoulder.

[7] On January 8, 2002, personal injury representative, Ms. Sharon Porter, created an injury note which we believe to be a summary of a telephone conversation she had with the Appellant. Ms. Porter did not testify at the appeal, but we find the injury note to be reliable in that it accords with the Appellant's testimony that his left shoulder was acutely painful following the accident. Ms. Porter documented the Appellant's complaints of a "lump on the side of his head, left side of neck is sore and especially left shoulder blade, could hardly move the left arm for a few days after the mva, ribs and lower back are sore, side of left calf is bruised". The Appellant also reported to Ms. Porter that he could not work the week following the accident because he could not move his arm and that he had returned to work because he did not have any sick time left.

The Appellant also reported to Ms. Porter that he could not do any of his activities of daily living following the accident because his arm was so sore he could not move, because of the shoulder. He stated it was better but still stiff and hard to move. The Appellant's testimony at the appeal regarding the pain in his left shoulder following the accident is consistent with Ms. Porter's injury note.

[8] The Appellant attended for an initial physiotherapy assessment on January 10, 2002, with Candra Sexton, a physiotherapy student. She noted a doctor's diagnosis of strain of the left shoulder and back pain. The Appellant reported left shoulder and upper arm and low back pain bilaterally. The Appellant also reported increased pain with any arm movement. The physiotherapy notes show sites of pain to be the left side of the neck and head, the left shoulder and the low back region. On January 14, 2002, Curtis Kucey, physiotherapist, diagnosed the Appellant with LBP II and WAD I without making any diagnosis regarding the Appellant's complaints of shoulder pain. The physiotherapy notes indicate that treatment will commence on the lumbar region but the shoulder will follow. The Appellant was discharged on March 5, 2002 after receiving 9 treatments for lumbosacral strain. It was noted that he had very limited function at the time of his last visit but that he had not returned for six weeks. There were clearly complaints of pain in the left shoulder; however, for some reason the physiotherapist failed to address this in his treatment and diagnosis.

[9] The Appellant completed his Application for Benefits on January 20, 2002. The Appellant reported high pain levels for injuries to his shoulder, low back and neck. He also reported pain in his mid back and headaches. The Appellant reported that his back was bothering him and he had a lot of pain in his shoulder which was making it difficult for him to do his job. The Appellant also reported a pre-existing condition of arthritis.

[10] The Appellant has many health problems which are not related to this appeal. We do not find it necessary to make any comments on these issues except to provide a brief summary of what other health issues were plaguing the Appellant following the accident. Subsequent to the accident, the Appellant complained of a painful right elbow and it was also noted that he had significant degenerative arthritis of his hips. In June 2002, it was determined that the Appellant

would require a replacement of his right hip. The Appellant underwent hip replacement surgery on December 24, 2002. SGI accepted 50% responsibility for causation of his hip pain and aggravation of his back pain.¹ It is not necessary for us to examine the medical documentation surrounding any other accident related injuries or pre-existing health problems and our review of the documentation has only been with respect to the Appellant's shoulder injury which is the subject of this appeal.

[11] Following his initial physiotherapy, the Appellant was reassessed on April 1, 2002. There does not appear to be any reference to the left shoulder injury at that time. The focus of the report is on his right hip and the lumbar spine. Similarly, a multi-disciplinary assessment completed on May 15, 2002 does not include the left shoulder in the "problems related to injury", although the report does note subjective complaints of left neck and shoulder pain which are getting a little better. In August 2002, the Appellant discussed the pain in his left shoulder with the occupational therapist that attended at his home to complete a home and work site evaluation. There is no indication of what the nature of the discussion was regarding the left shoulder, only that it was discussed.

[12] The Appellant testified that his shoulder pain was largely ignored by his treatment providers when the difficulties with his hip became apparent. He stated that although he was reporting the shoulder pain, he was not receiving any treatment. The medical documentation of a shoulder injury certainly tapers off after the initial complaints in January 2002 until February 2003 when the Appellant attended FIT for Active Living ("FIT") for a tertiary assessment. The Appellant reported many concerns including left shoulder pain and left arm numbness. The FIT team's Summary of Opinion was:

Primary Diagnoses (MVA related):

1. Right hip degenerative changes exacerbated by motor vehicle accident with total hip replacement
2. Mild to moderate depressive symptoms
3. Left shoulder dysfunction requiring further diagnosis
4. Whiplash associated disorder I (WAD I)
5. Cervicogenic headaches

¹ We make no findings with respect to causation of the right elbow, back pain or hip injuries.

6. Low back pain I (LBP I)
7. Mild driver and passenger anxiety

Secondary Diagnoses (MVA related):

1. Sleep disturbance (exacerbated by the motor vehicle accident)
2. Deconditioning (exacerbated by the motor vehicle accident)
3. Weight gain

Co-morbid Diagnoses (non-MVA related):

1. Cardiovascular risk factors (smoking, high caffeine intake, low activity level, positive family history, hyperlipidemia, obesity, chest pain not yet diagnosed)
2. Alcohol abuse – remote
3. Peptic ulcer disease
4. Depression
5. History of low back pain
6. Right knee pain
7. Osteoarthritis of the hips, right hand, right elbow with ulnar neuropathy and surgical repair
8. Remote Workers Compensation Board injuries and previous motor vehicle accident, resolved
9. Query dyslexia

The FIT team recommended that the Appellant undergo a medication review with his family doctor; attend upon an orthopedic surgeon for follow up of his hip restrictions; consultation regarding his shoulder tendonitis; undergo cardiac investigations and attend primary physiotherapy treatment for six to eight weeks, three times per week for his shoulder and hip. Following that they further recommended he attend 12 weeks of a tertiary streamed resource program. The chiropractic examination recorded signs of positive shoulder impingement on the left; positive testing for supraspinatus tendonitis on the left and palpable tenderness over the left supraspinatus muscle belly and tendon. This was consistent with the medical doctor's examination which reported "decreased range in abduction and external rotation with positive impingement sign" in the left shoulder and "crepitus around the rotator cuff area". FIT determined that the shoulder impingement was related to the motor vehicle accident.

[13] On March 4, 2003, SGI sent correspondence to the Appellant that the recommendations of the FIT team would be fully funded by SGI. The Appellant was referred to Dr. McKerrell for

investigation of his left shoulder complaints. In accordance with the FIT recommendations, the Appellant commenced primary level treatment on March 13, 2003.

[14] The Appellant attended upon Dr. McKerrell on April 30, 2003 for an examination of his left shoulder pain. Dr. McKerrell reported:

...

His left shoulder continues to bother him. He has noticed pain when lying on that side at night and discomfort when using his arm in abduction or flexion activities even with light lifting. He finds that there is an aching sensation in the left trapezius region and pain in the left occipital and frontal regions and around the region of his left ear. He is able to differentiate these pains as the shoulder pain is more movement related. The neck pain not so. He has noticed weak abduction and flexion in his left arm.

...

Examination of his shoulders reveals normal right shoulder. His left shoulder has full passive range of motion, but actively he finds discomfort through active flexion and abduction. He has a positive impingement sign. Moderate anterior lateral and posterior subacromial tenderness and moderate weakness in active flexion and abduction with slight supraspinatus wasting present on the left.

This man has impingement syndrome in his left shoulder, mechanical low back pain and is recovering uneventfully from a right hip replacement, secondary to avascular necrosis. I would suggest that before an active treatment program is instituted for his left shoulder, that a rotator cuff tear be ruled out and an arthrogram or MRI would be reasonable for this. I would favor an arthrogram, as it is inexpensive and easily available. If he did have a rotator cuff tear, he should have this surgically repaired at his age and he is sufficiently well recovered from his hip replacement at this point that he could proceed with surgical treatment regarding his shoulder. If the arthrogram or MRI showed that there was no rotator cuff tear, he should have a subacromial bursal injection of corticosteroid and local anesthetic in part to clarify how much of the discomfort comes from his shoulder, how much of it comes from his neck. His examination does suggest an element of mechanical neck pain today also. He appears to have no root impingement or disc protrusion, however, and at present, I would direct treatment towards his shoulders, that seems to be the focus of his upper body discomfort.

[15] On May 23, 2003, a physical examination of the Appellant's shoulder was conducted by CBI Physiotherapy and Rehabilitation Centre. The findings were:

...Left shoulder range of motion demonstrates full range of motion with discomfort through flexion and abduction. Neer's and Hawkin's impingement tests are positive for discomfort. There is tenderness upon palpation globally around the left shoulder. He demonstrates weakness with resisted shoulder external rotation, flexion and abduction....

[16] In accordance with Dr. McKerrell's recommendations, on June 4, 2003, the Appellant underwent an arthrogram of his left shoulder which showed no full thickness tear of his rotator cuff but did report mild degenerative change within the left AC joint. Subsequent to that, Dr. McKerrell recommended a subacromial bursal injection of corticosteroid and cleared the Appellant to participate in a 12 week tertiary program at FIT. He commenced tertiary treatment on June 24, 2003 and was discharged on October 28, 2003. At the time of discharge, the Appellant was still reporting shoulder pain although he had improved mobility. At discharge the FIT team noted left shoulder dysfunction requiring further diagnosis. The Appellant was to follow up with an orthopaedic specialist. The team also concluded that the Appellant had reached maximum medical improvement. SGI advised the Appellant that upon receipt of the report from the orthopaedic specialist they would consider any medical recommendations.

[17] The Appellant saw Dr. McKerrell on August 13, 2003. At that time, Dr. McKerrell believed that the Appellant should have a MRI to rule out any other pathology because the corticosteroid injection had not made any improvement in the pain that the Appellant was experiencing in his left shoulder. This report was copied to SGI on November 27, 2003. Dr. McKerrell requested that SGI consider funding an out of province MRI because the waiting list in Saskatchewan was so long.

[18] On January 22, 2004, Dr. Taillon reviewed the Appellant's file with respect to whether or not SGI should consider funding an out of province MRI for the Appellant's shoulder. Dr. Taillon reported:

Based on my file review, there has been documented left shoulder and neck injury related to the motor vehicle accident.

Dr. McKerrel has already done an arthrogram and tried a subacromial injection of cortisone. The MRI is definitely justified in this case.

It is my opinion that SGI should expedite this MRI.

[19] It is not clear to us nor was there any explanation provided as to why SGI waited so long to approve the funding for an out of province MRI for the Appellant. The Appellant was referred for an MRI in August of 2003, which was specifically requested by Dr. McKerrell to SGI on

November 27, 2003. The Appellant did not receive approval from SGI to attend for an out of province MRI until April 2004. We find this to be an unacceptable delay especially in light of SGI's correspondence dated November 23, 2003, which stated that they would consider any medical recommendations of the orthopaedic specialist and the recommendation of Dr. Taillon that the out of province MRI be funded.

[20] The Appellant underwent a MRI of his left shoulder on April 5, 2004. The findings of the MRI were:

There is a moderate osteoarthritic disease in the AC joint resulting in some bony and soft tissue hypertrophy. This causes some impingement on the superior aspect of the rotator cuff tendon at the site of the musculotendinous attachment. The supra and infraspinatus muscles and tendons are intact.

There is some thickening and increased signal identified within the midsubstance of the subscapularis tendon, compatible with some partial tearing. The proximal biceps tendon is within normal limits.

The anterior and superior labra are normal.

Bone marrow signal is within normal limits. The articular cartilage is unremarkable.

There is some fluid identified in the subacromial/subdeltoid bursa compatible with some mild bursitis.

IMPRESSION:

- 1) AC JOINT OSTEOARTHRITIS RESULTING IN SOME IMPINGEMENT ON THE SUPERIOR ASPECT OF THE SUPRASPINATUS MUSCLE AT THE SIT OF THE MUSCULOTENDINOUS JUNCTION.
- 2) MILD SUBACROMIAL/SUBDELTOID BURSITIS.

[21] On April 27, 2004, Dr. McKerrell reported:

[The Appellant] returns for a recheck. After a long delay, he has had his MRI done in Alberta on April 5. It shows a partial thickness tearing in the subscapularis tendon and some degenerative changes in that area with a subacromial bursitis present. This is typical of impingement and I suggested he consider an acromioplasty as he has failed conservative treatment with corticosteroid injections, etc.

[22] The Appellant continued to see Dr. McKerrell regarding left shoulder pain while he waited for surgery. In September 2004, Dr. McKerrell placed the Appellant on the urgent list for surgery due to the Appellant's complaints of pain in his left shoulder and the difficulty he was experiencing at work.

[23] On October 15, 2004, Dr. Alport, medical director for SGI, prepared a comprehensive report regarding the Appellant's left shoulder injury. Specifically, Dr. Alport was being asked to opine about causation and whether SGI should expedite the Appellant's surgery on his left shoulder. The report has been reproduced in its entirety as SGI has relied heavily upon his medical report. Dr. Alport stated:

This file was referred to me for approval for private surgery to his left shoulder. He was in a motor vehicle collision in 2001. The initial report did indicate that he had injured his left shoulder, amongst other things, but then we really didn't hear much at all about his left shoulder for two years. I think he was able to work for a year after the motor vehicle collision without difficulty. He was involved in pretty extensive assessments and treatment programs which, as you know, usually provide a lot of documentation. Documentation we received from CBI and from Bourassa's assessment team don't mention left shoulder problems very much, if at all. This leads me to think that if his left shoulder was injured in the accident, it was a minor injury.

Following the motor vehicle collision, his low back bothered him, and gradually his right hip became more and more symptomatic. X-rays showed that he clearly had pre-existing osteoarthritis of both hips, worse on the right than the left. A review of Dr. Mah's medical file didn't show much in the way of right hip symptoms, and therefore Dr. Taillon provided SGI with an opinion that the motor vehicle collision likely contributed about 50% to his right hip problems. (see note at the end of this report) [The Appellant] saw Dr. Begg several times following the accident. During those visits he never complained of left shoulder problems. The focus was always the right elbow and the right hip. Dr. Begg performed surgery on his elbow which was not for injury caused in the accident. As a result of Dr. Begg's untimely death, surgery on his right hip was performed by Dr. McIvor on December 24, 2002. I think the right hip surgery went extremely well.

We also received a consult from Dr. J. Markland, dated March 13th, 2002. Dr. Markland is a Rheumatologist, and therefore deals with sore joints. Her consultation reports problems with the right elbow, his knees, and his right hip. No mention of the left shoulder in the reports.

It appears that once the hip problem was improved, we started to receive information about the left shoulder. I am not exactly sure how or when [the Appellant] was referred to Dr. McKerrell, but we received an IME from Dr. McKerrell through STARR Rehab dated April 30th, 2003. This document suggests that the most significant injury at the time of the accident was his left shoulder problem and it reportedly prevented him from lifting his shoulder very much. It also suggests that low back problems and right hip problems were almost secondary to the left shoulder problems. I don't think this is the case:

- A review of the Emergency Room file written on the day of the just indicates he complained of pain on the left side of his body, and the physical examination indicated he had a normal neck examination and neurologic exam of the right and left upper extremities were normal.
- The initial physical therapy assessment performed January 10, 2002, about 2 weeks after the accident, says that the main pain was in the leg. The clinical findings were confined to the leg because this is the most symptomatic. The report indicates that the neck and the shoulders were to be examined at a future date.
- Subsequent reports such as the one I mentioned earlier in this report (CBI and Bourassa's clinic) continue to focus on the low back and the right hip problems and very little is mentioned about the left shoulder until we received the IME in April of 2003. Admittedly, this lack of documentation for most of two years is not evidence that the left shoulder was not injured, but it suggests to me that it was relatively minor in nature. The information I have review is certainly not consistent with an injury that would be quite symptom free for 2 years then suddenly start to deteriorate (it is difficult to think of any injury that would follow this pattern). This however is what we are presented with in this case...which makes me think his left shoulder problems are most likely unrelated to the accident of December, 2001.

It is apparent from reading the chart that his left shoulder symptoms have gradually become worse. In September 2004 he was placed on an urgent waiting list...which could take up to 4 months...for repair of the left shoulder. The diagnosis at this stage is an "impingement syndrome". He has had a normal left shoulder arthrogram. The MRI showed partial thickness tear of the subscapularis tendon, but think the more significant finding, and likely that which is most amendable to surgery is the impingement syndrome. The MRI shows moderate osteoarthritic disease of the AC joint which results in some soft tissue hypertrophy. There is no evidence that the AC joint was damaged in the motor vehicle collision. The AC joint is the joint closest to the shoulder strap or seatbelt, and therefore is subject to some stress when a driver is thrown forward in a motor vehicle collision. If injured, the symptoms are likely to be most severe shortly after the collision, and should then improve.

For the above reasons, I think it is likely that this man had a minor left shoulder injury, and is currently suffering from something primarily unrelated to the motor vehicle collision. We know he has arthritic hips, and arthritis also shows up on his low back x-rays. He has left AC joint arthritic changes, probably caused by the same process that has affected his other arthritic joints. Because the information available to me indicates that left shoulder problems were either so mild that they were not documented, or else there were no left shoulder problems at all, I think the net contribution of the motor vehicle collision to his current problems is minor. I would suggest 20% is a reasonable and fair estimate.

The reason this chart was referred to me was to contribute my opinion on the need to expedite surgery. At this time, I need to point out that this man's job description clearly indicates that he rarely has to use the left shoulder in his line of work, therefore any discomfort he has in it can not be considered disabling in my opinion. The record indicates that the only time he uses his left shoulder for anything very physical is when he needs to remove very young children from the home. (He is a child care worker). The older children, of course, can walk on their own if they need to be removed. If hostility is expected, I am aware that the police are asked to be involved. All other aspects of his job can be done with or without a sore left shoulder. It seems difficult to justify why this man requires expedited surgery if we base it on a believe that "he is just about to become totally disabled from his job".

I would guess that if it was approved now in the private clinic, he would have it within the next two or three weeks. It seems, however, he is already on the list to have it done within the next 2 to 3 months because he has been placed on the urgent list a month ago, and we are told it will be 3-4 months from that time. He is currently working, and my opinion is that he should continue to work until surgery is performed. I hope this report explains why I believe his current problems are only to a small degree, if any, related to the motor vehicle collision, and therefore I cannot necessarily support the need for expedited surgery. I know that SGI supported the request for OOP MRI, and that decision may be looked on as acceptance of responsibility for the shoulder problems. I don't necessarily agree... and would suggest that the findings on the MRI are useful and can be used to justify further adjudication and/or apportionment of this case.

[24] SGI issued a decision letter to the Appellant on October 20, 2004. **This letter is the subject of the Appellant's appeal.** It stated:

SGI's Medical Director has completed a review of your medical file information in relation to the request to fund surgery for your left shoulder on a private fee basis.

As you are aware, we are guided by the input and direction of our Medical Consultants. He has provided the following opinion based on the information available at this time. He states, "Because the information available to me indicates that any left shoulder problems were either so mild that they were not documented, or else there were no left shoulder problems at all, I think the net contribution of the motor vehicle collision to his current problems is minor. I would suggest 20% is a reasonable and fair estimate." He further states, "I believe his current problems are only to a small degree, if any, related to the motor vehicle collision, and therefore I cannot necessarily support expedited surgery."

Based on this review, we are unable to pay for private surgery to your left shoulder. However, SGI will fund 20% apportionment of any medical rehabilitation expenses you may incur which are related to your left shoulder. This would include 20% apportionment of income replacement benefit for wage loss on the day of surgery and post-operative period following.

[25] The Appellant underwent surgery to his left shoulder on January 10, 2005. He did not return to work following his surgery until February 28, 2005. The Appellant saw Dr. McKerrell in follow-up on March 1, 2005. The Appellant reported that he was doing very well. Dr. McKerrell's physical examination revealed he had regained full active range of motion of his shoulder in all planes and had only minimal weakness through the mid arc of abduction but full strength in flexion. Dr. McKerrell felt that the Appellant's shoulder injury was clearly related chronologically to the accident.

[26] On May 30, 2005, Dr. McKerrell sent a report to SGI regarding The Appellant's left shoulder. He reported:

[The Appellant] has impingement syndrome. The operation that he had was an acromioplasty to make more room for the rotator cuff to traverse the subacromial tunnel. You wonder if I had directly seen any arthritis in [the Appellant's] rotator cuff. Arthritis is a condition of a joint and does not affect the muscles around it directly. Therefore, there was no evidence of "arthritis" in [the Appellant's] rotator cuff. During an acromioplasty, when the rotator cuff muscles are intact, the articular surfaces of the shoulder are not directly visualized as this would mean dividing an otherwise intact rotator cuff. Rotator cuff pathology, in particular impingement syndrome, is not related to osteoarthritis of the shoulder. Osteoarthritis of the shoulder does not cause impingement. Advanced osteoarthritis of the acromioclavicular joint may cause some degenerative changes in the rotator cuff but [the Appellant] does not have advanced changes in his AC joint and I did not find osteoarthritis to contribute in any way to his present diagnosis of impingement syndrome. The onset of [the Appellant's] impingement syndrome was chronologically related to his motor vehicle accident and several x-rays of his shoulder have shown that he does not have arthritis of his shoulder.

[27] On July 13, 2005, Dr. Alport provided a further medical report. It stated:

Thank you for your memo dated June 22, 2005. I reviewed the 6 documents submitted recently in support of this claim. You have asked if this information significantly affects the opinion I provided October 15, 2004 and December 22, 2004. The answer is that the recently submitted information is useful to support my opinion, rather than to change my opinion, even though the consultants are suggesting that his impingement symptoms are accident related. Let me explain.

We received a report from Dr. McKerrell that includes an operative report dated January 10, 2005. The operative findings confirm that "there was an intact rotator cuff with some superficial fraying on the bursal surface and a moderately thickened subacromial bursa present. There was a moderately overhanging antero-lateral acromion." What this means is that the overhanging acromion process was impinging on the tendons causing inflammation. There was no tear of any tendons. The moderately overhanging acromion would be considered a normal piece of his anatomy unrelated to trauma. The fact that it was moderately overhanging leads to a predisposition to impingement when the arm is elevated. By removing the inferior portion of the acromion process, it decompresses the channel through which the tendons travel, or effectively "relieving the impingement". Had there been a significant tear demonstrated at the time of surgery, it would have supported the claimant's suggestion that he suffered a traumatic incident. The fact that his surgical procedure was very successful in relieving his symptoms, is highly suggestive that the impingement was the disabling pathology, and not the possible partial tearing of the subscapularis tendon demonstrated on the MRI. Note that this MRI finding was not addressed or repaired in the operative procedure.

While I certainly respect Dr. McKerrell's opinion, he has based his opinion of causation on the history available to him, which of course is that provided by his patient. As I explained in the previous reports, there is little documentation of left shoulder pain at all, and that which is present is minor, and even disappears from the documentation for a significant period of time. The accident occurred in 2001 and the initial consultation for any left shoulder problem was in May of 2003. I still consider any left shoulder injury sustained at the time of the motor vehicle collision to be minor, and in all likelihood it resolved quickly, and likely completely. He was pre-disposed to develop an impingement syndrome because of his moderately overhanging acromion which can not be considered motor vehicle related. The information provided by Dr. McIver on behalf of Dr. Begg supports my previous opinion that the left shoulder problem was never a significant problem in the early months and year following the motor vehicle collision.

[28] Dr. McKerrell responded to Dr. Alport's report on August 23, 2005. He reported:

1) What were my observations when you had your surgery?

You had impingement syndrome which is a pinching of the muscles of the rotator cuff of your left shoulder. I found that the tunnel was rather tight at the anterior and superior aspects which tends to pinch a muscle called the supraspinatus. This results in some degenerative changes within the muscle. It is also possible that the injury can result in some degenerative changes or rotator cuff tears. Your MRI had shown a partial thickness rotator cuff tear and this is not seen at the time of the surgery as the superficial surface of the muscles are intact and partial thickness tears occur within the interior of the tendon. The treatment for partial thickness tears is not a direct repair of the tear but rather decompressing the muscle by making more room for it. This is what the acromioplasty performs. There was some thickening present of the subacromial bursa which is a sac of fluid that surrounds the rotator cuff muscles. It tends to come from inflammation of the bursa which usually is a result of pinching and/or injury to the area.

2) What did I see to conclude the medical probability that this injury was from an MVA?

It is impossible to say, based on the surgery, what the cause of the injury is. It is certainly possible that an injury such as a motor vehicle accident that injures the rotator cuff, causes it to become somewhat thickened and subsequently more pinched. This is what impingement syndrome is. It is also possible that the pinching occurs on a congenital basis by the tunnel being slightly too narrow for muscles and over time, the muscles become pinched. Chronologically, as you described to me, your symptoms seemed to be related to the motor vehicle accident and hence, I concluded that that was the cause of it. It is impossible, however, to say that the findings on the MRI or at the time of the surgery are entirely due either to injury or to wear and tear chances but it seems likely, from your description of this, that the injury was the cause of your problems in your left shoulder.

You asked me to critique SGI's doctor's letter. This is a letter from Dr. J.N. Alport dated July 13, 2005. Dr. Alport says that he feels there were no tear of any tendons. Your MRI had suggested some increased signal within the midsubstance of the subscapularis tendon compatible with some partial tearing. We would not see this at the time of the rotator cuff decompression as we see only the exterior surface or bursal surface of the rotator cuff at that time and this surface was intact. The MRI suggested the surface is intact also. Partial thickness tears usually begin at the articular surface or within the substance of the tendon itself and are not directly seen at the time of an acromioplasty. The treatment for partial thickness tears is not to try and repair the degenerative area within the tendon but rather to decompress it and this is the purpose of the acromioplasty. Dr. Alport says that the MRI findings were not addressed or repaired in the operative procedure but indeed they were as the decompression is the treatment for the partial thickness tears. An injury does not have to result in a full thickness tear of the rotator cuff in order to cause symptoms. Often, impingement is trigger by an injury which results in some thickening of the rotator cuff tendons and subsequent impingement. This impingement would, in those circumstances, have not occurred had the injury not happened. Dr. Alport is correct in that the impingement occurs at the anteriolateral aspect of the acromion but it does not necessarily mean that the acromial shape, in itself, is the only cause of this problem and it may not have been a cause had there not been an injury present. Dr. Alport is correct in that I base my opinion only on the information which has been provided to me by yourself and I have not researched other documentation that SGI may have regarding the time prior to my seeing you as a patient on May 6, 2003.

[29] Dr. Mah, by way of written report, stated that the Appellant did not have pain in his left shoulder before his accident on December 29, 2001. Dr. Mah is the Appellant's designated primary physician. Mr. Brown, legal counsel for SGI, was able to confirm that there were

clinical notes on SGI's file from Dr. Mah for 1999-2001 and some different tests and x-rays. Mr. Brown advised that he could not say whether Dr. Alport had reviewed these files when he completed his reports.

[30] T.A. testified at the appeal on behalf of the Appellant. T.A. was the Appellant's supervisor at the time of the accident. T.A. testified that the Appellant's arm was bothering him after the accident but that he was unable to take more time off work because he had already used up all his sick time. T.A. advised that she paired him up with another investigator for six weeks to assist him with his job. T.A. admitted that she had no notes regarding the Appellant's health concerns after the accident and that she was testifying from recollection only.

LEGISLATION AND STANDARD OF REVIEW

[31] The Commission's power on appeal is provided in Subsection 193(7) of *The Automobile Accident Insurance Act*, R.S.S. 1978, c. A-35 (the "Act"). The Commission may:

- (a) set aside, confirm or vary the insurer's decision; or
- (b) make any decision that the insurer is authorized to make pursuant to Part VIII of the *Act*.

[32] Recently, the Saskatchewan Court of Appeal addressed the standard of review applicable for appeals to this Commission in *Allary v. Saskatchewan Government Insurance*, 2006 SKCA 89. In that case, the Court of Appeal noted that more than one standard of review was indicated by the legislation. The Court of Appeal suggested that the standard of review depends upon whether SGI has discretion to grant or deny the particular benefit claimed. In *Allary*, the claimant was seeking reimbursement of payments for medical and paramedical care as provided under Subsection 163(1) of the *Act*. The Court of Appeal held that because SGI does not have discretion to decide whether to pay the claimant such benefits, the standard of review of SGI's decision is correctness, not unreasonableness. It stated:

[19] There is no discretion on SGI's part with respect to these benefits. The victim is entitled to a benefit for medical and paramedical care, including transportation. The Regulations in effect at the appropriate time impose limits on the amount that will be paid but none of those limitations

appear to apply here. For example, s. 43 provides that an expense for which the insurer may be or is required to reimburse a victim pursuant to Division 7 of Part VIII of the Act or this Part is subject to any limit set out in the Act or these regulations or, where there is no limit as to amount, to an amount that the insurer considers is reasonable. Thus, where there is no discretion to provide a benefit, asking whether the decision was “unreasonable” is not the appropriate standard. The appropriate standard is correctness.

[33] The Court of Appeal concluded that, where an appellant disputes SGI’s decision and places SGI’s findings of fact in issue and there is no discretion whether to grant or deny the benefit, the standard of review is correctness. Specifically, it stated:

[20] Where the facts are placed in issue, as they are here, the appeal commission has an obligation to receive and consider any new evidence submitted by the appellant and, depending on the nature of the hearing which is conducted, to consider as well the evidence received by SGI in making the finding of fact or facts in dispute on the appeal. The appeal commission must determine whether the decision of SGI was erroneous having regard to all the evidence. The factual issue for determination within the case was whether there was a causal link between the benefits claimed and the injuries caused by the accident of September 8, 2001.

[21] Notwithstanding its comments on the appropriate standard of review, the Commission in fact applied the proper standard, i.e. correctness. It conducted a hearing, heard the evidence of the appellant and reviewed the record including certain documentary evidence concerning the issue of causation to determine whether or not there was a causal link between the transportation benefits and mental health benefits claimed and the injury.

[34] In this case, the Appellant has put SGI’s findings of fact in issue by disputing SGI’s conclusion that only 20% of his shoulder injury was caused by the motor vehicle. In light of the Appellant putting this finding of fact in issue, the factual issue for determination is whether there is a causal link between the benefits claimed by the Appellant and the shoulder injury.

[35] In the Appellant’s case, the basis upon which SGI provides Part VIII no fault benefits to the Appellant is set out in sections 101(1), 110 and 112 of *The Automobile Accident Insurance Act*² (the “Act”) and Section 18 of *The Personal Injury Benefits Regulations*³ (the “Regulations”) in force at the time of his accident on December 29, 2001. The relevant sections of the Act are:

101(1) This Part applies to bodily injuries caused by an automobile arising out of an accident that occurs on or after the date that this Part comes into force.

² RSS 1978, c. A-35 (1995)

³ Chapter A-35 Reg 3 (effective January 1, 1995).

110(1) In this section, “**rehabilitation**” includes any or all of the following measures, programs and treatments that the insurer considers necessary or advisable to contribute to the rehabilitation of a victim, to lessen the victim’s disability caused by the accident and to facilitate the victim’s recovery from the accident:

- (a) physical and acquired brain injury programs and treatment;
- (b) occupational and vocational training and programs;
- (c) alterations to a victim’s residence;
- (d) modification or purchase of vehicle for a victim;
- (e) purchase of special equipment for a victim;
- (f) any additional measure, program or treatment prescribed in the regulations.

(2) Subject to the regulations, the insurer may take any measure it considers necessary or advisable to contribute to the rehabilitation of a victim, to lessen a disability resulting from bodily injury and to facilitate the victim’s recovery from an accident.

112(1) A full-time earner is entitled to an income replacement benefit if, as a result of an accident, the full-time earner:

- (a) is unable to continue the full-time employment he or she held at the time of the accident;
- (b) is unable to continue any other employment that he or she held at the time of the accident in addition to the full-time employment mentioned in clause (a); or
- (c) is deprived of a benefit pursuant to the *Unemployment Insurance Act* (Canada) or the *National Training Act* (Canada), or any other prescribed benefit, to which he or she was entitled at the time of the accident.

Section 18 of the *Regulations* states:

18 A victim is unable to hold employment when a bodily injury that was caused by the accident renders the victim entirely or substantially unable to perform the essential duties of the employment that the victim:

- (a) performed at the time of the accident; or
- (b) would have performed but for the accident.

[36] In accordance with Section 101(1) of the *Act*, the Appellant must prove that his shoulder injury was caused in the motor vehicle accident and that there is no basis for apportionment by SGI. There is no entitlement to any benefits under Part VIII unless the bodily injury is caused by the motor vehicle accident.

[37] If the shoulder injury was caused in the motor vehicle accident and there is no basis for apportionment, then the Appellant will be successful in his appeal. The appropriate standard of review with respect to causation is that SGI’s decision must be correct. Therefore, in light of the

Appellant putting SGI's findings of fact on causation in issue, the Commission must determine whether an apportionment on causation is correct having regard to all of the evidence.

[38] In light of Mr. Brown's offer to pay the Appellant 100% of his rehabilitation and income replacement benefits regardless of our decision, this decision may be somewhat redundant. The parties have acknowledged that it is their intention to treat our findings with respect to causation and apportionment as applicable to the Appellant's entitlement to future benefits which are not directly be related to this appeal. Therefore, our decision will make findings of fact with respect to causation to assist the parties with respect to future entitlement of benefits, only in so far as causation of the shoulder injury is concerned.

ANALYSIS

[39] It is difficult to render a decision in this case where there are competing medical opinions, one by the surgeon who performed the surgery on the Appellant's left shoulder and the other opinion, being that of SGI's medical consultant who has completed a file review and has never seen or examined the Appellant. This would be an appropriate file for an independent third party medical opinion, however, the Appellant chose to proceed with his appeal and asked this Commission to arrive at a conclusion on causation of his left shoulder injury.

[40] It does not appear that Dr. Alport had reviewed the initial documents of Smithwick's Physiotherapy, which clearly document an acute injury to the left shoulder immediately after the accident. Similarly, the hospital records and the personal injury representative notes document a very painful left shoulder initially following the accident. It does not appear that Dr. Alport placed much weight on these documents, if any.

[41] Mr. Brown also advised the Commission that Dr. Alport has not had an opportunity to review Dr. McKerrell's opinion, dated August 23, 2005. Similarly, Mr. Brown could not say whether Dr. Alport had reviewed the medical charts of Dr. Mah prior to the accident to determine if there was documentation of a pre-existing left shoulder problem. In our opinion, these records were requested by SGI, were in SGI's possession and we conclude someone must have reviewed them for pre-existing conditions. They certainly were reviewed by Dr. Alport

with respect to the pre-existing hip conditions. We believe that if there had been any reference to pre-existing left shoulder problems, it would have been noted by one of the medical consultants or the personal injury representative and would have been relied upon by Dr. Alport and SGI. Dr. Mah reported that he was not aware of pre-existing left shoulder pain and we accept his report in that regard. We do not find any evidence of a pre-existing injury or complaints of pain to the left shoulder.

[42] An x-ray was taken of the Appellant's left shoulder on January 3, 2002 because he complained to Dr. Mah about shoulder pain. It did not show any degenerative changes to the shoulder. In May 2002, during his multi-disciplinary assessment at Bourassa's, the Appellant does subjectively complain about the pain in his left shoulder and neck. The Appellant also reports in his application for benefits that his shoulder is bothering him a lot. For some reason, the Application for Benefits was signed on November 26, 2002 even though the front page reports that it was completed on January 20, 2002. The Appellant reported that he completed it in January 2002 following the accident and we accept his testimony in that regard. He also made complaints to the occupational therapist, but testified that his complaints of left shoulder pain were largely ignored due to the problems with his right hip. Admittedly, there is not much documentation in 2002 which suggests the left shoulder injury is serious except for acute pain immediately following the accident.

[43] However, in February 2003, the FIT assessment team concluded that the shoulder impingement was related to the motor vehicle accident. This was a period of approximately 13 months from his initial complaints of serious shoulder pain. In his October 2004 medical opinion, Dr. Alport suggested two years had passed where nothing much was heard about his left shoulder pain and this is clearly an error on his part. Furthermore, Dr. Alport never addressed the FIT report in any of his medical reports so it is unclear whether he has reviewed these reports and how he has addressed FIT's finding that the shoulder impingement was motor vehicle accident related. Furthermore, Dr. Taillon was certainly of the opinion based on his file review that the shoulder injury had been documented and that it was related to the motor vehicle accident. All of this clearly supports a finding on a balance of probabilities that the shoulder impingement was caused by the Appellant's injuries in the accident. The secondary issue is

whether or not the shoulder impingement was caused entirely by the accident or whether a pre-existing condition or something entirely unrelated to the accident is contributing to the left shoulder impingement such that an apportionment would be appropriate.

[44] Dr. Alport, in his October 2004 medical report, apportioned 20% of the Appellant's shoulder injury as being caused by the motor vehicle accident and Dr. McKerrell found the motor vehicle accident to be 100% responsible for the Appellant's shoulder injury.

[45] Dr. Alport's October 15, 2004 medical opinion is troublesome in many ways. Although we agree with Dr. Alport that the Appellant was involved in some pretty extensive assessments and treatment programs in 2002, which did not make much mention of his left shoulder, Dr. Alport clearly placed very little emphasis on the early medical documentation of a serious injury to the Appellant's left shoulder, one that resulted in him reportedly being unable to lift his left arm for over a week after the accident due to pain in his shoulder. Dr. Alport further concluded that the Appellant never complained of left shoulder problems but this is contradicted by the Appellant's own evidence at the appeal. We found the Appellant to be a credible witness and we accept that he was complaining of left shoulder pain during 2002 but that it went largely untreated because of his hip problems. Normally we would expect to see documentation in the assessments but we know the early physiotherapist, Mr. Kucey, documented it and then proceeded only to treat the low back pain and reported that the shoulder would be examined later. Further, we find that the Appellant was suffering some very significant medical problems relating to his right hip throughout 2002 which eventually resulted in surgery to his hip and, therefore, we find it believable that this may have been the primary focus of his treatment by his medical practitioners. Dr. Alport also makes reference to the medical report of Dr. McKerrell. He clearly states he is not sure why the Appellant was referred to Dr. McKerrell, therefore, we must assume that Dr. Alport never reviewed the FIT report or the diagnosis of the FIT team regarding the Appellant's left shoulder impingement. This is another important error in Dr. Alport's medical opinion. Dr. Alport then goes through a review of the medical documentation. He does not mention the personal injury representative's notes of her conversation with the Appellant; Dr. Alport does not mention the practitioner's report of Dr. Mah which diagnosed an injury to the left shoulder and prescribed Vioxx; Dr. Alport does not reference the x-ray of the

left shoulder; and he does not refer to the physiotherapy notes of Candra Sexton which report a diagnosis of strain of the left shoulder. Dr. Alport goes on to conclude that the shoulder injury was very minor because it was not documented for two years. This is clearly not supported by a careful review of the medical documentation. We do not find this to be a situation where the Appellant reported no injury to his shoulder and then claimed an injury two years later. It may not have been focused upon in 2002, but it was clearly documented following the accident as an acute injury in the accident.

[46] Dr. Alport goes further in his report noting osteoarthritic disease of the AC joint, which is evident on the MRI. Dr. Alport concludes there is no evidence of damage to the AC joint in the accident stating that symptoms would be most severe shortly after the accident and then improve. Dr. Alport concluded that the shoulder injury was minor and that the Appellant's shoulder injury is primarily unrelated to the accident. He concluded that because the Appellant had arthritic changes in his other joints, the arthritic changes in the AC joint in the left shoulder must be caused by the same process. Dr. Alport arrived at this conclusion despite the lack of any pre-existing medical documentation which showed arthritic changes, a normal left shoulder x-ray and an absence of left shoulder injury or reported pain prior to the accident. Given his conclusions, Dr. Alport opines that only 20% of the Appellant's left shoulder problems relate to the accident.

[47] We find that in fact the Appellant's symptoms were most severe shortly after the accident, likely in the acute phase, and then improved somewhat. The Appellant thereafter still reported pain in the left shoulder but his testimony is that he was able to regain some of his range of motion that was lost immediately following the accident.

[48] It is our opinion that Dr. Alport's opinion on apportionment and causation in the October 15, 2004 medical report should be given very little weight and are not supported by the evidence. We have noted several inconsistencies and errors in the report which lead us to different conclusions than Dr. Alport. We find there to be no medical documentation which suggests that the Appellant had a pre-existing condition in his left shoulder. He clearly had significant complaints of pain immediately following the accident. Furthermore, the Appellant has other

significant pre-existing health problems which are noted throughout the file. We believe that a pre-existing problem in the left shoulder would have appeared in the medical file prior to the accident if it existed, just as the right hip and arthritis did.

[49] It is necessary to address the competing opinions of Dr. McKerrell and Dr. Alport following the surgery. Dr. McKerrell is an orthopaedic surgeon. Although, Dr. McKerrell's medical qualifications were not put in issue, we note that a review of his curriculum vitae shows extensive experience in reconstructive orthopaedics, sports medicine and arthroscopy.

[50] In this case, it is important that Dr. McKerrell actually performed the surgery to the Appellant's shoulder on May 30, 2005. Due to the fact that he actually has examined the Appellant and performed the surgery, we are of the opinion that his medical opinions should in this case, carry more weight than those of Dr. Alport, who has only reviewed documentation on the file, and has not had an opportunity to examine the Appellant or perform the surgery to his shoulder. It is our opinion that Dr. McKerrell is in a better position to provide a diagnosis with respect to the Appellant's shoulder injury because he performed the surgery which corrected the shoulder injury.

[51] Following the surgery, Dr. McKerrell provided an opinion to SGI in which he stated "the Appellant does not have advanced changes in his AC joint and I did not find osteoarthritis to contribute in any way to his present diagnosis of impingement syndrome". Dr. Alport made an assumption that the left AC joint arthritic changes which showed up on the MRI were probably caused by the same process that has affected his other arthritic joints. Dr. McKerrell appears to refute this statement by saying that there was not advanced changes in the Appellant's AC joint and that osteoarthritis was in no way contributing to the impingement syndrome.

[52] A further medical report of Dr. Alport must also be addressed. This is his report of July 13, 2005. Upon review of the operative report, Dr. Alport further concludes that a "moderately overhanging acromion process was causing the impingement" and that because the overhanging acromion would be considered to be a normal part of the Appellant's anatomy it would lead to a natural disposition to impingement when the arm is elevated. Dr. Alport further comments that the partial tearing of the subscapularis tendon was not addressed during operative repair. In

response, on August 23, 2005, Dr. McKerrell states that the partial tear would not be seen at the time of surgery because it would be within the interior of the tendon and the muscles are intact during surgery. He further states that the repair of a tear is the decompression of the muscle by making more room for it and that this is the purpose of an acromioplasty which was done. Dr. McKerrell also reports that the inflammation of the bursa will usually occur as a result of pinching or injury to the area. Dr. McKerrell candidly admits that impingement may be caused by an injury to the rotator cuff which causes it to become thickened or it can occur on a congenital basis. However, Dr. McKerrell concludes that the chronological order of the symptoms suggest to him that the motor vehicle accident is the cause of the injury. Dr. McKerrell further stated that without the injury to the shoulder, the shape of the acromion may not have caused the impingement.

[53] It is the August 23, 2005 medical report of Dr. McKerrell which has not been reviewed by Dr. Alport. A large part of Dr. Alport's medical opinion relies upon the fact that this was a very minor injury to the Appellant's shoulder which went unmentioned for a period of two years. Dr. Alport challenges Dr. McKerrell's opinion on the basis that he relied upon the chronological history provided by the Appellant as to when and how the injury occurred.

[54] In fact, we have identified many inconsistencies and errors with respect to Dr. Alport's medical opinions which in our opinion show that Dr. Alport failed to review several critical documents that do not support his finding this was a minor injury that went unnoticed for two years. On the contrary, we find that the chronology of symptoms support a finding that the Appellant's impingement syndrome is most probably caused by the injury to his left shoulder in the motor vehicle accident. We do not believe that Dr. Alport is correct in concluding that something other than the motor vehicle accident contributed to the Appellant's impingement syndrome.

[55] It is our opinion that, given the history of symptomology in the left shoulder immediately following the accident and then the diagnosis of an impingement syndrome approximately one year later by the FIT team as being caused by the accident, the Appellant has satisfied us on a balance of probabilities that the left shoulder impingement was a direct result of the injury to his

left shoulder in the accident. We rely upon the medical opinions of Dr. McKerrell. In this particular case, we are of the opinion that as the examining and operating surgeon on this file, deference should be given to Dr. McKerrell's opinion over that of SGI's medical consultant who only had the benefit of reviewing medical documentation and did not have the benefit of examining the Appellant or performing the shoulder surgery.

[56] Accordingly, we are satisfied that the Appellant is entitled to 100% of his benefits relating to the injury to his left shoulder. We find the medical reports of Dr. Alport to be based on errors not supported by the evidence. As such, the medical opinion of Dr. Alport with respect to an apportionment on causation is incorrect having reviewed and examined all of the evidence.

[57] In light of our findings on causation, SGI's decision regarding the apportionment of the Appellant's income replacement benefits and rehabilitation benefits is incorrect and set aside. The Appellant is entitled to 100% of his benefits relating to his shoulder injury.

[58] Accordingly, we find the decision letter of SGI with respect to the apportionment of the Appellant's shoulder injury to be incorrect based upon our findings of fact on causation. Therefore, the decision letter of SGI dated October 20, 2004 which provided the Appellant with a 20% apportionment of benefits for medical rehabilitation and income replacement relating to surgery to his left shoulder is set aside.

CONCLUSION

[59] The decision made by SGI dated October 20, 2004, which provided the Appellant with a 20% apportionment of benefits for medical rehabilitation and income replacement relating to surgery on his left shoulder is set aside. It is our opinion that there is insufficient medical evidence to support a finding of apportionment by Dr. Alport relating to the Appellant's shoulder impingement. Although SGI has already likely done so, they are ordered to provide the Appellant with 100% of his benefits relating to his surgery and post-operative recovery.

[60] As the Appellant has been successful in his appeal, he will be entitled to his costs associated with the appeal in accordance with Section 193(11) of *The Automobile Accident*

Insurance Act. This will include reasonable expenses in accordance with Section 96 of *The Personal Injury Benefits Regulations*. The Appellant is also entitled to reimbursement of his Appeal Fee in accordance with Section 86(4) of *The Personal Injury Benefits Regulations*.

Dated at Saskatoon, Saskatchewan, on [December 21, 2006](#).

Joy Dobko, Chair

Stephanie Pfefferle, Commission Member

Carol Olson, Commission Member