Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-06-74

PANEL:	**Ms Yvonne Tavares, Chairperson** **Ms Mary Lynn Brooks** **Ms Jean Moor**
APPEARANCES:	**The Appellant, [text deleted], was represented by [text deleted];** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Morley Hoffman.**
HEARING DATE:	**October 1, 2009**
ISSUE(S):	**Entitlement to Income Replacement Indemnity Benefits beyond August 20, 2005.**
RELEVANT SECTIONS:	**Sections 83(1) and 110(1)(a), (c), and (e) of The Manitoba Public Insurance Corporation Act ('MPIC Act')**

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

Reasons For Decision

The Appellant, [text deleted], is appealing the Internal Review Decision dated March 28, 2006 with respect to her entitlement to income replacement indemnity ("IRI") benefits beyond August 20, 2005. At the hearing of this appeal, the Appellant withdrew her appeal of the Internal Review Decision dated October 3, 2007.

The Appellant was involved in a motor vehicle accident on June 7, 2004 when the vehicle she was driving was struck from behind by another vehicle. As a result of this motor vehicle accident, the Appellant sustained injuries to her neck and back, and became entitled to Personal Injury Protection Plan ("PIPP") benefits pursuant to Part 2 of the MPIC Act. The Appellant had previously been involved in an accident on January 13, 2004 and sustained similar injuries in that accident. The Appellant indicated to her case manager that she was nearly recovered from the first injury when the second accident occurred.

At the time of the motor vehicle accident, the Appellant was employed as a delivery driver for [text deleted] on a part-time basis. Her duties involved loading a van with meals and delivering them. The Appellant was also self-employed as an electrologist on a part-time basis, 15 to 18 hours per week. This employment involved treating individuals for hair removal and operating an electrolysis machine.

Due to the injuries which the Appellant sustained in the motor vehicle accident, she was unable to continue with her employment as a delivery driver as she could not lift and had difficulty shoulder checking when she was driving. However, the Appellant was able to continue with the electrolysis business. As a result, the Appellant became entitled to IRI benefits based upon her delivery driver position.

At the time of the accident, the Appellant was classified as a temporary earner, having held regular employment as a self-employed electrologist and delivery person less than 40 hours per week and less than one year in duration in relation to the delivery driver position. As a temporary earner, MPIC was required to determine an employment for the Appellant as of the 180th day following the accident, as she was still unable to hold full-time employment due to her

injuries. Based upon the Appellant's history of employment, her employment category for ongoing IRI benefits was determined as electrologist. Since the Appellant was continuing to work on a part-time basis as an electrologist, her income earned from this employment was deducted from her IRI entitlement.

In a file note dated February 9, 2005, MPIC's case manager documented that:

> "Fiale (sic) status… The insured has been determined as an electrologist and is presently on a GRTW at [text deleted]. Recent x rays have diagnosed a shoulder problem, suspected rotator cuff, and the insured has been referred to [text deleted] for further examination re status and prognosis. Shoulder has been a problem since the accident but has not responded to conservative treatment. Cannot increase hrs of work at this point. Current medicals are pending prior to review by HCS. JDA being ordered."

The Appellant's family physician subsequently referred her to [Appellant's doctor #1] for assessment. In a report dated May 7, 2005, [Appellant's doctor #1] reported that:

> "This patient was first seen on February 21, 2005 at the request of [Appellant's doctor #2]. At that time, she indicated she had shoulder pain resulting from a motor vehicle accident of June of 2004. At that time, she indicated she also had jarred her left shoulder and neck area. She indicated that she had had no prior injuries to either shoulder before this accident. She had been previously treated with anti-inflammatory medication by her own physician.
>
> When examined she was found to have tenderness at the right rotator cuff insertion with significant limitation in range of motion through the gleno humeral joint. A diagnosis of adhesive capsulitis was raised and this can be a consequence to previous injury even several months delayed.
>
> Therefore, since she had had no prior difficulties my presumption is that she developed this progression of capsulitis as a result of her trauma of the accident of June 7, 2004. She was treated with injections and in follow up on April 25, she was found to have improvement in some of the range of motion but with still weakness.
>
> In regards to her work, she would have been limited from arm use at or above shoulder level so that she may have been somewhat restricted in her work capacity. I do feel she is capable of day-to-day activities though may have required analgesia to perform these."

A Jobs Demand Analysis ("JDA") was subsequently undertaken of the Appellant's employment on May 10, 2005. In a report dated June 2, 2005, the occupational therapist, who undertook the JDA reported that:

> "**Critical Physical Demands:**
>
> - Constant sitting.
> - Rare standing and walking.
> - Constant arm reaching to maintain arm in a static position of approximately 45 degrees shoulder flexion with approximately 90 degrees of internal rotation.
> - Constant pinch grip.
> - Constant static neck forward flexion of approximately 30 to 45 degrees.
>
> **Critical Physical Demands:**
>
> - Occasional sitting.
> - Frequent standing and walking.
> - Occasional to frequent arm reaching through out body range.
> - Occasional lifting of up to approximately 10 to 15 lbs. through out body range.
> - Occasional carrying of up to approximately 10 to 15 lbs.
>
> **Summary:**
>
> Following the U.S. Department of Labor classification, the position is rated as Sedentary. Note that this criteria does not specifically account for static body positioning of any type."

In a report dated June 21, 2005, the physiotherapist commented that:

> "Currently, [the Appellant] has fully passive range of motion to shoulder elevation, rotations.
>
> Shoulder girdle range of motion was much improved and on examination within normal limits; functionally elevation and adduction is decreased and weak. The scapula remains in an abducted position at rest with cervicothoracic kyphosis. Of note she has she has (sic) active trigger points to the infraspinatus, pectoralis minor, upper fibers of trapezius (always on a stretch) and levator scapula on the right. Resisted shoulder abduction is painful and weak, Grade 3 when last assessed. Middle fibers of trapezius have Grade2 strength…

> At this point I feel that I have addressed the main problem areas with limited success. Perhaps due to the fixed cervicsthoracic kyphosis and scapula position the shoulder musculature is in a constant strain position.
>
> I believe that [the Appellant] could manage her job, with frequent rest breaks during long client treatment sessions and between clients and increase her hours, (6-7 hours per day over 8-9 hours). I also would recommend consideration of other medical intervention of trigger point treatment in combination with continued home exercises to maintain any benefits that she may have from such treatment. She continues to have very painful and reactive trigger points despite the normal range of motion and these limit the tolerance she has for the modest exercises."

In a letter dated August 18, 2005, MPIC's case manager wrote to the Appellant to advise her that based upon the medical reports from the physiotherapist and from [Appellant's doctor #1], she had regained the functional capacity to perform her occupational duties on a full-time basis. Accordingly, her entitlement to IRI benefits would cease effective August 20, 2005 pursuant to Sections 110(1)(a), (c) and (e) of the MPIC Act.

[Appellant's doctor #1] provided a follow-up report dated November 4, 2005, wherein he advised that:

> "Further to my letter of May 7, 2005 this patient was seen in follow up June 24 and August 17 at which time she was found to have improvement in symptoms but still limitations in functional capacity due to aggravation of pain. Therefore, continued modified work load (i.e. partial hours) was recommended at these visits.
>
> Further assessment is planned in the form of an MRI to determine internal pathology and any need for surgery. She had needed daily analgesics using Naproxen for pain relief to do work and ADL.
>
> Therefore, pending further investigation, this patient continues to be limited in shoulder functions and is capable of partial work hours only."

An ergonomic assessment was subsequently ordered for the Appellant. In a report dated December 12, 2005, the occupational therapist who conducted the ergonomic assessment commented that:

"**Required Tasks**

Reaching: The majority of [the Appellant's] job requires that she reach over her clients to access the areas to perform the electrolysis. The main two areas [the Appellant] works on are the eyebrows and the bikini line. [The Appellant] sits in a chair to perform this task.

The length of reach required to perform her duties depends on the size of her client. Larger people would require her to reach higher (demanding more shoulder flexion) as well as causing [the Appellant] to place her shoulder into shoulder abduction to ensure clearance of her client's body.

When performing electrolysis, [the Appellant] must use her shoulder in both flexion and abduction both outside the effective arm reach range. When working with larger clients, [the Appellant] must increase the shoulder flexion and abduction angles of the shoulder to accommodate.
Ideally, a horizontal arm reach for frequent tasks should not exceed 10 inches of the worker. When working in the midsection of the client, [the Appellant] is required to reach 15 inches from the side of the bed (including the arms on the bed) to the working area.

Vertical arm reach for frequent tasks should not exceed 90 degrees of shoulder flexion. As seen in the photo above, [the Appellant] is working at approximately 70 – 80 degrees of shoulder flexion. This angle increases with larger clients.

Shoulder abduction angles also increase when working with larger clients. When arm abduction angles exceed 15 – 20 degrees, the compressive forces on the shoulder increase significantly. [The Appellant] must use greater than 15 – 20 degrees of abduction for larger clients…

[The Appellant] would benefit from the following treatment:

1. Resume with physiotherapy treatment to strengthen muscles and increase range of motion of the shoulder.
2. Repetitious static work, such as electrolysis, is very fatiguing on upper extremities, specifically [the Appellant's] right shoulder. It is important that [the Appellant] take rests between client tines. 5-10 minutes should be allowed between clients to help against pain from exhaustion. During this time, [the Appellant] could perform her range of motion exercises. For the long appointment times, [the Appellant] may need to take additional short breaks (1-2 minutes) to both rest her shoulder and perform stretches to keep her shoulder mobile and increase circulation."

A follow-up report was obtained from [Appellant's doctor #1] dated February 16, 2006 which advised that:

"Further to my letter of May 7, 2005, despite the injections done in the past, this patient has had continued shoulder pain that has affected her ability to do out-stretching and

> repetitive movements. Because of persisting symptoms, I elected to do an MRI and the results of the MRI are enclosed. I have submitted a referral for Orthopedic opinion regarding possible surgical intervention through arthroscopy.
>
> Presently, I have no other treatment to suggest other than pain relief or persistent pain but do feel that she is limited in her functional capacity for ADL and/or to the degree that she is limited in doing repetitive tasks especially at or above shoulder level."

A report from [Appellant's orthopedic specialist] dated August 9, 2006 advised that:

> "I saw this [text deleted] year old right handed electrologist at the request of [Appellant's doctor #1]. She was seen at [text deleted] on the 17th of July 2006. She complains of right shoulder pain which has been present since the 7th of June 2004, when she was driving her car which was stopped at a yield sign. She was rear ended. She had her right arm on the steering wheel. Has had it treated with Steroid injections which were of no help. Had some Chiropractic treatment and some physiotherapy and at the moment is doing a home exercise program. Complaints were that of pain. Was constant. When I examined her, she had full range of motion of the right shoulder, with the exception of internal rotation where she was missing 3 verbal (sic) heights. She had tenderness quite diffusely around the shoulder. Forward flexion was full with an equivocal impingement sign.
>
> She'd had an MRI which is report as showing a partial anterior labral tear. I felt that this was not in fact contributing to her clinical picture. I would expect it to be extremely unlikely that it would have occurred with the nature of the accident that occurred. I felt she had a diffused soft tissue pain about the shoulder, she was not likely to be helped by any surgical treatment. I had no advise as to any further investigations to be carried out on her. She did have some fairly marked weakness in all four directions in the shoulder and I did recommend a bit of a reconditioning program which I felt would help improved her symptomatology. There is no history of any pre existing conditions. With the full range of motion present the shoulder with the exception of the slight loss of internal rotation, I would consider this as almost no permanent impairment."

The Appellant sought an Internal Review of the case manager's decision of August 18, 2005. In a decision dated March 28, 2006, the Internal Review Officer confirmed the case manager's decision and dismissed the Appellant's Application for Review. The Internal Review Officer found that:

> "I note that the motor vehicle accident in which you say you sustained damage to your right shoulder was a low speed affair. This can be inferred from the minimal damage to your vehicle. Given that, I cannot disagree with [MPIC's doctor's] conclusion (in the assessment dated January 19, 2006), that:

> "It is medically not probable that [the Appellant] would have been exposed to a significant trauma that in turn would have resulted in disruption of a musculotendinous structure and/or cause a significant injury to a spinal disc and/or peripheral joint."
>
> These concerns about causation, arising right at the outset, are strengthened by the equivocal nature of the various medical explanations for what was causing your difficulties. For instance, [Appellant's doctor #1] initially diagnosed you as having right adhesive capsulitis. That diagnosis simply cannot stand given, for instance, your physiotherapist's report that you had recovered full range of motion in your right shoulder quite early in her course of treatment. As [MPIC's doctor] says in his January 19, 2006 assessment, you simply do "not have clinical findings in keeping with adhesive capsulitis."
>
> Your clinical presentation has suggested to some of your caregivers that you might have suffered a right rotator cuff tear (although it is hard to see how that could be possible given the minimal forces involved in the collision). The MRI done on January 23, 2006 conclusively demonstrates, however, that you have no evidence of a rotator cuff tear. The only abnormality detected is a "short segment tear involving the anterior labrum." The significance of this finding is unclear. [MPIC's doctor] has expressed the view (in the March 3, 2006 CARS note) that "it is not medically probable that the MRI findings account for her pain and/or developed from the MVA." That really involves two opinions: (1) the small tear in the labrum was not caused by the car accident, and (2) it does not account for your perceived pain in any event. [Appellant's doctor #1] really does not provide anything to rebut these views. His most recent letter suggests that you have significant functional limitations, but he does not indicate why the minimal findings on the MRI should lead to such a result, or why we should accept that they are a consequence of the car accident. (His report also does not make it clear whether he is sticking with the questionable diagnosis of adhesive capsulitis.)
>
> In all the circumstances, I do not think any basis has been shown for interference with the decision under Review. Accordingly, this Review will confirm it."

The Appellant has now appealed that decision to this Commission. The issue which requires determination on this appeal is whether the Appellant's right shoulder problems are connected to the motor vehicle accident of June 7, 2004 and whether these shoulder problems prevented her from holding employment as an electrologist beyond August 20, 2005. Prior to the appeal hearing, additional medical reports were submitted to the Appellant's file, as follows:

1. A report dated November 6, 2007 from [Appellant's doctor #1], wherein [Appellant's doctor #1] advised that:

"In response to your letter of Septmbe (sic) 19, 2007, I can provide information on my assessments only as I am not the primary physician in this patients care. She was first seen on February 1, 2005 at the request of [Appellant's doctor #2] for symptoms of right shoulder pain that she relates to a motor vehicle accident of June 2004 at which time she indicated that she jarred her left shoulder and neck. At that time she was found to have had significant limitation in range of motion with a diagnosis of a right rotator cuff injury and adhesive capsulitis. She was treated with injections on February 28, 2005 and on April 25, she was found to have reduced pain symptoms but with still weakness of reaching and lifting movements. On the follow-up on June 24, 2005 showed improvement in severity of pain but with still limitation in mobility. She has been able to continue with her work, but at a limited level of hours and limited reaching and overhead lifting. An MRI was performed and a copy is enclosed. An orthopedic evaluation was done by [Appellant's orthopedic specialist] and he did not recommend any surgical treatment.

This patient has continued shoulder pain with limitation in function for which analgesia has been provided. I feel that her symptoms are a result of residual tendonitis with associated myofascial pain. She does have some temporary relief with chiropractic treatment and massage, though I do not anticipate the resolution of her symptoms."

2. A report dated January 1, 2008 from [Appellant's doctor #1], wherein he advised that:

"In response to your letter of December 6, 2007, this patient was seen in follow-up on November 30, 2007, after MRI was performed on October 21, 2007. Please find enclosed a copy of the MRI result which does show some degree of progression and damage related to the supraspinatus tendon as well as development of mild AC joint arthrosis. As a result of these areas of damage, I have further suggested a repeat evaluation by an Orthopedic surgeon for the possibility of arthroscopic surgery.

As previously stated, her shoulder symptoms have been continuous and recurrent since the motor vehicle accidents of 2004 and she indicated to me that she had had no prior difficulty with her shoulders. I suspect there may have been some initial minor damage but this has become progressive with continued physical use of her shoulders. This may be successfully improved with surgery. I cannot, however, predict the specific prognosis but surgical intervention may at least improve her level of day to day function and pain."

3. An inter-departmental memorandum dated March 6, 2008, from [MPIC's doctor], Medical Consultant to MPIC Health Care Services, wherein [MPIC's doctor] notes that:

"It is documented that [Appellant's doctor #1] opined that some initial minor damage likely occurred as a result of the accident and became progressive with continued physical use of her shoulders. It is noted that [Appellant's doctor #1] referred [the Appellant] back to an orthopedic surgeon to determine whether arthroscopic surgery would be beneficial…

My interpretation of the information obtained from [Appellant's doctor #1's] report leads me to conclude that [Appellant's doctor #1] is of the opinion that if [the Appellant] sustained an injury to her rotator cuff as a result of the motor vehicle incident that occurred in 2004 that resulted in symptoms but no radiological evidence of damage over a two-year period of time but continued to use the right shoulder leading to the progressively deterioration in the rotator cuff tendons to the extent that abnormalities could be identified on an MRI. This theory, in my opinion, although possible, is not medically plausible for the following reasons:

1. [The Appellant] did not report any symptoms involving her right shoulder following the January 13, 2004 motor vehicle incident.

2. [The Appellant] did not present with any objective clinical findings suggestive of a rotator cuff injury following the June 7, 2004 motor vehicle incident. It should also be noted that during the incident her vehicle sustained approximately $500 in damage as a result of a rearend collision which would indicate minimal stress was transferred to [the Appellant], and as such, it is not medically probable the rotator cuff was subjected to a level of trauma that in turn might lead to problems and/or symptoms in the future.

3. When [the Appellant's] right shoulder condition was specifically addressed it is noted she had clinical findings in keeping with adhesive capsulitis which is a condition that develops in the majority of cases in the absence of a traumatic event.

4. When concern was raised with regard to the right shoulder symptoms being a byproduct of some type of rotator cuff abnormality, investigations performed to assess it well after the onset of symptoms did not identify any structural changes that might indicate an abnormality was evident involving the rotator cuff that in turn might lead to her symptoms and/or later difficulties.

Based on the above, it is not medically probable the abnormalities noted on the MRI performed in October 2007 are a byproduct of the motor vehicle incident [the Appellant] was involved in, in 2004.

It is not medically possible to determine the actual cause of the changes to the rotator cuff tendons that occurred between January 2006 and October 2007."

4. [Appellant's orthopedic surgeon's] report dated February 5, 2009, wherein [Appellant's orthopedic surgeon] advised that:

"When I examined [the Appellant] on May 23/08 she had limited mobility in all ranges of motion. She also had impingement signs and weakness indicating problems of the rotator cuff.

> Two MRI's had been performed the second of which demonstrated some rotator cuff tendinosis and partial rotator cuff tear. I did not review the findings of the initial scan.
>
> After discussion with [the Appellant] in regards to treatment options, we decided on a shoulder arthroscopy which was performed on January 05/09. At that time it was found she had a near full thickness tear of the rotator cuff and this was treated with a primary repair. The surgery went well with no complication. I have last seen [the Appellant] on January 19/09 at which point she was continuing to have some ongoing pain secondary to the surgery which was not unexpected at this stage of her recovery. I will be seeing her again in approximately one month's time.
>
> I do not have any record of a car accident which occurred on January 13/04 which was indicated in your letter. I also see no mention of this accident on consultation with [Appellant's orthopedic specialist].
>
> It is obviously impossible for me to point to a cause and effect relationship definitively between her accident and findings at the time of surgery. However, [the Appellant] does state that she had no shoulder problems prior to injury. Her poor response to physiotherapy and other conservative measures is also in keeping with a high grade partial rotator cuff tear contributing to her difficulties with the shoulder."

Appellant's Submission:

Counsel for the Appellant submits that the Appellant sustained an injury to her shoulder in the motor vehicle accident of June 7, 2004 which has prevented her from carrying out her occupational duties as an electrologist on a full-time basis. He argues that the motor vehicle accident of June 7, 2004 caused the Appellant's shoulder problems, which were eventually corrected by surgery in January 2009. He maintains that the overwhelming evidence is that the Appellant sustained a shoulder injury in the motor vehicle accident of June 7, 2004 and there is no other explanation for her injury and her chronic shoulder pain.

Counsel for the Appellant submits that the first MRI of the Appellant's shoulder was flawed and that [Appellant's orthopedic specialist's] opinion was based upon a cursory review of the Appellant. He argues that the first MRI and [Appellant's orthopedic specialist's] report should not be relied upon. Rather, counsel for the Appellant submits that the Appellant's evidence

should be preferred. As a result, counsel for the Appellant argues that the Appellant did sustain an injury to her shoulder in the motor vehicle accident of June 7, 2004. This injury prevented her from working as an electrologist on a full-time basis and resulted in the surgery of January 2009. Therefore, counsel for the Appellant submits that the Appellant is entitled to ongoing IRI benefits beyond August 20, 2005.

MPIC's Submission:

Counsel for MPIC submits that the Appellant's shoulder pain and strain are not related to the motor vehicle accident of June 7, 2004. He points out that the MRI conducted in 2006 does not show a rotator cuff tear. Accordingly, he argues that the Appellant must have developed a rotator cuff tear after the MRI conducted in early 2006 and prior to the MRI of October 2007 and those findings do not relate to the motor vehicle accident. He claims that rotator cuff tears can develop in the absence of trauma and it is more likely that the Appellant developed the rotator cuff tear independent of her motor vehicle accident-related injuries. He maintains that the findings of arthrosis and tendinosis in 2007 are not likely from the motor vehicle accident, but rather probably from overuse.

Additionally, counsel for MPIC submits that [MPIC's doctor's] reports should be preferred to those of [Appellant's doctor #1], as he had all of the Appellant's medical information. He argues that [MPIC's doctor's] opinion is more consistent with the MRI reports and [Appellant's orthopedic specialist's] report. Counsel for MPIC maintains that the bulk of the evidence is that the Appellant's shoulder problems are not from the motor vehicle accident, but must be related to some other cause. As a result, Counsel for MPIC submits that the Appellant's appeal should be dismissed and the Internal Review Decision dated March 28, 2006 should be confirmed.

Decision:

Upon hearing the testimony of the Appellant, and after a careful review of all of the medical, paramedical and other reports and documentary evidence filed in connection with this appeal, and after hearing the submissions of counsel for the Appellant and of counsel for MPIC, the Commission finds that the Appellant's IRI benefits should be reinstated effective August 21, 2005.

Reasons for Decision:

Upon a review of all of the evidence before it, the Commission finds that the termination of the Appellant's IRI benefits as of August 20, 2005 was inappropriate as there was insufficient evidence before the case manager regarding the Appellant's ability to work on a full-time basis. In that regard, we note [Appellant's doctor #1's] letter of May 7, 2005, wherein [Appellant's doctor #1] notes that "in regards to her work, she would have been limited from arm use at or above shoulder level so that she may have been somewhat restricted in her work capacity". Additionally, [Appellant's doctor #1's] letter of November 4, 2005, reiterates those concerns. In his letter of November 4, 2005, [Appellant's doctor #1] states that:

> "Further to my letter of May 7, 2005 this patient was seen in follow up on June 24 and August 17 at which time she was found to have improvement in symptoms but still limitations in functional capacity due to aggravation of pain. Therefore, continued modified work load (i.e. partial hours) was recommended at these visits…
>
> Therefore, pending further investigation, this patient continues to be limited in shoulder function and is capable of partial work hours only."

[Appellant's doctor #1's] reports raise a logical doubt about whether the Appellant was able to do her work on a full-time basis without restrictions as of August 20, 2005.

Additionally, the treating physiotherapist, [text deleted], in her report of June 21, 2005 suggests that:

> "I believe that [the Appellant] could manager her job, with frequent rest breaks during long client treatment sessions and between clients and increase her hours, (6-7 hours per day over 8-9 hours). I also would recommend consideration of other medical intervention of trigger point treatment in combination with continued home exercises to maintain any benefits that she may have from such treatment. She continues to have very painful and reactive trigger points despite the normal range of motion and these limit the tolerance she has for the modest exercises."

The Commission finds that the physiotherapist was suggesting that the Appellant could manage her job by taking nine hours to do work that she used to be able to do in seven hours. Based upon the medical reports from the physiotherapist and from [Appellant's doctor #1], the Commission finds that the Appellant had not regained the functional capacity to perform her occupational duties as an electrologist on a full-time basis as of August 20, 2005 and therefore the termination of IRI benefits was premature.

The Commission also finds that the Appellant's current shoulder problems, for which she undertook surgery in January of 2009 are related to the motor vehicle accident of June 7, 2004. We find that the Appellant consistently reported shoulder problems from the time of the motor vehicle accident. Although a rotator cuff tear was not initially diagnosed, we find that the shoulder area was compromised by the motor vehicle accident and we find that this led to the development of her further and continuing shoulder problems. The fact that she continued to work throughout the time since her motor vehicle accident, in an occupation which certainly impacted her shoulder area, may have further aggravated her injury/shoulder condition. Upon a consideration of the totality of the evidence before us, the Commission finds that it is likely that the Appellant's rotator cuff tear was caused by an accumulation of use on top of the injuries she sustained in the motor vehicle accident. It may have been a combination of factors, but certainly

the motor vehicle accident played a role as the initial cause of the shoulder problem, which was aggravated by continued use in the Appellant's occupation as an electrologist. The ergonomic assessment of the Appellant's occupational duties dated December 12, 2005 establishes that repetitious static work, such as electrolysis, is very fatiguing on upper extremities, specifically the Appellant's right shoulder. In summary, the Commission finds that the motor vehicle accident of June 7, 2004 compromised the Appellant's shoulder; the shoulder was therefore susceptible to damage; continued use of the shoulder, in the Appellant's occupation as an electrologist resulted in an aggravation of the Appellant's shoulder problems and the eventual shoulder surgery in January 2009.

Accordingly, the Commission finds that the Appellant's IRI benefits shall be reinstated effective August 21, 2005 and shall continue until such time as terminated in accordance with the MPIC Act. Interest in accordance with Section 163 of the MPIC Act shall be added to any amount due and owing to the Appellant.

Accordingly, the Appellant's appeal is allowed and the Internal Review Decision dated March 28, 2006 is therefore rescinded.

Dated at Winnipeg this 31st day of December, 2009.

YVONNE TAVARES

MARY LYNN BROOKS

JEAN MOOR