LICENCE APPEAL TRIBUNAL

TRIBUNAL D'APPEL EN MATIÈRE DE PERMIS

Safety, Licensing Appeals and Standards Tribunals Ontario

Tribunaux de la sécurité, des appels en matière de permis et des normes Ontario

Ontario

Tribunal File Number: 18-004375/AABS

In the matter of an Application pursuant to subsection 280(2) of the *Insurance Act,* R.S.O. 1990, c. I.8, in relation to statutory accident benefits.

Between:

G.R.

Applicant

and

Aviva General Insurance Company

Respondent

DECISION

ADJUDICATOR: **Craig Mazerolle**

APPEARANCES:

Representative for the Applicant: Lisa Bishop

Representative for the Respondent: Amanda Lo Cicero

Held by Written Hearing: **November 26, 2018**

OVERVIEW

[1] While waiting for a red light on June 17, 2016, the applicant was rear-ended. To assist in her recovery, the applicant sought medical and attendant care benefits from the respondent, pursuant to the *Statutory Accident Benefits Schedule*[1] (the "*Schedule*"). When the respondent refused to pay for some of these benefits, the applicant applied to this Tribunal.

[2] As I will explain below, I find that the applicant is entitled to the benefits listed in the disputed treatment plans. She is also entitled to a 20% award on the disputed functional impairment assessment. She is not entitled to an attendant care benefit.

ISSUES

[3] In a letter dated November 12, 2018, the applicant informed the Tribunal that several issues had been resolved (i.e., the remaining $200.00 from a partially approved treatment plan for physiotherapy services; an attendant care assessment; and a psychological assessment). The remaining benefits in dispute are:

(i) $772.36 per month for attendant care benefits for the period of June 17, 2016 to date and ongoing;

(ii) Physiotherapy services as recommended by Springdale Physiotherapy Services: $3,091.00 (treatment plan submitted on October 25, 2016), $2,665.00 (treatment plan submitted on October 25, 2016), $2,778.00 (treatment plan submitted on July 5, 2017), and $4,100.50 (treatment plan submitted on March 7, 2018);

(iii) $3,491.48 for psychological services as recommended by Springdale Physiotherapy Services (treatment plan submitted on November 8, 2016);

(iv) $1,350.00 for a functional impairment assessment recommended by Springdale Physiotherapy Services (treatment plan submitted on January 21, 2017); and,

(v) $2,000.00 for a chronic pain assessment recommended by Springdale Physiotherapy Services (treatment plan submitted on August 21, 2017).

[4] She is also requesting interest, costs, and an award under *Regulation 664*.

[1] *Effective September 1, 2010*, O. Reg. 34/10.

ANALYSIS

Attendant Care Benefits

[5] Entitlement to attendant care benefits is determined under s. 19 of the *Schedule*. Briefly, insurers are responsible for paying all reasonable and necessary expenses for the attendant care services that an insured person *incurs* as a result of an accident. If an expense has not been paid for by an insured person—or if there is no promise to pay for services rendered—the Tribunal may still deem an expense to have been incurred if "an expense was not incurred because the insurer unreasonably withheld or delayed payment of a benefit": see s. 3(8).

[6] Further, unless an insured person is found to have been catastrophically impaired, an insurer is only required to pay this benefit for 104 weeks post-accident. Presently, unless the applicant is one day found to have been catastrophically impaired, there can be no ongoing entitlement beyond June 15, 2018.

[7] The respondent submitted that the applicant has not provided any evidence of incurred services. In response, the applicant cited the case of *McMichael and Belair Insurance Company Inc.*[2] for the proposition that there is no need to incur attendant care services. However, this case predates the 2014 changes to the *Schedule* that introduced the incurred services requirement.

[8] In the alternative, the applicant raised the Tribunal's discretionary power to deem an expense incurred, i.e., s. 3(8). Specifically, the applicant stated that the respondent unreasonably held her to the funding limits of s. 18(1) of the *Schedule*, i.e., the *Minor Injury Guideline*. An insured person cannot receive an attendant care benefit from an insurer under this limit, so the applicant argued that she could have not have incurred these services even if she wanted to.

[9] I do not accept this argument, as the applicant was removed from this funding limit in January 2017. Therefore, even if it was the reason why she did not receive attendant care services up to that point, why did she then fail to incur them from January 2017 to the 104 week mark in June 2018? This explanation lacks credulity, and so I decline to exercise my discretion under s. 3(8).

[2] FSCO A02-001081 (March 2, 2005).

Medical Benefits

[10] Entitlement to medical benefits is determined under ss. 14 and 15 of the *Schedule*. Briefly, the applicant has the onus of demonstrating on a balance of probabilities that the expenses listed in a treatment plan are reasonable and necessary as a result of injuries caused by the accident.

[11] The first of the disputed physiotherapy treatment plans (i.e., the plan submitted on October 25, 2016 for $3,091.00) provided the following justification for the proposed physical therapy:

> It is months following the MVA and symptoms of pain and limitations in the lumbar spine, cervical spine and shoulder persist. Another course of therapy is recommended by the facility as well as their family physician. This patient has shown progress however has not reached maximal medical recovery. Therapy is incomplete until this status has been reached.

This goal would be reached through various physical modalities.

[12] The treatment plan for the disputed psychological services then listed the intended goals for this form of therapy as: “address depressive/anxious thoughts after the accident”. This goal would be accomplished through 12 therapy sessions lasting 90 minutes each, as well as several reassessments.

[13] In support of these plans, the applicant argued that the proposed physical therapy is needed to address her ongoing complaints of pain, as well as the effects that this pain is having on her day-to-day activities. She also cited case law that established pain reduction as a valid reason for approving treatment.

[14] Then, in support of the disputed psychological services, the applicant submitted that she requires ongoing psychotherapy to address her accident-related psychological challenges. She also noted that the severity of this impairment was confirmed by respondent’s psychological assessor, Dr. Shari Schwartz.

[15] In response, the respondent contended that the applicant’s physical injuries were largely soft tissue in nature, and that any pain associated with these injuries resolved itself shortly after the accident. Additionally, the respondent pointed to the applicant’s own statements to its assessors, wherein she questioned the efficacy of this physical treatment.

[16] In regard to the psychological treatment, the respondent argued that, since the applicant was already receiving OHIP-funded psychotherapy at the time, it was

not reasonable to fund duplicate services. This argument was reflected in the conclusion of its assessor, Dr. Schwartz. In her report (dated January 27, 2017), the assessor concluded that psychological treatment was still needed, but the proposed plan "is not considered to be reasonable and necessary… as [the applicant] is currently receiving individual and group therapy."

[17] I find that the applicant has established on a balance of probabilities that both the physical and psychological treatments at issue are reasonable and necessary.

[18] Starting with the physical treatment, the records before me demonstrate that these modalities have assisted the applicant in managing her long-standing, accident-related pain—an outcome that has been considered a valid treatment goal in past decisions.[3]

[19] First, the treatment records from Springdale Physiotherapy show that the applicant largely experienced pain relief after receiving this physical therapy. The efficacy of this physical treatment was also documented in the orthopaedic assessment from Dr. Omar Dessouki (report dated September 19, 2017, i.e., over a year after the accident). Specifically, Dr. Dessouki noted that the applicant reported "a temporary reduction in her pain symptoms and an increase in her range of motion, which she attributes to her physical therapy treatment."

[20] In response, the respondent highlighted the applicant's comments about how the efficiency of this physical therapy had likely reached its limits. That is, in the respondent's report from Dr. Frank Loritz (dated July 21, 2017), the applicant stated that these services were "providing temporary symptomatic relief whose therapeutic efficacy had plateaued." The report later noted that ongoing pain in her neck and right shoulder "would resolve after therapy but re-develop after two days." Even in spite of these admissions, the records before me still establish that the applicant has relied on this treatment to help manage her accident-related pain. It may not be the only remedy she needs (e.g., she told Dr. Loritz that she takes 30 tablets of Tylenol per week), but I am satisfied that it is a necessary part of her overall pain management regime.

[21] I would also note that the records from Springdale Physiotherapy state that the service providers occasionally review exercises and stretches that the applicant can do at home. This form of self-directed, physical activity was recommended by several of the respondent's assessors.

[3] *West v. Aviva Canada Inc.*, FSCO A09-002136 (February 3, 2012).

[22] In sum, I find that the applicant is entitled to the four physiotherapy plans.

[23] In regard to the psychological treatment, there is extensive evidence of the significant emotional distress that the applicant has experienced since the accident. For instance, in the month following the accident, the applicant brought herself to the emergency room due to her uncontrollable anxiety about driving. Then, in August 2016, the applicant was referred to both individual and group psychotherapy through the Etobicoke General Hospital. Records from these psychotherapy programs directly link the accident to her mental health struggles, and she was eventually removed from the *Minor Injury Guideline* in January 2017 on account of an accident-related, psychological impairment.

[24] These program records also demonstrate the relief she has received from attending regular psychotherapy sessions. Whether it is learning relaxation techniques or discussing her daily motivation levels, both individual and group therapy appear to be important tools for addressing her accident-related, psychological impairment.

[25] Though the respondent reasonably concluded that there was no need to fund a duplicate form of psychotherapy, this OHIP-funded therapy eventually ended on October 17, 2017. Therefore, I find that any psychological services recommended by this treatment plan (and then incurred after this date) are both reasonable and necessary.

Costs of Examination

[26] The stated goals of the functional impairment assessment are as follows: determine if the applicant suffered from any ongoing physical limitations; determine whether the applicant could "safely perform" household and daily tasks; determine if the applicant could one return to her "pre-accident status"; establish "safe parameters" for the applicant; and determine whether further assessments and/or rehabilitation is required.

[27] It should be noted that this assessment has also been referred to as a "functional abilities evaluation".

[28] The stated goals of the chronic pain assessment were then listed as follows: "To facilitate a chronic pain assessment to identify barriers to recover and treatment options available for the patient." The service provider also noted that a potential barrier to recovery was the applicant's "psychological overlay", and so there was also the intention of determining if she would be "a candidate for chronic pain program".

[29] Beyond a general comment about how the proposed treatment and assessments are all "reasonable and necessary for her recovery", the applicant did not make any specific arguments in support of the functional impairment assessment. However, in support of the chronic pain assessment, the applicant cited Dr. Dessouki's orthopaedic assessment. Specifically, this report indicated that the applicant continued to experience pain and limitations to her daily activities in September 2017, i.e., a year after the accident.

[30] Similar to its arguments about the physical treatment in dispute, the respondent argued that the applicant has failed to provide any convincing evidence to support her claims. Specifically, it pointed to records suggesting the applicant's pain has largely subsided, and that her accident-related injuries no longer impede her daily activities (i.e., factors that the adjudicator used in *17-002301 v. The Personal Insurance Company*[4] to deny a similar request).

[31] First, I find the proposed functional impairment assessment is reasonable and necessary. It is undisputed that the applicant stopped working immediately after the accident. It is also undisputed that she was still off work when this treatment plan was submitted. The evidence then suggests that her pre-accident employment was quite physical (e.g., lifting boxes, standing for extended periods, etc.), and there is also evidence that the applicant intended on one day returning to work. Therefore, a determination of her functional capacity (and whether she can return to "pre-accident status") will likely assist the applicant in determining what treatment is necessary to return to this status.

[32] A similar conclusion was reached by Dr. Dessouki, who suggested that applicant would benefit from an "up-to-date functional abilities evaluation", namely as a means of further documenting her impairments.

[33] Then, in his first report authored for the respondent (dated January 27, 2017), Dr. Michael Hanna also recommended a functional abilities evaluation. This suggestion was made even though he had found that she "did not sustain a permanent impairment, from a musculoskeletal perspective".

[34] Yet, it should be noted that this same assessor ended up changing his opinion shortly thereafter. That is, in a report issued less than a month later (i.e., on February 21, 2017), Dr. Hanna then concluded:

> Based on my previous in-person assessment on October 25, 2016 and available documentation, the claimant sustained soft tissue

[4] 2017 CanLII 77345 (ON LAT) ("*The Personal*").

> injuries as a result of the accident in question. The Treatment and Assessment Plan OCF-18 is for a Functional Abilities Evaluation. Under barriers to recovery section, the therapist states “serious extent and nature of injuries”, it is unclear what type of serious injuries the therapist is referring to. Not only is this inaccurate, it is also misleading. From a physical perspective, there is no objective evidence that the claimant sustained more than soft tissue injuries as a result of the accident. Therefore, the Treatment and Assessment Plan (OCF-18) dated January 21, 2017 is not considered reasonable and necessary.

[35] Though the respondent denied the evaluation on the basis of this latter report, I do not find Dr. Hanna’s second conclusion to be a compelling prognosis of the applicant’s medical needs. Specifically, Dr. Hanna does not appear to be taking issue with any of the proposed methods that the service provider intends on using during this assessment. Instead, Dr. Hanna relied on a single statement in the treatment plan to question whether the applicant’s physical impairments required such an assessment. This finding stands in stark contrast to the conclusion he had reached about the applicant’s medical state a few weeks before, and I do not see how this statement about her barriers to recovery would alter this conclusion.

[36] Taken together, I do not find the assessor’s reasons for this change to be compelling, and, instead, I find that the applicant has presented sufficient evidence to support the reasonable and necessary nature of this treatment plan.

[37] I also find that the proposed chronic pain assessment is reasonable and necessary. According to records before the Tribunal, the applicant continued to experience ongoing pain in the year following the accident. For instance, in the month following her request for the chronic pain assessment, the applicant reported ongoing pain and headaches to Dr. Dessouki. Though these complaints were self-reported, the assessor did note that the applicant “did not demonstrate any non-organic signs”, and this self-report is mirrored in the treatment plans for physiotherapy from October 2016 and July 2017. Finally, the applicant’s reported physical limitations following the accident (e.g., those limitations that formed the basis of her Form 1, dated August 2, 2016) are consistent with this reported pain.

[38] The respondent has challenged the applicant’s account by again citing her comments to its assessors. For instance, in the psychological assessment from Dr. Schwartz, the applicant stated that her pain from the accident was “much

better". However, the applicant also informed Dr. Schwartz that she was still feeling pain in her right shoulder and low back. This pain required ongoing physiotherapy, as well as monthly visits to her family physician (i.e., a sharp increase in the number of appointments she had before the accident).

[39] Then, in the report from Dr. Deborah Rabinovitch (i.e., the physiatrist that authored the report recommending the respondent deny this assessment), the assessor noted that the applicant had returned to her daily activities. Yet, Dr. Rabinovitch also noted that the applicant had a disproportionate conception of her ongoing pain, with "demonstrated significant pain-focused behaviours".

[40] Therefore, while I accept that her pain was improving in and around the time when this treatment plan was submitted, there is still sufficient evidence that it was having persistent physical and psychological impacts on her day-to-day life. As such, a chronic pain assessment might allow the applicant to better understand her accident-related impairments (including a possible "psychological overlay" to this pain). It could also help her service providers formulate a more effective treatment regime.

[41] I would also note that I do not find the circumstances from *The Personal* to have much resonance with the present matter, as the recovery of the applicant in *The Personal* was much more profound. For instance, while the current applicant has been unable to return to her physically demanding, pre-accident employment, the applicant in *The Personal* returned to playing "elite soccer 5-6 times per week – more often than she did before accident".[5] This earlier applicant also did not miss school, save for five months of gym class.

Costs and Award Request

[42] Section 10 of Regulation 664 permits the Tribunal to "award a lump sum of up to 50 per cent of the amount to which the person was entitled at the time of the award together with interest on all amounts then owing to the insured" if the Tribunal "finds that an insurer has unreasonably withheld or delayed payments".

[43] The applicant claimed the decision to hold her to the funding limits of s. 18(1) constituted an unreasonable withholding of the benefits. She also cited the respondent's general handling of the file as "malicious, arbitrary, high-handed and which departed to a marked degree from ordinary standards of behavior expected of a sophisticated insurance company." The respondent countered this narrative by stating that it acted in accordance with the *Schedule*.

[5] *Ibid* at para. 36(i).

[44] While I find that the respondent largely adjusted these disputed benefits in a fair and even-handed manner, I do take issue with its handling of the proposed functional impairment assessment. To review: the applicant submitted a request for this assessment on January 21, 2017; in an unrelated report released on January 27, 2017, Dr. Hanna suggested the applicant should complete a functional abilities evaluation; the respondent issued a explanation of benefits on February 6, 2017 informing the applicant that the treatment plan for the proposed functional impairment assessment was being sent for a paper review; Dr. Hanna released a report on February 21, 2017 that found this proposed assessment to not be reasonable and necessary. As noted above, I do not find that the assessor provided a convincing account for why his opinion changed in this short period of time.

[45] Therefore, in light of my earlier findings, I find the respondent's reliance on Dr. Hanna's changing opinion was an unreasonable withholding of this assessment. I would also question why the respondent felt it necessary to submit this treatment plan for a further review when its assessor had already recommended a similar assessment just a few days before. Taken together, this behaviour constitutes an unreasonable withholding of the benefit, and an award is, therefore, merited.

[46] I make this finding even though I have no evidence to suggest that this withholding was done in bad faith. Rather, the respondent's actions seem, at worst, careless. As such, I do not agree with the applicant that a 50% award in merited. Instead, the applicant is entitled to an award amounting to 20% of the denied assessment (as well as interest on this award in accordance with s. 10 of *Regulation 664*).

[47] Rule 19.1 of the *Common Rules of Practice & Procedure*[6] then states that costs may be awarded when "another party in a proceeding has acted unreasonably, frivolously, vexatiously, or in bad faith". In the present matter, the applicant simply asked the Tribunal to award "the reasonable costs of these proceedings." Without any account for why she believed the respondent acted "unreasonably, frivolously, vexatiously, or in bad faith", I cannot award costs in this proceeding.

CONCLUSION

[48] I find that the applicant is entitled to the benefits listed in the disputed treatment plans (with the caveat that only those psychological services incurred after

[6] *Licence Appeal Tribunal, Animal Care Review Board, Fire Safety Commission (October 2, 2017)*.

October 17, 2017 are payable). She is also entitled to a 20% award on the disputed functional impairment assessment.

[49] The respondent has raised issues about whether these treatment plans have been incurred. I find that these benefits shall become payable when the applicant is able to demonstrate that they have been incurred.

[50] However, as my understanding is that the functional impairment assessment has yet to be incurred, I am satisfied that this expense can be deemed incurred in accordance with s. 3(8). The evidence before me suggests that the applicant has taken steps to incur each assessment that has been approved by the respondent. Therefore, in light of my earlier finding about the award, I am satisfied that the applicant would have incurred the functional impairment assessment, but for, the respondent's unreasonable withholding of this benefit. As such, I shall use the discretion afforded to me under s. 3(8).

[51] The respondent also noted that some of these disputed services were incurred before their respective treatment plans had been submitted. Section 38(2) of the *Schedule* states that an insurer is not responsible to pay for services that are incurred before a treatment plan has been submitted, and so it argued that it is not responsible for paying these expenses. The applicant has not presented any argumentation or evidence in response. At any rate, I find that she is not entitled to payments for any services that were incurred before the related treatment plan was submitted to the respondent.

[52] The applicant is also entitled to interest in accordance with s. 51 of the *Schedule* and s. 10 of *Regulation 664*.

Released: August 14, 2019

Craig Mazerolle
Adjudicator