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

Date: 2018-05-07
Tribunal File Number: 17-002614/AABS
Case Name: 17-002614 v Aviva Insurance Company of Canada

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

Between:

M.C.

Applicant

and

Aviva Insurance Company of Canada

Respondent

DECISION

ADJUDICATOR:	**Anna Truong**
APPEARANCES:	M.C., the Applicant Julia Abd Elseed, Counsel for the Applicant Ajay Shukla, Representative for Aviva Karla Gnanasegram, Counsel for the Respondent
Heard in-person on:	**November 27, 2017 and January 10, 2018**

OVERVIEW

[1] M.C. (the "Applicant") was involved in an automobile accident on May 1, 2015, and sought benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010* (the "*Schedule*"), which were denied by the Respondent.

[2] The Applicant disagreed with the Respondent's decision and submitted an application to the Licence Appeal Tribunal – Automobile Accident Benefits Service (the "Tribunal"). The matter proceeded to a Case Conference, but the parties were unable to resolve the issues in dispute.

ISSUES TO BE DECIDED

[3] The following are the issues to be decided:

1. Did the Applicant sustain predominately minor injuries as defined under the *Schedule*?

If the answer to issue one is no:

2. Is the Applicant entitled to attendant care benefits in the amount of $353.94 per month from May 1, 2015 to May 1, 2017?

3. Is the Applicant entitled to a medical benefit outlined in the following physiotherapy treatment plans submitted by Toronto Healthcare Clinic Inc.:

    a. Treatment plan dated October 10, 2015, in the amount of $2,512.00?

    b. Treatment plan dated March 09, 2016, in the amount of $1,276.00?

4. Is the Applicant entitled to a medical benefit outlined in the following chronic pain treatment plan dated October 3, 2016, submitted by Toronto Healthcare Clinic Inc., 2016, in the amount of $8,595.34?

5. Is the Applicant entitled to a medical benefit outlined in a treatment plan for assistive devices dated March 09, 2016, submitted by Toronto Healthcare Clinic Inc. in the amount of $660.00?

6. Is the Applicant entitled to the cost of an attendant care needs assessment outlined in a treatment plan dated December 16, 2015, submitted by Toronto Healthcare Clinic Inc. in the amount of $1,521.26?

7. Is the Applicant entitled to the cost of a chronic pain assessment outlined in a treatment plan dated June 9, 2016, submitted by Toronto Healthcare Clinic Inc. in the amount of $2,000?

8. Is the Applicant entitled to an award pursuant to section 10 of Ontario Regulation 664 ("O/Reg 664"), because the Respondent unreasonably withheld or delayed payments?

9. Is the Applicant entitled to interest on any overdue payments?

RESULT

[4] Based on the totality of the evidence before me, I find the MIG does not apply to the Applicant's impairment. I find the Applicant is not entitled to attendant care benefits, any of the physiotherapy treatment plans in dispute, or the chronic pain assessment and treatment plan. I find the Applicant is entitled to the cost of the attendant care assessment, the assistive devices, interest and an award pursuant to O/Reg 664.

ANALYSIS

[5] A two day in-person hearing was conducted. The Applicant, Dr. Domenic Minella, Lyndy Goldlust, Dr. Grigory Karmy and the adjuster, Corrinne McMurray, all testified and were cross-examined. I have reviewed all the testimony, submissions and evidence led during the hearing and I have only summarized what I found relevant to my determination below.

Applicability of the Minor Injury Guideline

[6] The Minor Injury Guideline ("MIG") establishes a framework for the treatment of minor injuries. The term "minor injury" is defined in section 3 of the *Schedule* as "one or more of a strain, sprain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury." The terms "strain", "sprain," "subluxation," and "whiplash associated disorder" are also defined in section 3. Section 18(1) limits recovery for medical and rehabilitation benefits for such injuries to $3,500 minus any amounts paid in respect of an insured person under the MIG.

[7] Subsection 18(2) of the *Schedule* makes provision for some injured persons who have a pre-existing medical condition to receive treatment in excess of the $3,500 cap. To access the increased benefits, the injured person's healthcare provider must provide compelling evidence that the person has a pre-existing medical condition, documented prior to the accident, which will prevent the injured person from achieving maximal recovery if benefits are limited to the MIG cap.

[8] Subsection 38(8) states an insurer must give the insured person notice within 10 business days of receiving a treatment plan, "the medical and any other reasons why the insurer considers any goods, services, assessments and examinations, or the proposed costs of them, not to be reasonable or necessary."

[9] If an insurer fails its obligation under subsection 38(8), it triggers the consequences in subsection 38(11), which states: 1. The insurer is prohibited from taking the position that the insured person has an impairment to which the Minor Injury Guideline applies and 2. The insurer shall pay for all goods, services, assessments and examinations described in the treatment and assessment plan that relate to the period starting on the 11th business day after the day the insurer received the application and ending on the day the insurer gives a notice described in subsection (8).

[10] As explained later in paragraphs 31 to 33 of this decision, I find the Respondent breached subsection 38(8) with respect to the treatment plans dated December 16, 2015 and March 9, 2016. The consequences in subsection 38(11) are therefore triggered and the Respondent is prohibited from taking the position the MIG applies to the Applicant's impairments. This prohibition applies to the entire file, not the individual treatment plans, because the word "impairment" is used. The Applicant's impairment applies to the entire file and is the basis of all benefits sought. Therefore, the Respondent is prohibited from asserting the MIG applies to the Applicant's impairments on the entire file.

[11] In conclusion, the MIG does not apply to the Applicant's impairments pursuant to subsection 38(11), because the Respondent breached its obligations under subsection 38(8).

Attendant Care Benefits

[12] Section 19 of the *Schedule* states the insurer shall pay for all reasonable and necessary expenses that are incurred by or on behalf of the insured person as a result of the accident for services provided by an aide or attendant [Emphasis added].

[13] Section 3(7)(e)(iii) provides two situations for an expense to be considered incurred:

> (iii) the person who provided the goods or services,
>
> a. did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or
>
> b. sustained an economic loss as a result of providing the goods or services to the insured person.

[14] The Applicant conceded at the hearing he has not incurred any attendant care expenses. However, he argued the principle from *McMichael v. Belair Insurance Co.* ("*McMichael"*), a decision of Director Delegate Makepeace of the Financial Services Commission of Ontario ("FSCO"), which was upheld at Divisional Court,

applies and his attendant care benefits should be deemed incurred. The Applicant coined this as the "*McMichael* principle".

[15] I do not find the *McMichael* principle applies in this case. The facts are vastly different. Mr. McMichael was a catastrophically injured Applicant with well-documented requests for funding due to his financial struggles and the life circumstances he found himself in as a result of the accident. In this matter, there is no evidence before me of the Applicant's financial situation and any similar requests made to the Respondent. Furthermore, *McMichael* was decided under the previous iteration of the *Schedule* before the definition of incurred was added and clarified. Therefore, I am not persuaded by the Applicant's argument his attendant care expenses should be deemed incurred.

[16] The Applicant testified at the hearing he lived with his brother at the time of the accident and post-accident, he got married and lived with his wife. He testified he received help from his brother and wife with attendant care tasks post-accident, but he did not submit any evidence in support of this. Based on the evidence before me, I find the Applicant has not satisfied the definition of "incurred" pursuant to the *Schedule.* Therefore, I find the Applicant is not entitled to attendant care benefits in the amount of $353.94 per month from May 1, 2015 to May 1, 2017.

Physiotherapy Treatment Plans, Chronic Pain Assessment and Treatment

[17] Sections 14 and 15 of the *Schedule* provides an insurer is only liable to pay for medical expenses that are reasonable and necessary as a result of the accident. The Applicant bears the onus of proving on a balance of probabilities the treatment plan is reasonable and necessary.

[18] The Applicant claims entitlement to two physiotherapy treatment plans that total $3,788, a chronic pain assessment in the amount of $2,000 and a chronic pain treatment plan in the amount of $8,595.34.

[19] During the Applicant's testimony, he did not state he needed or wanted further physiotherapy. During his examination-in-chief, he testified he stopped attending treatment, because he had to work and he felt the treatment was not really helping him long-term. He testified there was temporary relief, but not much. I note the Applicant's counsel used a leading question and asked if the temporary relief was helping him perform his day-to-day tasks, to which the Applicant said yes. However, further along his examination-in-chief, the Applicant testified the severity of his pain stayed the same over time and he stopped getting treatment, because it did not help. He also testified after he stopped treatment, he managed his pain through rest and Advil. During cross-examination, he agreed with the Respondent's counsel that he stopped attending treatment, because it was not helping him and did not relieve his pain.

[20] The Applicant submitted two OCF-3 Disability Certificates, one dated November 5,

2015, and the other dated June 9, 2016. Both were completed by Dr. Domenic Minnella, chiropractor. The injuries listed consists of predominantly soft tissue injuries and remain almost identical, except for the addition of the word “chronic” in the second certificate. Dr. Minella is the service provider on all the physiotherapy and chronic pain treatment plans. He also testified at the hearing. I did not find Dr. Minella’s testimony helpful as he mainly read off the treatment plans and opined the treatment plans are reasonable and necessary. Since he was the service provider on the treatment plans he opined on, his opinion did not add anything. Despite all this, I note the Applicant testified at the hearing, he does not know who Dr. Minella is.

[21] Dr. Grigory Karmy completed a Chronic Pain Assessment Report dated September 2, 2016, and he testified at the hearing. At the hearing, Dr. Karmy testified the bulk of the Applicant’s injuries were soft tissue injuries. He testified the Applicant did not have a joint problem, but he had joint symptoms. He further testified there could be disc involvement, but he cannot confirm. To date, no one has recommended the Applicant obtain any diagnostic imaging of his back and none was put before me.

[22] In the Respondent’s Occupational Therapy/Attendant Care Assessment Report dated January 19, 2017, Lyndy Goldlust, occupational therapist, stated the Applicant reported he could perform all his attendant care tasks and demonstrated the mobility to do so during the assessment. Ms. Goldlust further noted the Applicant’s range of motion was all within normal limits.

[23] In the Respondent’s Physiatry Reported dated May 24, 2017, Dr. Julie Millard, physiatrist, stated her clinical examination did not demonstrate any ongoing accident related physical impairment. She opined based on the history, physical examination and her review of documentation, the Applicant sustained soft tissue musculoligamentous injuries to his low back and left shoulder. She noted the Applicant reported less tolerance for certain activities that required forward bending, but noted he did not specifically report any functional limitations. Furthermore, she noted there was no impairment in strength, the Applicant had full range of motion, his neurological examination was normal and the Applicant reported he could perform all of his personal care and household duties independently.

[24] Dr. Millard provided a definition of “maximum medical recovery” (“MMR”) from the American Medical Association, Guide to Evaluation of Permanent Impairment – 6th Edition, which states:

> Maximum medical recovery is defined as the point at which a condition is stabilized and is unlikely to change (improve or worsen) substantially within the next year with or without medical treatment. While symptoms and signs of the condition may wax and wane over time, further overall recovery or

deterioration is not anticipated.

[25] Using that definition, Dr. Millard opined the Applicant had reached MMR. Dr. Millard went on to explain passive modalities are most beneficial early on. Based on all these reasons, Dr. Millard concluded the physiotherapy treatment plans were not reasonable and necessary. She recommended the Applicant continue with a well-illustrated home exercise and stretching program.

[26] Based on all the medical evidence before me, it appears the Applicant suffered soft tissue injuries and an exacerbation of pre-existing injuries as a result of the accident. While the MIG does not apply to the Applicant due to a procedural breach by the Respondent, the injuries he sustained in the accident are predominantly soft tissue injuries. The Applicant has returned to work as a janitor, which is a physically demanding job. He does not take any prescription medication for his pain. He has returned to playing basketball and he is able to do all of his self-care tasks. At the hearing, the Applicant testified he can do most things physically and it is his headaches that interfere with his functioning. None of the treatment recommended appears to deal with his headaches. It is all treatment for soft tissue injuries.

[27] Given the Applicant's testimony and the medical evidence before me, I find the physiotherapy treatment plans in dispute are not reasonable and necessary. By the Applicant's own admission, physiotherapy treatment was not helping him, so he stopped. He reported no functional limitation, which was confirmed by Ms. Goldlust, and Dr. Millard found no objective signs of any accident related impairment. Furthermore, Dr. Karmy testified the main component of the Applicant's accident related injuries are soft tissue in nature. For the same reasons, I also find the chronic pain assessment not reasonable and necessary.

[28] I note the chronic pain treatment plan provides a lot of passive modalities. In fact, outside of the psychological components, the physical treatment is almost identical to the ones listed in the physiotherapy treatment plans. As stated above, that course of treatment was not helpful to the Applicant and I have already found it not reasonable and necessary. Furthermore, the Applicant conceded during the hearing, he was not claiming any psychological issues as a result of the accident. Therefore, based on the evidence before me, I find the chronic pain treatment plan is not reasonable and necessary.

[29] The Applicant argued some of these treatment plans should be payable, because the Respondent failed to provide Dr. Millard's report to the Applicant within the 10 business days required under subsection 38(13). While I agree the Respondent breached its obligations under the *Schedule*, unlike subsection 38(8), which triggers the consequences in subsection 38(11), there are no consequences outlined in the *Schedule* for the breach of this obligation and I cannot arbitrarily impose one. Therefore, I am not persuaded by the Applicant's argument these treatment plans are payable due to the Respondent's breach of subsection 38(13).

[30] For all the reasons above, I find the Applicant is not entitled any of the physiotherapy treatment plans, the chronic pain assessment or the chronic pain treatment plan.

Treatment Plan for Assistive Devices

[31] The treatment plan for assistive devices dated March 09, 2016 was submitted to the Respondent on March 22, 2016. The Respondent denied the treatment plan on April 13, 2016, more than the ten business days set out in subsection 38(8). Since the Respondent breached subsection 38(8), the mandatory consequence in subsection 38(11) is triggered and the Respondent must pay for all the goods described in the treatment plan.

[32] While "incurred" is not a requirement under subsection 38(11), the Respondent's occupational therapy assessor, Ms. Goldlust, noted the Applicant already possessed some of the items requested in the treatment plan, but did not inquire as to when they were purchased. Since the Respondent breached its obligations under subsection 38(8), the Applicant is entitled to all the assistive devices outlined in the treatment plan dated March 9, 2016, pursuant to subsection 38(11).

Attendant Care Assessment

[33] The treatment plan dated December 16, 2015, outlining an attendant care assessment was submitted to the Respondent on December 18, 2015. At the hearing, the adjuster testified this treatment plan was denied on the Health Claims for Auto Insurance ("HCAI") system and no denial letter has ever been sent. The Respondent denying a treatment plan on HCAI does not comply with its obligations under subsection 38(8). Therefore, the Respondent has breached its obligation under subsection 38(8) and the consequence in subsection 38(11) is triggered. The Applicant is entitled to payment for the cost of the attendant care assessment.

An Award Purusant to O/Reg 664

[34] The Applicant wrote to the Tribunal objecting to new documents submitted by the Respondent in its responding submissions with respect to the award under O/Reg 664. I allowed the documents into the hearing record for two reasons. First, had the Respondent referred to these documents during its closing submissions, it would have formed part of the hearing record, so the written format of the submissions do not change that. Secondly, there is no prejudice to the Applicant if I allow these documents in, because he had these documents prior to the hearing and he also had an opportunity to address these documents in his reply submissions. Having said that, the documents the Respondent submitted did not change or have any influence on my decision with respect to the award.

[35] Section 10 of O/Reg 664 states an amount of up to 50 per cent with interest on all amounts owing may be awarded if an insurer has unreasonably withheld or delayed payments. The Applicant is seeking an award pursuant to section 10, because he alleges the Respondent unreasonably withheld or delayed payment of benefits. The threshold for an award under O/Reg 664 is very high. In this case, I find the threshold has been met.

[36] I am granting an award due to the Respondent's handling of the treatment plan dated December 16, 2015 outlining the attendant care assessment and partially due to the treatment plan dated March 9, 2016, for assistive devices. To date, the Respondent still has not responded to the December 16, 2015 treatment plan. As mentioned above, a denial on HCAI is insufficient to meet the Respondent's obligations under the S*chedule.* Once it became clear the Respondent had breached its obligations under subsection 38(8) with respect to providing notice, the Respondent should have immediately provided notice compliant with subsection 38(8) and/or paid the benefit. Instead, the Respondent unreasonably maintained its initial denial and to date has still not provided a proper denial pursuant to subsection 38(8). The Respondent should have paid these benefits upon clarification. It was unreasonable for this treatment plan to proceed to a hearing.

[37] For these reasons, I am inclined to award 50% pursuant to section 10 of O/Reg 664. Therefore, the Applicant is entitled to an award equivalent to 50% of the amounts owing plus interest.

Interest

[38] Since I found benefits payable, the Applicant is entitled to all applicable interest.

CONCLUSION

[39] For the reasons outlined above, I find the Applicant is entitled to the attendant care assessment, the assistive devices, interest and an award pursuant to O/Reg 664. However, he is not entitled to attendant care benefits, the physiotherapy treatment plans, the chronic pain assessment, or the chronic pain treatment plan

Released: May 7, 2018

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Anna Truong, Adjudicator