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**

Tribunal File Number: 16-003617/AABS

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:

R.F.

Applicant

and

The Guarantee Company of North America

Respondent

DECISION

ADJUDICATOR: **Lori Marzinotto**

APPEARANCES:

For the Applicant: Robert H. Littlejohn, Counsel
Ryan Hurst, Counsel

For the Respondent: Hermina Nuric, Counsel

Ministry of the Attorney General: **Andrea Bolieiero, Counsel**

Heard in-person: **August 29-31, 2017 & October 10-11, 2017**

BACKGROUND

[1] R.F. (the "applicant") was injured in an automobile accident on February 27, 2014, and sought benefits pursuant to the *Statutory Accident Benefits Schedule – Effective September 1, 2010* (the "*Schedule*").

[2] The applicant applied for certain medical benefits that were denied by the respondent. The applicant disagreed with the denials and submitted an application to the Licence Appeal Tribunal – Accident Benefits Service (the "Tribunal").

[3] The parties were unable to resolve the issues in dispute at the case conference and an in-person hearing was scheduled to determine the applicant's entitlement to several denied or partially approved treatment plans.

ISSUES IN DISPUTE

[4] The following issues were listed as issues to be determined at the hearing in the case conference adjudicator's Order dated March 17, 2017:

(a) Is the applicant entitled to receive a Medical Benefit in the amount of $1,285.00 for Chiropractic Services pursuant to a Treatment and Assessment Plan (OCF-18) dated August 20, 2014?

(b) Is the applicant entitled to receive a Medical Benefit in the amount of $4,212.13 for Physiotherapy Services pursuant to a Treatment and Assessment Plan (OCF-18) dated October 29, 2015?

(c) Is the applicant entitled to receive a Medical Benefit in the amount of $1,646.75 for Physiotherapy Services pursuant to a Treatment and Assessment Plan (OCF-18) dated December 10, 2015?

(d) Is the applicant entitled to receive a Medical Benefit in the amount of $1,850.00 for Chiropractic Services pursuant to a Treatment and Assessment Plan (OCF-18) dated December 10, 2015?

(e) Is the applicant entitled to receive a Medical Benefit in the amount of $1,397.00 for Physiotherapy Services pursuant to a Treatment and Assessment Plan (OCF-18) dated January 16, 2015?

(f) Is the applicant entitled to receive a Medical Benefit in the amount of $1,340.00 for Chiropractic Services pursuant to a Treatment and Assessment Plan (OCF-18) dated January 22, 2016?

(g) Is the applicant entitled to receive a Medical Benefit in the amount of $1,397.00 for Physiotherapy Services pursuant to a Treatment and Assessment Plan (OCF-18) dated April 20, 2016?

(h) Is the applicant entitled to receive a Medical Benefit in the amount of $790.00 for Chiropractic Services pursuant to a Treatment and Assessment Plan (OCF-18) dated April 5, 2016?

(i) Is the applicant entitled to receive a Medical Benefit in the amount of $1,892.26 for Occupational Therapy Services pursuant to a Treatment and Assessment Plan (OCF-18) dated June 23, 2016?

(j) Is the applicant entitled to receive a Medical Benefit in the amount of $1,376.17 for Drivers Rehabilitation Services pursuant to a Treatment and Assessment Plan (OCF-18) dated September 29, 2016?

(k) Is the applicant entitled to receive a Medical Benefit in the amount of $149.63 for Occupational Therapy Services pursuant to a Treatment and Assessment Plan (OCF-18) dated January 26, 2016?

(l) Do the applicant's injuries fall within the Minor Injury Guideline (the "MIG")?

[5] From the opening submissions provided by the parties, it was unclear whether issue 4(l) remained an issue in dispute. I inquired with the parties who confirmed that the applicant's injuries were no longer considered to fall within the MIG; however, the issue of when the applicant's injuries were no longer considered to fall within the MIG by the respondent was a very live issue.

[6] There is a dispute between the parties as to the date the applicant's injuries were no longer considered minor by the respondent and I am therefore required to make a decision on this as it affects my decision on several of the treatment plans in dispute. [1]

[7] The applicant also served a Notice of Constitutional Question regarding the constitutional validity and applicability of section 17.1 of the *Statutory Powers Procedure Act,* R.S.O. 1990, c. S-22 (*"SPPA"*) and Rule 19 of the *Licence Appeal Tribunal Rules of Practice, Version 1 (April 1, 2016)* (the *"Rules")*.

[8] The Constitutional Question will be decided after my decision on costs is released and the Ministry of the Attorney General has advised whether it will be taking a position and/or making submissions on the issue.

[9] After the release of my decision on costs, if the applicant intends to pursue the Constitutional Question, the applicant is to notify the Tribunal and copy the Ministry of the Attorney General.

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[1] Several preliminary issues and motions were raised at the beginning and during the hearing, some of which I addressed at the hearings, others I reserved on including the claim for a special award. The details and orders can be found in Appendix "A".

RESULT

[10] The applicant's injuries are not predominately minor injuries as defined by the *Schedule* given the respondent failed to provide notice in accordance with s.38(8) of the *Schedule* and accordingly, given the consequences set out in s.38(11) of the *Schedule*, the respondent is prohibited from taking the position that the applicant had an impairment to which the MIG applied.

[11] I further find that all of the treatment plans in dispute are reasonable and necessarily with the exception of the treatment plan at issues 4(i), 4(k) and part of issue 4(j).

[12] Regarding the in-home assessment (4)(i), little if any evidence was presented with respect to the reasonableness and necessity of an in-home assessment and therefore the applicant has not proven on a balance of probabilities entitlement to this benefit.

[13] At the end of the hearing it was conceded by the respondent that the driver rehabilitation services (4)(j) were necessary. The treatment plan was previously partially approved. The respondent did not agree that the amount proposed by Skill Builders was reasonable and necessary. While I agree with the respondent that the amount is not reasonable, I do not agree with the amount approved by the respondent and Order that the treatment plan be approved in the amount of $2,205.63, rather than the respondent's approved amount of $1,777.59.

[14] Interest was not an issue listed in dispute nor did the parties make submissions on the issue of interest; however, as per s. 51(2) of the *Schedule,* the insurer shall pay interest on the overdue amounts, as such, I find that interest is payable on the benefits I found owed to the applicant.

[15] I found the applicant to be credible and forthright, motivated and believed the treatments helped him. It was clear that the applicant wanted to get better and at times the desperation of his situation came through in his testimony.

BACKGROUND

[16] On the day of the accident, the weather conditions were poor. There were white-outs, ice on the roads and snow was piled up. The applicant's car was stopped on the highway for about 10 minutes because there was an accident ahead. The applicant's vehicle was hit by another car that sideswiped him, the airbags were deployed and his car was deemed a right off.

[17] After the accident, the applicant testified that he has headaches every day that range from medium to debilitating, ringing in his ears, nerve entrapment in his neck and upper back and shoulder pain.

[18] At the time of the accident, the applicant was 60 years old and was employed at the Toronto District Catholic School Board in the maintenance department where he had been working for 30 years. He commuted from Barrie, Ontario to Toronto Ontario, daily for work. After the accident he had difficulty driving and developed driver anxiety which he has not been treated for.

[19] After the accident, the applicant attempted to go back to work but could not drive the long commute because of his driving anxiety. If there was snow he would call in sick. It was painful for him to drive from Barrie to Toronto every day and he was afraid to leave the house to go to work and worried about traffic.

[20] Although he had no previous plans to do so, in September 2014 the applicant took early retirement. He had trouble physically at work after the accident and could not fully perform his duties.

[21] The applicant testified that psychologically he is depressed and partially attributes this to the lack of assistance from the respondent and feels "abandoned" by them.

[22] Prior to the accident, the applicant was very sports-minded and it was the applicant's form of relaxation. He was involved in hockey tournaments throughout Ontario, played baseball, golf and would play lacrosse with his grandson. After the accident he attempted hockey and golf and found he could do neither without significant pain. He could not shoot the puck and to use the applicant's words "golfing just about killed me".

[23] Prior to the accident he would do most of the maintenance outside, assisted with laundry, dishes and helped around the house.

[24] After the accident, the applicant could no longer maintain his property and in 2015, moved to a much smaller home and property.

[25] In terms of personal hygiene, the applicant explained that prior to the accident he could stay in the bathtub and read and can no longer do that and requires a shower seat and a removable showerhead.

ANALYSIS

Applicant's Removal from the MIG

[26] There is a dispute between the parties as to when the applicant's injuries were no longer considered minor by the respondent. Even after a five day hearing, the date was still unclear.

[27] The reason that the respondent removed the applicant from the MIG was communicated at the hearing, seemingly for the first time. The respondent advised that the applicant was removed from the MIG on a good faith basis and that it "appears" that the applicant was removed for psychological reasons. There were no additional details or explanation provided by the respondent on this issue.

Breach of s. 38(8)

[28] Regardless of my inability to determine an exact date that the applicant's injuries were no longer considered in the MIG, I find that the respondent is in breach of s.38(8) and therefore, the consequences set out in s.38(11) of the *Schedule* apply. Accordingly, the respondent is prohibited from taking the position that the applicant had an impairment to which the MIG applied.

[29] Once an insurer receives a treatment and assessment plan, s.38(8) of the *Schedule* requires the insurer to comply with four procedural requirements: i) respond to the insured person within 10 business days; ii) notify the insured what it will pay; iii) notify the insured what it will not pay; and, iv) provide the medical reasons and all of the other reasons why the insurer considers any of the goods, services, assessments and examinations, or the proposed costs of them, not reasonable and necessary.

[30] The respondent failed to meet the procedural requirements in s.38(8), specifically, with respect to the first treatment plan at issue dated August 20, 2014 (issue 4a) it failed to respond within 10 days of receiving the treatment and assessment plan.

[31] The first issue in dispute 4(a) is a treatment plan for chiropractic treatment dated August 20, 2014.[2] The respondent submits that it was not submitted to them until October 17, 2014. This appears to be the case as the submission to Health Claims for Auto Insurance ("HCAI") date is October 17, 2014. During the hearing the respondent's counsel indicated that the respondent issued a denial on October 29, 2014 by sending the Insurer Fax Back. The applicant submitted, even if the Insurer

[2] Exhibit #6

Fax Back was sent October 29, 2014, which he did not admit to, s.38(8) requires the notice approving or denying the relevant OCF-18 to be delivered to the insured.

[32] Section 38(8) states *"…the insurer shall give the insured person a notice …"*. There was no evidence that an Insurer Fax Back or denial was sent to the insured before the November 6, 2014 denial letter.

[33] At the time the submission was made, a copy of the Insurer Fax Back was not submitted into evidence. On the third day of the hearing, I requested that the parties submit a joint correspondence brief which was to include all of the denial letters. The parties submitted a joint correspondence brief ("JCB") electronically on September 21, 2017.

[34] Included at tab 1 of the JCB was the denial letter dated November 6, 2014, addressed to the applicant at his Barrie home address, which indicated that the respondent would not pay for the goods and services in the OCF-18 dated August 20, 2014, received on October 17, 2014. The letter also indicated that the letter was being sent in accordance with s.38 of the *Statutory Accident Benefits Schedule* ("SABS") and to accept it as their notice.

[35] Behind page 3 of the denial letter at tab 1 of the JCB, is a copy of an Insurer Fax Back which is dated October 29, 2014. The Insurer Fax Back is listed as an enclosure on the November 6, 2014 letter.

[36] I have not been provided with evidence that demonstrates the Insurer Fax Back was sent to the applicant, his counsel, (or even the provider for that matter) on October 29, 2014, the date indicated on the Insurer Fax Back.

[37] The evidence indicates that the respondent provided notice to the applicant of its denial of the August 20, 2014 treatment plan for the first time on November 6, 2014. Even if the applicant received the letter dated November 6, 2014 on the same day, this is 14 business days after the OCF-18 submission into HCAI. Accordingly, the respondent is in breach of s. 38(8) and therefore s. 38(11) is triggered.

[38] Even if there was evidence proving that the Insurer Fax Back was sent to the applicant on October 29, 2014, the respondent is still in breach of s. 38(8) as it does not comply with the additional requirements of s. 38(8).

[39] While the Insurer Fax Back indicates that the respondent does not approve the OCF-18, if fails to include any of the other enumerated requirements in s.38(8). In addition to the four requirements listed above, there is a fifth requirement as set out

in s. 38 (9) which requires the insurer to state that it believes the MIG applies to the insured's injuries, if in fact it believes the MIG applies.

[40] There is no such language in the Insurer Fax Back. The Insurer Fax Back fails to comply with the *Schedule* or *Augustin v. Unifund Assurance Co.*,[3] a frequently cited case on what is considered a proper denial by an insurer.

[41] In its closing submissions, the respondent appears to make the argument that it was not relying on s.38(8) in its response to the August 20, 2014 OCF-18 but was "guided by sections 33(5) [sic] and (6) of the SABS, not section 33(8) [sic]".[4] At the time, the respondent submits, the applicant had not consumed the $3,500 available under the *MIG* and was therefore entitled to rely on s. 38(5). I reject this submission in its entirety. The November 6, 2014 denial letter clearly indicates the respondent is relying on s.38(8) in not agreeing to pay for the treatment plan.

[42] In its closing submissions, the respondent further states that it did not "accept the OCF-18 until October 29, 2014, which is the date on which it responded to the HCAI submission..." This is contrary to what the November 6, 2014[5] denial letter states which clearly indicated "*We have received your Treatment and Assessment Plan (OCF-18) dated August 20, 2014 on October 17, 2014...*"

Consequences of s. 38(8) Breach

[43] Having found that the respondent breached s.38(8), s.38(11)(1) prohibits the respondent from taking the position that the MIG applied "in any future notices or responses to additional requests for medical benefits...."[6]

[44] In addition, the insurer is required to pay for services incurred during the period starting on the 11th business day after the insurer received the application and ending on the day the insurer gives a notice in compliance with s. 38 (8).

[45] Although the effect of s. 38(11) is that the insurer cannot take the position the applicant is in the MIG, it does not mean that all of the subsequent treatment plans

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[3] *Kadian Augustin v. Unifund Assurance Company*, 2013 CarswellOnt 15809 (F.S.C.O. Arb.) FSCO A12-00045
[4] The sections in paragraphs 88-92 are sometimes listed as s. 33(5), s.33(6) in error. It is clear the respondent meant to refer to s.38(5) and s.38 (6) because the text of the sections are quoted in paragraphs 91 and 92 of the respondent's closing submissions.
[5] The letter is dated November 6, 2014, not November 7, 2014 as indicated in the respondent's closing submissions.
[6] *M.F.Z. v. Aviva Insurance Canada, 16-000517/AABS, J.C.C. v. Aviva Insurance Company of Canada, 16-000663/AABS, Reconsideration Decisions,* dated September 22, 2017 at para 40 & 42.

are automatically payable. Previous Tribunal decisions clearly established this.[7] Accordingly, for the August 20, 2014 OCF-18, I must determine whether the applicant attended treatment sessions described in the OCF-18 on the 11th business day after the OCF-18 was received by the insurer (November 3, 2014)[8] until proper notice was provided to the insured.

[46] The August 20, 2014, OCF-18 was for 21 chiropractic sessions, the applicant attended well in excess of 21 sessions after November 3, 2014[9] and the entirety of this treatment plan (issue 4a) is payable. The parties provided a treatment chart setting out the dates and types of all treatment obtained by the applicant (the "Treatment Chart").[10] The Treatment Chart was agreed upon by the parties and entered as Exhibit #2 for the hearing.

[47] The insurer did not cure its defective notice for the August 20, 2014 treatment plan until May 19, 2015 when the respondent served Insurer's Examination ("IE) Reports of Dr. John James O'Sullivan (Orthopaedic Surgeon) and Dr. Verity Jayne John (Neurologist)[11] and accordingly, pursuant to s. 38 (11) 2, the treatment plan (issue 4(a) shall be payable by the insurer. Applying *M.F.Z. v. Aviva*, I do not need to assess whether this treatment plan is reasonable and necessary.

[48] I Order that the treatment plan at issue 4(a) is payable by the respondent.

[49] For subsequent treatment plans, the applicant must still prove that the treatment is reasonable and necessary.

Date of Respondent's Proper (Compliant) Notice

[50] I will first deal with when proper notice was provided to the applicant for the remaining treatment plans in dispute. The applicant did not raise the issue of whether the subsequent notices were delivered to the insured within 10 business days, therefore I will assume that they were timely. However, the issue of whether the notices provided a medical reason for denial was raised.

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[7] *M.F.Z. v. Aviva Insurance Canada, 16-000517/AABS, J.C.C. v. Aviva Insurance Company of Canada, 16-000663/AABS, Reconsideration Decisions,* dated September 22, 2017.

[8] The November 6, 2014 denial letter indicates that the OCF-18 dated August 20, 2014 was received on October 17, 2014. The 11th business day after the OCF-18 was received by the insurer would be November 3, 2014.

[9] The Treatment Chart (Exhibit #2) indicates all treatment that was attended by the applicant.

[10] The Treatment Chart was agreed upon by the parties and entered as Exhibit #2 for the hearing and was a very useful aid to the Tribunal.

[11] Exhibit #39

[51] Subsequent to the non-compliant notice of November 6, 2014, the next notice that I was provided with is dated February 24, 2015[12].

[52] The February 24, 2015 denial letter denied the treatment plan dated January 16, 2015 (received by the insurer on February 7, 2015)[13] prepared by a physiotherapist which proposed 12 treatment sessions. The OCF-18 indicated that the injury was not a predominantly minor injury and amongst the listed injuries, indicated the applicant had Whiplash Associated Disorder (WAD 3) with neurological signs and concussion.

[53] I find the notice is non-compliant and find *Augustin* applies. The respondent provided the case *Gao v. State Farm Mutual Automobile Insurance Company (FSCO A13-002281)* which found that the insurer was not expected to "invent a medical or other reason where it has not been provided with any medical documentation." While I agree with this proposition, I do not agree it is applicable to the facts in this case.

[54] While the denial letter indicates "*we will not pay for any of the goods or services…as upon review of available medical documentation feel that your injuries may fall within the parameters of the Minor Injury Guideline.*" - it is unclear why treatment is being denied.

[55] While the wording in the notice, suggests that the insurer feels the applicant's injuries fall within the MIG, the wording "*feels that your injuries may….*" are not unequivocal to communicate to the applicant that the treatment is being denied because his injuries fall within the MIG. There is nothing to indicate in the February 25, 2014 denial <u>why</u> the insurer "feels" the applicant's injuries fall within the MIG. As in *Augustin,* this denial is unsupported and does not provide a reason, medical or otherwise, explaining why the respondent is refusing to pay the treatment.

[56] On February 17, 2015 and February 25, 2015, the insurer had scheduled independent examinations of the applicant in order to "*determine if injuries sustained fall under the parameters of the Minor Injury Guideline…*"

[57] I am aware that the OCF-18 dated August 20, 2014 (issue 4(a)), 6 months post-accident, for chiropractic service, indicated that the applicant's injuries were predominantly minor. It is reasonable that having received one OCF-18 indicating the applicant's injuries were minor and one indicating they are not would cause some concern or confusion for the insurer. The fact remains that the insurer did not

[12] This denial letter was entered as Exhibit 24 (Tab 3 Applicant's brief, p.42-43) and also included in the JCB (Exhibit #66 at tab 2).
[13] Issue 4(e) in dispute

indicate why it was denying the treatment plan dated January 16, 2015. If it was due to the two differing OCF-18s, it could have easily said so and indicated that in the subsequent notice.

[58] The absence of a medical or other reason for the denial in the February 24, 2015 letter is more glaring given the applicant still had not exhausted the $3,500 MIG treatment limit. I agree with the reasons in *Augustin.*[14] It is reasonable to require an insurer who refuses to pay for claims (where the MIG limits are still available and in this case may have been the first or second treatment plan submitted) to provide something more than wanting a medical opinion to assist "*in determining whether the injuries sustained fall under the parameters of the Minor Injury Guideline.*"

[59] As stated in *Augustin*, this undermines the purpose of the MIG which is to provide access to speedy or early treatment.

[60] I was not presented with evidence to demonstrate that the insurer cured its defective notice for the January 16, 2015 treatment plan and accordingly, pursuant to s. 38 (11) 2, the insurer is required to pay for treatment incurred starting on the 11th business day after the insurer received the application[15] and ending the day the insurer gives notice in compliance with s. 38(8).

[61] The applicant received in excess of 12 physiotherapy sessions after February 23, 2015. The Treatment Chart indicates the applicant attended 12 physiotherapy sessions between February 23, 2015 through to and including April 20, 2015.

[62] Accordingly, the entirety of the treatment plan at issue 4(e) is payable by the insurer[16].

[63] Whether the remaining denial letters for the remaining issues in dispute were compliant with s.38(8) was not argued at the hearing.

[64] I need not decide whether the remaining denial letters were compliant with s.38(8) and must decide whether the remaining treatment plans are payable based on whether they are reasonable and necessary.

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[14] *Kadian Augustin v. Unifund Assurance Company* at para.23

[15] The 11th business day was February 23, 2015

[16] In its closing submissions, the applicant submitted that a compliant denial with respect to the August 20, 2014 and January 16, 2015 treatment plans was not sent until May 19, 2015. However, the letter does not indicate the treatment plan it is referring to. It does attach two IEs which both indicate the issues in dispute as the OCF-18 dated August 20, 2014 and does not mention the January 16, 2015 OCF-18.

THE REMAINING TREATMENT PLANS / ISSUES IN DISPUTE
4(b), 4(c), 4(g), 4(d), 4(f), 4(h), 4(i), 4(j)

[65] The remaining treatment plans deal with the following:

- chiropractic treatment (issues 4(d), 4(f), 4(h));
- physiotherapy treatment (issues 4(b), 4(c), 4(g));
- driver rehabilitation (issue 4(j));
- remaining unapproved balance of $149.63 (issue 4(k)) occupational therapy; and,
- In-home assessment (issue 4(i)) [17].

[66] There was extensive medical evidence presented at this hearing.

[67] In addition to substantial documentary medical evidence, both parties called several medical witnesses:

Applicant's Medical Witnesses	
Dr. Statton	Chiropractor
Dr. Bedard	Treating Physician
Beata Sadowska	Physiotherapist
Dr. Berbrayer	Physiatrist
Respondent's Medical Witnesses	
Dr. Lazarou	Neurologist
Dr. John James O'Sullivan	Orthopaedic Surgeon
Dr. Mathoo	Physiatrist & Pain Medicine Specialist

[68] The applicant has received a significant amount of chiropractic and physiotherapy treatment, in excess of 150 chiropractic treatments and in excess of 130 physiotherapy treatments. We heard during the hearing that despite the respondent denying the treatment plans, the applicant continued to attend treatment and is indebted to the treatment facility.

[69] The applicant has not returned to his pre-accident activities of daily living and still experiences pain and headaches even after receiving treatment for more than 3.5 years. This, according to the respondent, demonstrates that the treatment is

[17] Issue 4(i) is listed as a Treatment and Assessment Plan for occupational therapy services, however, the Treatment and Assessment Plain is for an occupational therapy in-home assessment recommended by Rehab First.

ineffective and fosters dependence and submits that an insurer should not have to continue to pay for ineffective treatment.

[70] The applicant disagrees that the treatment is ineffective. Weighing the applicant's and the respondent's evidence, I prefer the applicant's evidence over the respondent's and I find that the applicant has established that the treatment plans for chiropractic treatment and physiotherapy are reasonable and necessary.

[71] Section 14 and 15 of the *Schedule* provide that an insurer is only liable to pay for medical and rehabilitation expenses that are reasonable and necessary as a result of the accident. The applicant bears the onus of proving on a balance of probabilities that the expenses are reasonable and necessary.

[72] Section 15 of the *Schedule* requires the respondent to pay for all reasonable and necessary medical benefits including chiropractic and physiotherapy services and other goods and services of a medical nature that the insured requires, other than for goods and services otherwise provided under the *Schedule.* This requires that I review the treatment and assessment plans, their stated goals and expected outcomes in the context of the applicant's overall impairments.

[73] Although not binding on this Tribunal, I am guided by the following factors set out in *Violi and General Accident Assurance Company of Canada* (P99-00047, September 27, 2000) ("*Violi*") in coming to my decision:

(a) the treatment goals, as identified, are reasonable;

(b) these goals are being met to a reasonable degree; and

(c) the overall costs [not just financial, but also investment of time, etc.] of achieving these goals is reasonable taking into consideration both the degree of success and the availability of other treatment alternatives.

[74] The remaining three (3) chiropractic treatment plans are for a total of 56 treatment plans and progress exams. It is important to note that the applicant has received well in excess of 56 chiropractic treatments for the time span at issue. From December 10, 2015 (the date of the treatment plan at issue 4d) through to the end of July 2017 (the last recorded treatment dates provided at the hearing), the applicant attended 71 chiropractic treatment sessions without access to funding from the respondent.

[75] The respondent has denied the chiropractic treatment because it states it is not reasonable and necessary. The respondent submits the applicant does not require facility based treatment and that the treatment is ineffective.

[76] The remaining three (3) physiotherapy treatment plans prepared by Beata Sadaowska are for a total of 37 physiotherapy sessions and 24 manipulations.[18]

[77] From October 29, 2015 (the date of the treatment plan at issue 4b) through to the end of July 2017 (the last recorded treatment dates provided at the hearing), the applicant attended 82 physiotherapy sessions.

[78] Applying the factors in *Violi,* the goals as identified in the treatment plans, are reasonable and the evidence demonstrates the goals are reasonably being met thus satisfying the first two factors in *Violi.*

[79] The goals in the chiropractic and physiotherapy treatment plans are similar: pain reduction, increase strength, increase range of motion, return to activities of normal living and decrease occurrences of headaches.

[80] Throughout the hearing we heard from the applicant, his wife, Dr. Statton, and Ms. Sadowska that when the applicant received treatment he had less pain, fewer headaches, better strength and increased range of motion. The applicant had better function when he was receiving treatment. When treatment was stopped he would lose mobility, had less range of motion and degenerated.

[81] Pain relief has been held to be a legitimate goal of treatment[19] and a legitimate goal of dealing with chronic pain, even if it does not promote recovery.[20] Dr. Bedard's evidence was that the applicant's symptoms are chronic. Dr. Alpert opined that the applicant has moderate to severe chronic pain[21], Dr. Berbrayer diagnosed the applicant with chronic pain syndrome.[22] Dr. O'Sullivan, who conducted an Orthopaedic assessment as well as subsequent paper reviews confirmed that the applicant has chronic pain.[23]

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[18] It was not clear if the manipulations required a separate visit or if the manipulations would be provided during the physiotherapy sessions.

[19] *Violi* at pg 5, *L.W. v. The Co-operators General Insurance Company, 2016 Canlii 93133 (ONLAT) at para. 29*

[20] *S.L. v. Pembridge Insurance Company, 2017 Canlii 12600 (ONLAT) at para. 40*

[21] Dr. Alpert, Orthopaedic Assessment Report, dated October 13, 2016 (Ex#55)

[22] Dr. Berbrayer, Physiatrist Assessment Report, dated August 5, 2016 (Ex#59)

[23] Dr. O'Sullivan, Orthopaedic Insurer's Examination, examination date March 27, 2017, Report dated May 31, 2017, Ex#32

Applicant's Evidence

Dr. Bedard

[82] The applicant has been regularly seeing Dr. Bedard, his family doctor of over fifteen years. Dr. Bedard testified at the hearing.

[83] The applicant testified that he has headaches almost every day that range from medium to debilitating, ringing in his ears, nerve entrapment in his neck and upper back and shoulder pain. If he does not get chiropractic treatment his headaches are severe. The applicant was consistent in his evidence that he feels worse without treatment and has decreased ability to function.

[84] The applicant's evidence that he feels worse without treatment was supported by Dr. Bedard. Dr. Bedard noted that when the applicant's physiotherapy had stopped the applicant experienced pinching in his neck which was associated with the applicant's headaches,[24] missing physiotherapy and chiropractic treatment made the applicant's headaches worse.[25]

[85] When treatment continues over a long period of time, the respondent questions whether it is effective. As in *Violi*, "effectiveness of on-going repetitive treatment cannot simply be assumed." In order to test the effectiveness of treatment, periodically withdrawing treatment and monitoring the consequences is suggested.[26]

[86] In March 2014, Dr. Bedard recommended physiotherapy. In May 2014, Dr. Bedard noted that "physio wants him to take time off". On August 5, 2014, Dr. Bedard noted that the applicant stopped physiotherapy for his neck because he did not feel it was helping. The respondent made much of this statement and asked the applicant whether Dr. Bedard's notes were accurate.

[87] The applicant was clear in his response and indicated at the time it was accurate but that it was getting worse. At the time, the physiotherapy was not working but the chiropractic treatment was.

[88] The applicant did not attend physiotherapy for a 6 month period from June 16, 2014, to December 22, 2014, (according to the Treatment Chart).

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[24] Dr. Bedard note of January 16, 2017.
[25] Dr. Bedard note of March 29, 2016.
[26] *Violi* p.6

[89] After this 6 month break from physiotherapy[27] and as of December 22, 2014, the applicant was still having headaches and neck pain and returned to the chiropractor and physiotherapist. The applicant was also using self-directed exercises and was exercising at the gym.

[90] As of March 19, 2015, the applicant, who had resumed receiving chiropractic and physiotherapy, had fewer headaches (from daily to 2-3 per week) and their intensity had improved.

[91] As of June 3, 2015, the applicant was still receiving chiropractic treatment, but had stopped going to physiotherapy since May 4, 2015. At this point he had ongoing neck pain on the right side which was radiating to the shoulder, pain when turning his head to the right and numbness into C8.

[92] Shortly after this, on June 18, 2015, the applicant reported to Dr. Bedard that the pain feels better and he is able to get more done. At this point he had not received physiotherapy since May 4, 2015 and had been without a chiropractic treatment for 2 weeks (since his last visit on June 3, 2015). Dr. Bedard still noted the applicant's chronic neck pain, depression and anxiety.

[93] It is clear that the applicant's symptoms fluctuate. Beatta Sadowska, the applicant's physiotherapist confirmed this when giving her evidence at the hearing.

[94] On July 29, 2015, Dr. Bedard referred the applicant to Dr. Godfrey (Physiatrist) who diagnosed the applicant with right C8 radiculopathy.[28]

[95] Other than 1 chiropractic treatment on August 28, 2015, the applicant went almost three months without treatment. Dr. Bedard was supportive of the applicant resuming treatment. It is significant that Dr. Bedard noted that the applicant would continue with treatment for pain control.

[96] By November 3, 2015 the applicant was still experiencing pain which was interfering with his ability to be active with his family and overall ability to function.

Dr. Statton

[97] Dr. Statton, the applicant's treating chiropractor, testified that when he examined the applicant after the accident, the applicant was distraught, in a lot of pain, had limited range of motion, complained of numbness and tingling in his hand, reduced memory and was dizzy. Dr. Statton was consistent in his evidence that as he treated the

[27] And approximately 4 month break from chiropractic treatment (returned to chiropractic treatment on October 16, 2014

[28] Exhibit #34

applicant, he had better range of motion, less spasms, fewer headaches, less inflammation and better posture. When the applicant is not treated he degenerates, has worse range of motion, and worse headaches. Dr. Statton testified that on-going treatment kept the applicant functioning.

[98] Dr. Statton included evaluations of the applicant on the treatment plans he prepared and documented that the applicant had less pain and improved range of motion, better strength, reduced nerve entrapment and better use of his upper extremities.

[99] Dr. Statton used what he referred to as "mechanical therapy" which relates to treatment to realign the spine, the "McKenzie method" which he described as a great treatment option for disc injuries and helps to reduce radiculopathy. Dr. Statton testified that these treatments help reduce impingements which effectively helps to reduce cervicogenic headaches which the applicant had been diagnosed with.

[100] Dr. Statton's clinical notes and records were entered as Exhibit #27. Although I was unable to interpret them, Dr. Statton was able to explain his notations during his testimony.

[101] Dr. Statton explained that the applicant had taken a four month break from treatment. When he returned for treatment on October 16, 2014, Dr. Statton could not adjust the applicant's neck, and they could only do range of motion exercises.

[102] Dr. Statton testified, by looking at his notes, that the applicant was treated from October 20, 2014 to December 16, 2014 and as he treated the applicant, he had better range of motion, less spasms, and less headaches. Part of the treatment goals was always to improve range of motion of the neck, spine and reduce headaches. The treatments were achieving those goals.

[103] Dr. Statton explained that even though the applicant did indicate he had pain, which can be caused by inflammation from treatment but the applicant was still improving. When the applicant did not get treatment, he had less function.

[104] Dr. Statton was challenged by the respondent as to whether he was meeting the College of Chiropractors standards of practice in his record keeping requirements for example, keeping contemporaneous notes and conducting re-assessments. Dr. Statton was able to demonstrate through his notes that he was following the standards of practice.

[105] Dr. Statton opined that the applicant's radiculopathy has gone down with treatment which lessens headaches. Dr. Statton agrees with Dr. Lazorou when he states that

cervicogenic headaches may benefit from physical therapy programs directed at musculokeletol neck pain.

[106] Dr. Statton was clear in stating that the applicant needs supportive care and the applicant's symptoms worsen when he goes without treatment.

Dr. Berbrayer

[107] The applicant also called Dr. Berbrayer, a Physiatrist, who diagnosed the applicant with having a concussion, post-concussive syndrome, myofacial pain of the cervical spine, right C8 radiculopathy, chronic pain syndrome and cervicogenic headaches, amongst other diagnoses.

[108] Dr. Berbrayer examined the applicant[29] and reviewed extensive medical documents as listed in his report dated August 5, 2016.

[109] The respondent asked Dr. Berbrayer whether the treatment the applicant was receiving was ineffective given the applicant has continued with clinic based therapy and his condition is getting worse. Dr. Berbrayer questioned the insurers assertion that the treatment was not helping the applicant and further testified that if the applicant discontinued the treatment, he would be worse and the treatment is actually controlling his injuries from getting worse and allows him to function.

[110] Dr. Berbrayer agrees that the applicant would benefit from physiotherapy and chiropractic treatment and opined that they are both reasonable and necessary.

[111] Dr. Berbrayer considered other treatment options for the applicant and opined that surgery however; was not an option, the applicant was worried about side effects of medications and that the applicant feared needles. Dr. Berbrayer did indicate in his report dated August 5, 2016 that the applicant would benefit from being seen at a Multi-Disciplinary Pain Clinic that would determine the type and duration of medical treatment required.[30]

[112] There was considerable disagreement regarding whether the applicant has C8 radiculopathy. Dr. Bedard noted that the applicant exhibited numbness in his 1st and 2nd digits which correlates to C6 radiculopathy not C8 radiculopathy. In Dr. Berbrayer's assessment, the applicant had numbness in his 3rd, 4th and 5th digits which correlates to C7 and C8 radiculopathy.

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[29] Dr. Berbrayer indicated that you cannot diagnose without an examination of the patient/applicant
[30] Exhibit #59 p.393

[113] Dr. Berbrayer noted that upon examination, the applicant had neck tenderness, decreased rotation, pain with rotation to the right and pain with flexion of the neck and notes intermittent paresthesia in the right upper extremity involving the 3rd, 4th and 5th digits. Dr. Berbrayer testified that this is enough to look at a type of radiculopathy, whether it is C8, C6 or C7.

[114] This hearing is not about whether the applicant has C8 radiculopathy but whether the treatment plans denied by the respondent are reasonable and necessary.

[115] There is ample medical evidence and evidence from the applicant to prove on the balance of probabilities that the chiropractic treatment and physiotherapy treatments are reasonable and necessary.

Beatta Sadowska

[116] The applicant's treating physiotherapist, Beatta Sadowska, also gave evidence. Her treatment consists of providing manual therapy, assisting the applicant with supervised exercises and stretch release techniques, shock wave therapy, traction and the use of the TENS machine for example. She treated the applicant for cervicogenic headaches in the C1 and C2 spine levels.

[117] Ms. Sadowska testified that they were progressing with his treatments and some of the applicant's symptoms were getting better. Following treatment, the applicant reported feeling better. In order to find out how sustainable the results were, breaks in treatment were taken.

[118] She indicated that a break was taken between May 4, 2015 to September 2, 2015 and upon his return the applicant reported that his neck pain was the same as before.

[119] Ms. Sadowska gave evidence that the applicant's symptoms kept fluctuating and it took a shorter period of time to correct his symptoms if he continued therapy than when he took breaks. She further testified that the applicant may require treatment on an as needed basis because of his fluctuating condition – "It gets better, it gets worse".

[120] Ms. Sadowska testified that the treatment, which she described as "dynamic", was reasonable and necessary. The applicant did not test the same at every visit. She treated the applicant based on the status he presented at the time. She treated the most pronounced issues and complaints from the applicant. Ms. Sadowska has not been treating the same areas all of the time. The applicant has "flair ups" and she

treats the areas that are impaired at the time. Her treatment is not focused on one area and she uses different modalities.

[121] Ms. Sadowska indicated that the applicant has persistent neck issues. She is currently treating the applicant once per week but had been seeing him twice per week when he had flair ups with headaches. The frequency of treatment depends on his status. Ms. Sadowska agrees that physiotherapy and chiropractic treatment is reasonable and necessary based on both a reported decrease in pain and also an increase in overall function.

Dr. Lazarou

[122] Dr. Lazarou, a Neurologist, conducted an insurer's examination of the applicant on April 29, 2016 and a further assessment on April 10, 2017.

[123] On first examination on April 29, 2016, the applicant was experiencing numbness in the digits in his right hand, neck pain and occipital headaches.

[124] Dr. Lazarou indicates that the neck pain is musculoskeletal and the occipital headaches are likely cervicogenic and related to neck pain.

[125] Dr. Lazarou indicates that neck pain is alleviated by physiotherapy.[31]

[126] Despite the fact that Dr. Lazarou indicates that neck pain is alleviated by physiotherapy, he states that the treatment plan for physiotherapy dated October 29, 2015 (Issue 4(b) is not reasonable and necessary from a neurological perspective because there is no neurological injury due to the accident.

[127] Dr. Lazarou states the chiropractic treatment plan dated December 10, 2015 in the amount of $1,850.00 (Issue 4(d) and chiropractic treatment plan dated January 22, 2016 in the amount of $1,340.00 (4 (f)) treatment is not reasonable and necessary from a neurological perspective given the absence of any neurological injury sustained as a result of the accident.

[128] Dr. Lazarou confirms that the applicant appears to be experiencing cervicogenic headaches as a consequence of the accident. He further indicates that the prognosis of cervicogenic headaches would be tied to the prognosis of the applicant's musculoskeletal neck pain. He further confirms that as of April 10,

[31] Exhibit #45, p.8/10

2017[32], the applicant continues to experience cervicogenic headaches and that the applicant "has not reached maximum medical recovery".[33]

[129] The fact that Dr. Lazarou indicates that the applicant's headaches relate to his neck pain, that neck pain is alleviated with physiotherapy and that the applicant has not reached maximum medical recovery does not reconcile with stating the treatment plans are not reasonable and necessary.

Dr. O'Sullivan

[130] Dr. O'Sullivan, an orthopaedic surgeon, conducted orthopaedic examinations of the applicant on February 17, 2015 and March 29, 2017 and also completed a paper review.

[131] Dr. O'Sullivan testified that when he examined the applicant on March 29, 2017, the applicant had less numbness in his right hand and this is at least 60% improved

[132] Dr. O'Sullivan indicated in his report that there was evidence of pre-existing cervical disc disease and bilateral foraminal stenosis at the C5/6 and C6/7 levels. He opined that given the applicant's complaints and objective findings on physical examination, the prognosis of the applicant's cervical strain injury, suffered as a direct result of the accident, is poor. The applicant has suffered an exacerbation of pain associated with his cervical spine and myofascial components of his neck and shoulder girdles. There is objective evidence of decreased range of motion. According to Dr. O'Sullivan, the applicant "does have chronic pain."

[133] Dr. O'Sullivan acknowledged the diagnosis of right sided C8 radiculopathy but noted there was some discrepancy as to the accuracy of the diagnosis. Dr. O'Sullivan notes that the applicant's symptoms have "significantly improved".

[134] Dr. O'Sullivan stressed that "passive" chiropractic and "passive" physiotherapy is neither reasonable nor necessary. Dr. O'Sullivan noted that the applicant's past medical history was positive for osteoarthritis and degenerative disc disease/chronic low back pain, was known to have ongoing right and left hand numbness and chronic neck pain. He further noted that Dr. Godfrey, physiatrist, performed EMG/nerve conduction studies with evidence of a right C8 radiculopathy. At the hearing, Dr. O'Sullivan indicated that he did not find evidence of C8 radiculopathy; however, in his report dated December 16, 2015,[34] Dr. O'Sullivan indicated that the applicant "has had an exacerbation of pre-existing degenerative disc disease and

[32] This was the date of examination as stated in report
[33] Neurology Examination Report, assessment conducted on April 10, 2017, Ex #47
[34] Exhibit #53

cervical changes as well as radiculopathy". He has increased pain and decreased function of his cervical spine. "This has delayed the recovery from his injuries sustained in the subject accident".[35]

[135] It was Dr. O'Sullivan's opinion that the treatment plans (4a), (4e), (4b),[36] (4d), (4f) & (4c)[37] were neither reasonable nor necessary. He indicated that the treatment the applicant was receiving was passive therapy and he would not support passive therapy, which by this time was one year post accident. Dr. O'Sullivan noted that the applicant does require range of motion and strengthening exercises for the cervical spine and upper extremities, particularly the shoulder girdles but that this could be carried out in a self-directed manner in the form of a personal exercise program. The applicant did provide evidence that he was participating in self-directed exercises; however he was still experiencing pain. Even if Dr. O'Sullivan was correct that the chiropractic treatment and physiotherapy the applicant was receiving is "passive" and not necessary any longer, the applicant was participating in self-directed exercise programs and was still experiencing pain.

Dr. Mathoo

[136] Dr. Mathoo, a Physiatrist, conducted a paper review insurer's examination on September 28, 2017.

[137] Based on the medical documents reviewed, Dr. Mathoo opined that the applicant sustained a WADII injury, cervical neck strain and associated cervicogenic headaches. He did not support the diagnosis of a cervical radiculopathy at any level as a direct result of the accident.

[138] Notably, Dr. Mathoo indicates in his report that the applicant's injuries were properly managed within the MIG. He further notes in his report that there was no compelling evidence of a pre-existing condition that would exclude the applicant's injuries from the MIG. This is directly contradicted by Dr. O'Sullivan who stated that the applicant "did have a medical condition that existed prior to the motor vehicle accident. He had cervical disc disease."[38] Dr. Mathoo does acknowledge that the applicant did suffer from degenerative spondylosis of the spine prior to the accident but in his opinion, this would not exclude the applicant from the MIG.

[139] I do not give much, if any weight, to Dr. Mathoo's evidence. He did not conduct a physical examination. There was ample evidence (as noted above) of pre-existing

[35] Exhibit #47 at page 719
[36] Exhibit #53
[37] Exhibit #54
[38] Exhibit #47 at page 719

conditions in the medical documents. Dr. Mathoo acknowledged reviewing the Post-104 Determination report dated May 31, 2017, yet does not comment on it in his paper review. Despite Dr. O'Sullivan indicating in the report that the applicant had a medical condition prior to the accident and that he has had an exacerbation of the degenerative changes in his cervical spine which has delayed the applicant's recovery, Dr. Mathoo indicates the applicant could have been treated within the MIG. This also ignores the fact that the applicant was removed from the MIG by the respondent by, at the very latest, February 8, 2016, prior to Dr. Mathoo's report.

Alternative Treatment

[140] The third *Violi* factor to be addressed deals with the overall cost [not just financial but also investment of time, etc.] of achieving the goals of treatment, taking into consideration both the degree of success and the availability of other treatment alternatives. I find that the applicant has met this third factor.

[141] Dr. Bedard referred the applicant to Dr. Godfrey requesting an assessment for possible surgical decompression.[39] We heard evidence during the hearing that surgery was not an option for the applicant.

[142] As of November 3, 2015 the applicant had physiotherapy, traction, rest as well as a trial of NSAIDS (nonsteroidal anti-inflammatory drugs) and Cymbalta. We heard evidence that the applicant has a fear of needles and therefore could not receive treatment that involves injections.

[143] We also heard evidence that the applicant does not want to take more medications and wants to avoid medication as much as possible.

[144] A chronic pain management program was recommended by Dr. Berbrayer. We heard evidence that chronic pain management programs include components such as chiropractic and physiotherapy treatment in addition to teaching patients to direct their own care and different pain management techniques.

[145] A chronic pain management program may be an option however; Dr. Bedard's evidence was that there is a large waiting list in the applicant's community. When the applicant goes without treatment, the evidence was that he is worse off. Waiting for a chronic pain management program without treatment would be difficult for the applicant. While a chronic pain management program may be available, the evidence established that the applicant requires supportive care which the applicant is receiving through chiropractic and physiotherapy.

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[39] Dr. Bedard CNR dated November 3, 2015

[146] Overall, the denied treatment amounts to approximately 150 sessions of combined chiropractic and physiotherapy in the amount of $13,917.88. The applicant has attended in excess of this amount of treatment. There was no dispute that the treatment has been incurred. The applicant is indebted to the chiropractic and physiotherapy clinic and has committed to paying for the services. For the applicant, the treatment is successful as it improves his symptoms and reduces his pain.

Skill Builders – Issue 4(j)

[147] The applicant avoids driving especially in the winter and does not want to drive on the highway and has anxiety. He has not driven by the accident scene. He attempted to go back to work after the accident but the commute was too difficult. If there was snow he would call in sick. He submitted that he has not received treatment for his driving anxiety.

[148] The applicant's claim for driver rehabilitation services was submitted on an OCF-18 dated September 20, 2016, in the amount of $3,153.76 prepared by Skill Builders Physiotherapy & Rehab Centre ("Skill Builders").[40] A Driving Evaluation Report also dated September 20, 2016, was prepared by Maria Wright, who is identified as an Occupational Therapist, Certified Driver Rehabilitation Therapist and Licensed Driving Instructor.

[149] $1,777.59 of the $3,151.76 OCF-18 for Skill Builders was approved by the respondent. $1,376.17 is the balance outstanding and unapproved.[41]

[150] Dr. Bedard supported the driver retraining and referred the applicant to Skill Builders given the applicant's vehicle anxiety. Skill Builders would also re-assess the applicant's neck pain.

[151] Dr. Bedard testified that it is the only driving assessment facility in the region and it conducts assessments for the Ministry of Transportation as well. He was not aware of any other clinic in the area that offers assessments similar to Skill Builders.

[152] At the conclusion of the hearing, the respondent indicated it was not disputing the reasonableness or necessity of the driver retraining, it was only the rate that is at issue.

[153] I agree with the respondent that the rates submitted are not reasonable and necessary; however, I also disagree with the amount approved by the respondent.

[40] Exhibit #10
[41] Exhibit #66 Tab 17

[154] I find that the applicant is entitled to $2,205.63 for the Skill Builders OCF-18. Respectfully, the calculations in the OCF-18 and the Denial are difficult to reconcile. The breakdown of my calculation is included in **Appendix "B".**

Calculation of Skill Builders OCF-18

[155] The OCF-18 indicates that "driving instruction services are not under the application of the Professional Fee Guidelines. Please note in the October 30, 2003 bulletin that the fees for driving training are outside of the Professional Fee Guideline."

[156] The parties provided written closing submissions on this issue. The applicant provided a Financial Service Commission ("FSCO") Professional Services Guideline from 2003 which did not include hourly rates. I did not find the 2003 Guideline helpful in determining this issue.

[157] It is widely known that the FSCO Professional Services Guidelines have been updated several times since 2003.

[158] Both parties seemed to suggest that the hourly rates payable by an insurer related to services not covered by the Guideline are to be determined by the parties.

[159] However, it appears from the OCF-18 as well was Ms. Wright's Driving Evaluation Report that the services were to be provided by an Occupational Therapist and each session would focus on teaching cognitive behavioural strategies to improve confidence, deal with anxiety, teaching and practicing rules of the road and defensive driving. Occupational Therapists are covered by the Profession Services Guidelines.

[160] Skillbuilders charged a rate of $164.80 in some instances and $144.80 in others even though it appears to be for the same service (same Code). This rate takes into account that the Occupational Therapist is also a driving instructor, the use of adapted cars and the higher costs of insurance. This is akin to charging for each specialty an individual has, i.e. a fee because the individual holds an occupational therapist designation and a second fee because the individual holds a driving instructor designation. I agree with the respondent that this rate is not reasonable and necessary and is in excess of what a psychologist may even charge (which is the highest fee available in the Professional Services Guideline of September 2014.[42]

[42] The September 2014 FSCO Professional Services Guideline was not entered as an exhibit but referred to in the applicant's and respondents closing submissions.

[161] I note that the Professional Services Guideline of September 2014 indicates that the maximum hourly rate occupational therapists may charge is $99.75.

[162] In the respondent's denial letter[43], it indicates that it agrees to fund the Occupational Therapy/driver rehabilitation therapy sessions as per fee guidelines of $99.75, yet, did not seem to use this figure in its calculation.[44]

[163] Skill Builders would agree to provide the driver rehabilitation services at a rate of $99.75 per hour but indicated the respondent would have to supply a rental vehicle with a training brake and proper insurance.[45]

[164] I find that the Professional Services Guideline of September 2014 is applicable to this case. It indicates that the *Professional Services Guideline* "includes all administration costs, overhead, and related costs, fees, expenses, charges, surcharges."

[165] I find the hourly rate applicable is $99.75, which is the rate for Occupational Therapists, a rate the respondent agreed to pay and a rate that Skill Builders was prepared to accept, albeit with additional fees, which I find to be overhead and not payable as per the Professional Services Guideline of September 2014.

[166] I agree with the respondent that brokerage service fees are not payable as this is not a covered medical or rehabilitation expense under the *Schedule*.

[167] Accordingly, the applicant is entitled to $2,205.63 rather than $1,777.59 as previously approved by the respondent, for the Skill Builders OCF-18 (issue 4(j).

In-Home Assessment (Issue 4(i)

[168] Listed as occupational therapy services, the treatment plan is for an in-home assessment.

[169] The applicant seeks an in-home assessment to identify and address the applicant's physical, emotional and cognitive issues resulting from the accident and to make recommendations to promote the applicant's resumption in his daily activities.

[170] The additional comment section of the treatment plan indicates that the in-home assessment, as well as an attendant care assessment is required to identify

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[43] Exhibit
[44] I note that the respondent paid a rate of $58.19 per hour for items 1. Training and 2. Training but paid $99.75 for item 4. Training, all of which have the same Codes.
[45] Exhibit #13

occupational performance issues related to the applicant's injuries, assess his safety and need for treatment.

[171] Dr. O'Sullivan agreed that an in-home assessment would be necessary given the applicant "is limited with regard to his heavier home maintenance and housekeeping chores but has resumed participation in some household tasks."[46]

[172] I find that the applicant has failed to prove that an in-home assessment as proposed is reasonable and necessary.

[173] The treatment plan indicates that the applicant is at an increased risk for falls and injuries and indicates that since the accident he has lost his balance approximately four times and this has resulted in several falls and further injuries due to his reduced balance.

[174] During the applicant's examination-in-chief, he indicated that his memory "was not great". He also indicated that his balance was "a bit off" but did not go so far as to indicate that he had fallen as a result or was at risk of injury.

[175] With respect to the applicant's personal care, he indicated that before the accident he would stay in the bathtub and read. Currently, he only showers while being seated with a removable showerhead.

[176] Dr. Alpert completed an orthopaedic assessment of the applicant and completed a report on October 13, 2016. While the report does indicate that the applicant had ongoing limitations in his ability to do home maintenance/housekeeping and prior recreational activities of daily living such as hockey, there is no indication in the report that the applicant requires attendant care. In fact, the report specifically states that the applicant reported that he is able to perform self-care tasks.

[177] I am not convinced that an in-home assessment is necessary for the applicant to carry out his activities of daily living.

[178] There was evidence that the applicant moved to a smaller property because he was unable to do most of the outside maintenance and assisted less with the household chores after the accident. However, the respondent correctly points out that housekeeping and home maintenance benefits (s.23) are subject to the purchase of optional benefits. I was not presented with evidence that the applicant had purchased optional benefits and therefore, the applicant is not entitled to housekeeping and home maintenance benefits.

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[46] Exhibit #47, question #11, p.g.719

Issue 4(k) Occupational Therapy Services $149.63

[179] The last issue in dispute in the amount of $149.63 is the unapproved portion of a treatment and assessment plan (OCF-18) dated January 26, 2016 in the amount of $2,552.88 for "counselling, promoting health and preventing disease." The approved portion of the treatment plan includes 10 sessions of the same services.

[180] I was not presented with evidence on the reasonableness and necessity of the unapproved portion. I find that the applicant did not meet his onus with respect to the balance of this treatment plan and accordingly it is not payable by the respondent.

ORDER

[181] I order that given the respondent's breach of s.38(8) of the *Schedule,* and as a result of the consequences set out in s.38(11) of the *Schedule,* the respondent was prohibited from taking the position that the MIG applied as of November 3, 2014;

[182] The applicant is entitled to payment of the following treatment plans in the noted amounts:

a) Medical Benefit in the amount of $1,285.00 for Chiropractic Services pursuant to a Treatment and Assessment Plan (OCF-18) dated August 20, 2014;

b) Medical Benefit in the amount of $4,212.13 for Physiotherapy Services pursuant to a Treatment and Assessment Plan (OCF-18) dated October 29, 2015;

c) Medical Benefit in the amount of $1,646.75 for Physiotherapy Services pursuant to a Treatment and Assessment Plan (OCF-18) dated December 10, 2015;

d) Medical Benefit in the amount of $1,850.00 for Chiropractic Services pursuant to a Treatment and Assessment Plan (OCF-18) dated December 10, 2015;

e) Medical Benefit in the amount of $1,397.00 for Physiotherapy Services pursuant to a Treatment and Assessment Plan (OCF-18) dated January 16, 2015;

f) Medical Benefit in the amount of $1,340.00 for Chiropractic Services pursuant to a Treatment and Assessment Plan (OCF-18) dated January 22, 2016;

g) Medical Benefit in the amount of $1,397.00 for Physiotherapy Services pursuant to a Treatment and Assessment Plan (OCF-18) dated April 20, 2016;

h) Medical Benefit in the amount of $790.00 for Chiropractic Services pursuant

to a Treatment and Assessment Plan (OCF-18) dated April 5, 2016;

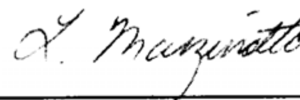
i) Medical Benefit in the amount of $2,205.63 for Drivers Rehabilitation Services pursuant to a Treatment and Assessment Plan (OCF-18) dated September 29, 2016;

[183] The applicant is entitled to interest on overdue payments in accordance with s.51 of the Schedule.

[184] In accordance with my Order on Preliminary Issue #2 – Special Award- I order that the respondent provide its written submissions and evidence on the Tribunal's jurisdiction to grant a special award and whether the applicant is entitled to a special award by September 14, 2018; the applicant's response is due September 28; and, the respondent's reply, if any, is due October 5, 2018. The respondent's and applicant's submissions shall not exceed 10 pages, double spaced, 12 point Arial or Times New Roman font and the respondent's reply shall not exceed 5 pages. The page limits are exclusive of evidence and case law.

[185] The parties are ordered to provide written submissions with respect to costs in accordance with the above noted deadlines for the special award. The respondent's and applicant's submissions shall not exceed 5 pages, double spaced, 12 point Arial or Times New Roman font and the respondent's reply shall not exceed 2 pages. The page limits are exclusive of evidence and case law.

Released: August 27, 2018



Lori Marzinotto, Vice-Chair

APPENDIX "A"

PRELIMINARY ISSUES and MOTIONS

#1 – Dr. Berbrayer Report Dated August 11, 2017

The respondent objected to Dr. Berbrayer's Report Dated August 11, 2017 being admitted into evidence.

The applicant served the respondent Dr. Berbrayer's Report Dated August 11, 2017 on August 14, 2017 which was the day before the deadline indicated in the Motion Order released August 15, 2017.

By the Motion Order of Terry Hunter on August 3, 2017, "all evidence" was to be exchanged and submitted by August 15, 2017. The Order of Paul Gosio dated March 17, 2017, distinguishes between "all other evidence" and "expert evidence". The addendum report of Dr. Berbrayer dated August 11, 2017 specifically addresses the treatment plans and issues in dispute. The original report of Dr. Berbrayer dated June 16, 2016, was obtained in the context of the tort action and the respondent submits that getting a responding report to the report dealing with the tort claim was not necessary for the LAT application. If the addendum report is allowed in at this stage, it prejudices the respondent because it deals with the issues in dispute (the reasonableness and necessity of chiropractic treatment and/or physiotherapy treatment) and the respondent should be allowed to respond.

I reserved my decision on this preliminary issue in order for the respondent to seek instructions on whether it wanted to cross-examine Dr. Berbrayer on the report and/or obtain a responding report. The respondent obtained instructions and advised that if the report was allowed in, it intended on obtaining a responding report and cross-examine Dr. Berbrayer.

ORDER: At the hearing, I ordered that the addendum report of Dr. Berbrayer dated August 11, 2017, be allowed in evidence. In order to balance any prejudice to the respondent, the respondent is entitled to obtain a responding report which shall be served by October 2, 2017. I ordered that no further reports may be admitted thereafter and that any issues raised in the reports may be addressed through examination or cross-examination.

The hearing began in August 2017 and was continued on October 10, 2017 by telephone to hear any examination-in-chief and cross-examination of Dr. Berbrayer and the practitioner (to be determined) who prepares the responding report.

#2 – Addition of a Special Award Reg. 664 – Motion

The applicant has brought a motion seeking to add a claim for a special award. The applicant submits that he has been unreasonably denied treatment outside of the MIG. His assessors comment on the reasonableness and necessity of the treatment and the applicant feels abandoned by the respondent insurer. The applicant further submits that the respondent denied the treatment solely on the basis that the applicant is in the MIG, it has not stated that the treatment plans are not reasonable and necessary. The applicant also indicates that issue 4(a), the August 20, 2014 treatment plan, was denied outside of the required 10 day period and as a result, is unable to rely on the MIG as a reason to deny the treatment.

The Respondent submits that there is some confusion as to the test for a special award and states that the test is whether there was an unreasonable denial which is based on the information the insurer has at the time of the denial. If the respondent decides that the treatment plan is reasonable and necessary at a later time that does not necessarily mean that a special award should be granted.[47]

The respondent submits that just because there was a denial and now we may have all of the information we need, if I find that the treatment plans are now reasonable and necessary it does not mean that a special award is warranted.

The respondent submits that with respect to the first treatment plan, the response was provided within 10 days.

The Respondent also questions whether the tribunal has the jurisdiction to grant a special award. Section 282(10) of the *Insurance Act* gave FSCO the jurisdiction to grant a special award but that section has since been repealed. *Ontario Regulation 664* is similar but it does not say that the Tribunal has the jurisdiction to grant an award. It is only in extraordinary circumstances that a special award should be awarded and that is contingent on whether the Tribunal has jurisdiction and therefore, a request to add a special award should not be taken lightly.

ORDER: I ordered that the issue of whether the applicant is entitled to an award pursuant to section 10 of regulation 664 (often still referred to as a special award) be added as an issue for the hearing. I agree with the respondent that to decide whether the applicant is in fact entitled to a special award without full submissions is akin to trial by ambush. If the applicant is successful in whole or in part in this appeal, I will ask the parties for written submissions on entitlement and rule on the issue then. With respect to the jurisdictional argument raised by the respondent, I indicated that to date the Tribunal has heard many cases on the issue of a special award and from its motion material, I did not take the arguments to mean that the Tribunal does not have jurisdiction to add a special award as an issue in dispute but rather whether the Tribunal has jurisdiction to award it. In the

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[47] *Aviva Canada Inc. v. Peters, FSCO Appeal P06-00013*

event that the applicant is successful I will request submissions on the jurisdiction at the same time as submissions on entitlement.

#3 - Production of Adjuster's Log Notes -The applicant requests the production of the adjuster's log notes. The applicant is seeking the log notes for the period up to February 2016 (when a FSCO application was filed) and from February 5, 2016 (the period that the FSCO application was closed) to October 25, 2016, the time the LAT application was submitted.

The applicant requests the log notes because he cannot determine when the respondent remove him from the MIG and does not know why he was removed from the MIG.

The respondent claims litigation privilege from the date of the application. The issues in the FSCO and LAT applications overlap. The applicant agreed that there are issues in the FSCO and LAT applications that overlap and that there are new issues in dispute as well.

The respondent acknowledged that the applicant was removed from the MIG. It takes the position that he was removed on February 8, 2016 and a letter was sent to his counsel advising that the applicant "had been removed from the *Minor Injury Guideline*".

The respondent submits that "it appears" the applicant was removed from the MIG in "good faith" on February 8, 2016 based on evidence of psychological impairment.

The applicant submits that it is clear he was taken out of the MIG prior to February 8, 2016 because the February 8, 2016 correspondence indicates the applicant "*had been removed*" from the MIG.

ORDER: At the hearing, I ordered that the respondent produce the log notes redacted for privilege. There is a significant issue as to when the applicant was removed from the MIG and it is not clear from the evidence presented when that was.

Subsequent to my Order, the respondent consented to providing the log notes which were entered as Exhibit #57.

#4 - Applicant requests the Clinical Notes and Records from Dr. Lazarov (CNRs from the last assessment in 2017 are missing)

The respondent did not object to producing the CNRs if in fact he made notes during that assessment.

Given that the respondent did not object I did not hear submissions or make an order.

#5 - Respondent's Objection to Applicant's Spouse Testifying

The respondent objected to the applicant's wife testifying. The respondent submits that the applicant's wife has a history of over exaggerating and provided an example where

she insisted that the applicant be sent for a neurocognitive assessment the results of which were normal. In addition, the respondent submits that the case conference summary requires the parties to list the witnesses they intend to call at a hearing.

The applicant submits that on July 21, 2017 he put the respondent on notice that he would be calling his spouse to testify[48]. The respondent did not object when it received the letter indicating that the applicant's wife would be called as a witness.

The case conference order dated March 17, 2017 lists the witnesses who, at that time, the parties intended to call. Paragraph 7 ordered the parties to disclose particulars with respect to the witnesses the parties intended to call in accordance with Rule 9.2 of the *Licence Appeal Tribunal's Rules of Practice* (the "Rules") which requires the parties to disclose a list of witnesses a party may call to give evidence and a brief description of the anticipated testimony at least 10 days before the hearing.

ORDER: I find that the applicant complied with the March 17, 2017 order and the *Rules* when he put the respondent on notice by letter dated July 21, 2017 that he would be calling his wife to testify. The respondent did not deny receiving the July 21, 2017 correspondence and had ample time to address concerns prior to the hearing. The applicant's wife is not an expert and this is not a situation where the respondent will need a corresponding report for example and her evidence will be given its proper weight.

[48] Exhibit #1

APPENDIX "B: - Calculation of Issue 4(j) – Driver Rehabilitation (Skill Builders)[49]

G/S Ref	Description	Quantity	Cost (OCF-18)	Total count	Total Cost	Ordered
1	Training, cognition & learning	1.5	217.20	3	651.60	149.63x3=448.88
1	**Approved by insurer**	1.5	87.29 (58.19/hr)	3	261.87	
2	Training, cognition & learning	1.00	144.80	5	724.00	99.75x5=498.75
2	**Approved by insurer**	1.00	58.19/hr	5	290.95	
3	Provider travel time, provider to treatment	1.00	144.80	5	724.00	99.75x5=498.75
3	**Approved by insurer**	1.00	58.19	5	290.95	
4	Training, cognition & learning	2.00	329.60	1	329.60	99.75x2=(199.50/hr) = 199.50
4	**Approved by insurer**	2.00	58.19 + 99.75/hr x 2 = (315.88)	1	315.88	
5	Provider travel time, provider to treatment	1.00	164.80	1	164.80	99.75
5	**Approved by insurer**	1.00	58.19 + 99.75/hr = 157.94	1	157.94	
6	Brokerage service	0.5	49.88	1	49.88	0.00
6	**Approved by insurer**				0.00	
7	Brokerage service	0.5	49.88	1	49.88	0.00
7	**Approved by insurer**				0.00	
8	Documentation support activity	1.0	200.00	1	200.00	200.00
8	**Approved by insurer**	1.0	200.00	1	200.00	
9	Documentation support activity	1.0	200.00	1	260.00	260.00
9	**Approved by insurer**	1.0	200.00	1	260.00	
	Auto insurer total				**3153.76**	
	Approved by insurer				**1777.59**	
	Ordered Total					**$2,205.63**

[49] The calculations in the OCF-18 were incorrect. I have calculated the rate at $99.75 per hour and multiplied by the number of sessions indicated under the "total count" column.