Citation: K.M. v. Aviva Insurance Company, 2019 ONLAT 18-010438/AABS

Date: January 14, 2019
File Number: 18-010438/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:

K.M.

Applicant

and

Aviva Insurance Company

Respondent

DECISION AND ORDER

ADJUDICATOR: **Marisa Victor**

APPEARANCES:

For the Applicant: Kim Mohammed-Sieudhan, Paralegal

For the Respondent: Sjawal Bhutta, Counsel

HEARD: In Writing **Hearing: June 17, 2019**

OVERVIEW

[1] The applicant, K.M., was involved in an automobile accident on June 13, 2016, and sought and received accident benefits from the respondent ("Aviva") pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010 (the "Schedule").* After Aviva denied the applicant's requests for further treatment, on the basis that the proposed plans and examinations were not reasonable and necessary, the applicant submitted an application to the Licence Appeal Tribunal - Automobile Accident Benefits Service (the "Tribunal") to appeal the denial.

[2] After reviewing the parties' submissions, I find the proposed treatment and assessments are not reasonable and necessary.

ISSUES

[3] The following are the issues in dispute:

i. Is the applicant entitled to receive medical benefits in the amount of $3,939.43 for chiropractic services recommended by Complete Rehab Centre in a treatment plan submitted March 13, 2017, and denied by the respondent on May 15, 2017?

ii. Is the applicant entitled to receive medical benefits in the amount of $1,816.74 for chiropractic services recommended by Complete Rehab Centre in a treatment plan submitted July 23, 2018, and denied by the respondent on July 28, 2018?

iii. Is the applicant entitled to receive the costs of examination in the amount of $2,460 for a psychological assessment recommended by Dr. Jon Mills in a treatment plan submitted August 30, 2017, and denied by the respondent on September 26, 2017?

iv. Is the applicant entitled to receive the costs of examination in the amount of $2,680 for an orthopedic assessment recommended by Dr. Duong Nguyen in a treatment plan submitted August 15, 2017, and denied by the respondent on August 17, 2017?

v. Is the applicant entitled to receive the costs of examination in the amount of $2,680 for a chronic pain assessment recommended by Complete Rehab Centre in a treatment plan submitted August 1, 2018, and denied by the respondent on August 2, 2018?

vi. Is the applicant entitled to interest on any overdue payment of benefits?

RESULT

[4] The applicant has not established that the claimed benefits are reasonable and necessary. As there are no overdue payment of benefits, the applicant is not entitled to interest.

PRELIMINARY ISSUE

[5] Aviva states that it would be procedurally unfair to allow the applicant to rely on certain portions of her family doctor's records. First, Aviva argues that the applicant failed to disclose these records in accordance with the Rules.[1] Additionally, Aviva argues that the records were not fully disclosed in the applicant's case conference summary (the family doctor's records says "page 1 of 3" but the other pages are not disclosed) and the documents were not provided to any of the doctors who conducted assessments.

[6] In response, the applicant provides no explanation as to why these documents were not previously disclosed or where the missing pages are.

[7] I do not find that the disclosure of the family doctor's records violates the Rules. The case conference order does not state that new evidence, beyond that which was provided prior to the case conference, is barred. The case conference order sets dates for the submission of submissions and evidence. The applicant submitted the family's doctor's records in accordance with the case conference order, and therefore complied with the timelines in the Rules.

[8] There does not appear to be a violation of the Rules or of the case conference order. Neither has the respondent pointed to prejudice it would suffer if the documents are considered. That being said, the missing pages of the doctor's records can go to the weight placed on those documents.

[9] The documents are admitted.

ISSUE I - THE APPLICANT IS NOT ENTITLED TO THE FIRST TREATMENT PLAN FOR CHIROPRACTIC SERVICES

[10] I find that the applicant has not shown that it is reasonable and necessary to receive the chiropractic services.

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[1] *Licence Appeal Tribunal, Animal Care Review Board, and Fire Safety Commission Common Rules of Practice & Procedure, Version I (October 2, 2017)* (the Rules)

[11] Before deciding on each plan, I note that the onus is on the applicant to establish that the disputed plan is reasonable and necessary.

[12] The treatment plan of $3,939.43 for chiropractic services was initially denied because the respondent took the position that the applicant was within the Minor Injury Guideline (MIG). The applicant states that the respondent subsequently removed the applicant from the MIG and, therefore, this treatment plan should be approved.

[13] The applicant states that her injuries included the following: sprain and strain of the cervical spine, thoracic spine, lumbar spine, and shoulder joint; stress, disorders of initiating and maintaining sleep; as well as psychological complaints including anxiety and mood disturbances. Further, the applicant claims that she gave birth prematurely to twins as a result of the accident. She required a c-section on June 20, seven days post-accident, despite being due July 15. The twins then suffered from low birth weight and respiratory distress, while the applicant suffered from postpartum depression, asthma attacks, breast feeding issues, incision issues and ongoing physical pain related to the birth. She seeks chiropractic treatment to address all of the above.

[14] The respondent states that there is no evidence the applicant requires further chiropractic treatment beyond what she has already received. The respondent states that after the applicant was removed from the MIG, two other chiropractic treatment plans at the same facility were approved. The respondent states that this plan is no longer needed.

[15] The respondent also requested that the applicant attend an IE with Dr. Abuzgaya, in May 2017, who diagnosed the applicant with a lumbosacral sprain but found the applicant had full range of motion. Around the same time, the respondent approved a different treatment plan for $2,200 at the same chiropractic facility. The respondent then approved a further treatment plan for chiropractic treatment dated July 10, 2017. The respondent states that despite the approvals, the applicant elected not to attend the chiropractic clinic until May 2018. The respondent states that there is no evidence of a need for further treatment.

[16] The respondent also argues that the medical documentation does not support that the applicant's twins were born prematurely as a result of the accident and therefore chiropractic treatment to address those alleged concerns is not related to the accident. The respondent points to the following:

i. Ambulance call report notes the applicant has a scheduled c-section June 20;

ii. The applicant reported to Dr. Mills, her own psychologist, that an ultrasound was done at the hospital following the accident and she was advised that her babies were fine; and

iii. The applicant reported to Dr. Abuzgaya that she delivered her babies via scheduled c-section on June 20.

[17] Finally, the respondent submits that the applicant has failed to address whether the denied treatment plan is reasonable and necessary and is instead relying on the fact that the applicant is now out of the MIG.

[18] I agree with the respondent's position. The applicant has failed to submit evidence that shows on a balance of probabilities that the treatment plans are reasonable and necessary. This is especially true in light of the two chiropractic plans that were approved after the denied plan at issue. There is no evidence from the applicant showing that an additional chiropractic treatment plan beyond what has already been received is reasonable and necessary.

[19] In relation to the birth of the twins, I also agree with the respondent that the medical evidence does not support that the c-section was ordered as a result of the accident or that the delivery date was changed as a result of the accident. The applicant has failed to show on a balance of probabilities that the birth and any related post-partum complaints are related to the accident.

[20] The evidence fails to support that the denied treatment plan for chiropractic treatment is reasonable and necessary.

ISSUE II - THE APPLICANT IS NOT ENTITLED TO THE SECOND TREATMENT PLAN FOR CHIROPRACTIC SERVICES

[21] I also find that the appellant has not shown that this treatment plan for chiropractic services is reasonable and necessary. My conclusion is based on the applicant's failure to adduce enough evidence to support the need for the plan.

[22] The applicant's submissions are entirely based on the adequacy of the denial on July 28, 2018. The applicant did not provide further evidence as to why the treatment plan is reasonable and necessary.

[23] The applicant states that the plan was denied on July 28, 2018 on the basis that the applicant was in the MIG but did not offer any medical reason as to the denial. However, the applicant was previously taken out of the MIG on September 26, 2017. The applicant also says that the denial by the respondent is inadequate and therefore triggers the mandatory provisions of s. 38(11) of the *Schedule*.

[24] The respondent states that the second treatment plan was denied following the IE conducted by Dr. Siddiqui on October 2, 2018. The respondent wrote to the applicant on October 16, 2018 and advised that, based on Dr. Siddiqui's findings in the IE, the denial was maintained. Dr. Siddiqui found that that applicant had full range of motion and therefore no further treatment was reasonable or necessary.

[25] The respondent did not provide a response to the appellant's submissions regarding the adequacy of the denial.

[26] I find that the initial denial is inadequate given the applicant was already out of the MIG at the time the treatment plan was denied. However, the denial was proper as of October 16, 2018 when the applicant was provided with the IE report and a formal denial based on that report. The mandatory provisions of s. 38(11), that incurred treatments are to be paid for until proper notice is given, is triggered between July 28, 2018 and October 16, 2018. That being said, I was provided with no evidence that the any benefits had been incurred during that time.

[27] Beyond the date of the proper denial, the applicant has failed to provide evidence that supports that the treatment plan is reasonable and necessary. Dr. Siddiqui's IE report, on the other hand, provides evidence that the applicant would not benefit from the treatment plan given that she has reached maximal recovery and has full range of motion. The evidence does not support that the treatment plan is reasonable and necessary.

ISSUE III - THE APPLICANT IS NOT ENTITLED TO RECEIVE THE COST OF THE EXAMINATION FOR PSYCHOLOGICAL ASSESSMENT

[28] I find that the appellant has not shown that the denied amount of the treatment plan for a psychological assessment ($1317.93) is reasonable and necessary.

[29] The applicant notes that she submitted a second treatment plan for $2,460 for psychological services. The applicant submits that the respondent's IE conducted by Dr. Moshiri showed that she suffers from insomnia disorder, sleep

disorder, adjustment disorder, mixed anxiety and depressed mood. The applicant states that, based on that IE, the first treatment and assessment plan by Dr. Mills that recommends a full psychological assessment, should have been approved. Additionally, Dr. Mills' assessment was incurred and completed on August 18, 2017. The applicant summarizes the resume of Dr. Mills and his recommendation that a full assessment is needed. The applicant states that Dr. Mills' opinion is enough to establish that the plan is reasonable and necessary.

[30] The respondent states that the treatment plan was partially approved in the amount of $1,322.07 and the dispute is only for the remaining $1,317.93. Dr. Moshiri calculated that the approved amount was reasonable based on seven hours of assessment at a rate of $149/hour and $200 for completion of the OCF-18. The respondent states that the applicant has failed to address why the remaining amount is reasonable and necessary. The respondent also states that the assessment contemplated in the plan was actually completed by Mr. Dhaliwal, M.Sc. under the supervision of Dr. Mills, yet there are no particulars with regard to the level of that supervision.

[31] I find that the applicant failed to address that some of the plan was approved, and what the remainder of the treatment plan was for. The applicant has therefore failed to show how the treatment plan is reasonable and necessary. Further, I find the applicant's reliance on Dr. Mills' qualifications and opinion lacking as sufficient evidence that the plan is reasonable and necessary. This is because neither the initial assessment nor the incurred assessment were conducted by Dr. Mills. Instead the assessments were conducted by other individuals under Dr. Mills' supervision without any details as to what that supervision amounts to. Given the lack of information regarding Dr. Mills' involvement in the assessments, it is difficult to place any weight on Dr. Mills' qualifications and opinion.

[32] The onus is on the applicant to establish that the portion of the plan denied is reasonable and necessary. I find that the totality of the evidence presented fails to establish that that the remainder of the denied plan is reasonable and necessary.

ISSUE IV - THE APPLICANT IS NOT ENTITLED TO RECEIVE THE COST FOR AN ORTHOPAEDIC ASSESSMENT

[33] I find that the appellant has not established that the orthopaedic assessment is reasonable and necessary.

[34] The applicant argues that the treatment plan was denied based on Dr. Siddiqui's IE on October 2, 2018 that found that the applicant had no barriers to recovery and had no substantial limitations or restrictions. The applicant states no weight should be given to this report given the opinion was reached without reviewing essential medical documents. The applicant does states that Dr. Siddiqui's report supports that the applicant has continuing neck pain, headaches, shoulder pain and back pain.

[35] The applicant submits that, in contrast, Dr. Nguyen, the applicant's orthopaedic specialist, found during the orthopaedic examination at issue that the applicant's injuries were serious and permanent based on the chronic nature of the applicant's symptoms and impaired functional ability. For that reason, the assessment should be approved.

[36] The respondent agrees that the denial was based on Dr. Siddiqui's IE. Dr. Siddiqui found that the applicant's injuries were soft tissue in nature and there would be no further benefit from a second orthopaedic assessment.

[37] The respondent submits that based on Dr. Siddiqui's report, the applicant did not sustain an orthopaedic injury, has functional range of motion and is independent in all self-care tasks, therefore the assessment is not reasonable and necessary.

[38] The respondent further submits that Dr. Nguyen's report should be discounted as it states that the applicant suffers from a serious and permanent injury, but that test is applicable only in a tort claim and has no bearing on accident benefits and has no relevance to the Schedule.

[39] I find that the applicant has failed to show that an orthopaedic assessment is reasonable and necessary. I disagree that Dr. Siddiqui's IE should be given no weight based on the failure to review other medical records. The applicant does not state which records would support the need for an orthopedic assessment or how those records contradict Dr. Siddiqui's findings.

[40] Neither party addressed the findings of the earlier orthopaedic assessment conducted by Dr. Abuzgaya in May 2017 on behalf of the respondent. This report was done eleven months after the accident. At the time, the applicant had returned to her part-time job and was enrolled in a Coronary Care nursing program. She did not report any difficulties with activities of daily living. Her primary concern was lower back pain.

[41] In comparison, Dr. Nguyen's "Orthopedic Medicolegal Assessment Report" was conducted approximately a year later. The report diagnoses soft tissue injuries and chronic pain. The conclusion notes that the chronic pain had resulted in a loss of earning capacity, inability to perform activities of daily living, housekeeping activities, social/recreational activities as well as work. I prefer the earlier information in Dr. Abuzgaya's report that indicates the applicant has returned to work and has no difficulty with activities of daily living. Later, the applicant reports similar information to Dr. Siddiqui, several months after Dr. Nguyen's report. I also prefer the evidence of Dr. Siddiqui that finds the applicant has soft tissue injuries and that there is no barrier to recovery as she did not suffer an orthopedic injury in the accident.

[42] It is also unclear how Dr. Nguyen found a loss of earning capacity, and loss of ability to work. The applicant self-reports that she works part-time as a cashier at the grocery store and works full-time as a registered nurse. The applicant does not report symptoms of chronic pain that disrupt her work or social life. I therefore find that the applicant has failed to establish that the denied orthopaedic assessment is reasonable and necessary.

ISSUE V - THE APPLICANT IS NOT ENTITLED TO THE CHRONIC PAIN ASSESSMENT

[43] I find the applicant has failed to establish that she suffers from chronic pain symptoms such that the treatment plan is reasonable and necessary.

[44] The applicant argues that the treatment plan is reasonable and necessary because she has not reached maximal medical recovery and continues to suffer from pain three years after the accident. She states that her medical evidence establishes she suffers from chronic pain syndrome. In particular, the applicant states the family doctor records of Dr. Abbasiranjbar confirm chronic mechanical back pain and dysfunction of the SI joints.[2] In addition, the applicant points to Dr. Nguyen's recommendation for a chronic pain assessment.

[45] The respondent states that Dr. Siddiqui's IE addressed this treatment plan as well. The respondent states that the applicant's medical documents do not establish chronic pain as there are only three family doctor visits that note ongoing pain (not including the 2018 records). Finally, the respondent relies on the fact that the applicant has returned to full time work, has been on several vacations and therefore does not show the activities of someone experiencing

[2] These are the 2018 records disclosed through the hearing process and referred to under preliminary issue.

chronic pain. The respondent states that the applicant fails to meet the criteria set out in the LAT decision of *MNM v. Aviva Insurance Canada* (17-007825/AABS) ("MNM").

[46] Although the decision in MNM is not binding on me, I do find that the criteria for chronic pain syndrome discussed in that decision is helpful. The decision refers to the criteria in the American Medical Association which requires three of the following criteria to be met before chronic pain syndrome is diagnosed:

i. Use of prescription drugs beyond recommended duration;

ii. Excessive dependence on health care providers;

iii. Secondary physical deconditioning due to disuse, or fear-avoidance due to pain;

iv. Withdrawal from social milieu, work, recreation or other social contracts;

v. Failure to restore pre-injury function after a period of disability, such that the physical capacity is insufficient to pursue work, family or recreational needs;

vi. Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression or nonorganic illness behaviors.

[47] I find that the applicant has only arguably met one of the above criteria. First, the applicant's medical records establish a prescription for Naproxen; however, the 2018 medical records note the applicant states "takes rarely only when pain is very bad". This does not show use beyond the recommended duration. There is no evidence to support criteria ii or iii. I do not find the evidence supports criteria iv, given the applicant's return to work and that she completes activities of daily living. The only criteria she arguably meets is criteria vi.

[48] I also find the applicant has failed to establish that she suffers from chronic pain symptoms through her medical records. The medical documentation points to three appointments in 2017 with her family doctor, each complaining of pain in different body parts - upper back and pain (Feb 10, 2017), right shoulder pain (February 28, 2017) and back pain (November 7, 2017). The 2018 record appears to report chronic pain, though two pages are missing. There is no information as to how the doctor came to this conclusion or whether it takes into account her return to work and ability to take part in daily activities. I find that these records do not establish chronic pain syndrome.

[49] Given the above, the treatment plan is not reasonable or necessary.

ISSUE VI: THE APPLICANT IS NOT ENTITLED TO INTEREST ON ANY OVERDUE PAYMENT OF BENEFITS

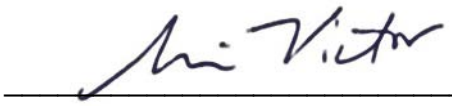
[50] As there are no overdue payment of benefits, the applicant is not entitled to interest on any overdue amounts.

CONCLUSION

[51] The applicant has failed to establish on a balance of probabilities that the denied treatment and assessment plans are reasonable and necessary.

[52] As there are no overdue payment of benefits, the applicant is not entitled to interest on any overdue amounts.

Released: January 14, 2018



Marisa Victor
Adjudicator