LICENCE APPEAL TRIBUNAL

TRIBUNAL D'APPEL EN MATIÈRE DE PERMIS

Safety, Licensing Appeals and Standards Tribunals Ontario

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

Ontario

Tribunal File Number: 17-003957/AABS

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

Between:

[The applicant]

Applicant

and

Aviva Insurance Canada

Respondent

DECISION

ADJUDICATOR: **Anita Goela**

APPEARANCES:

Counsel for the Applicant: Kaity Yang

Counsel for the Respondent: Ramandeep Pandher

Written Hearing: **May 24, 2018**

OVERVIEW

[1] [The applicant], was injured in a motor vehicle accident (“accident”) on October 4, 2015. The car was written off as a loss due to extensive damage.

[2] The applicant was 24 years old at the time of the accident and reported pain to her neck, shoulders, back and hips. She also reported psychological injuries including depression, anxiety and post-traumatic stress.

[3] The applicant applied for and was denied certain benefits under the *Statutory Accident Benefits Schedule - Effective September 1, 2010* ("*Schedule*") from the respondent, Aviva Insurance Canada. She appealed the denials to the Licence Appeal Tribunal – Automobile Accident Benefits (“Tribunal”).

ISSUES

[4] I must decide the following issues in dispute:

(a) Is the applicant entitled to receive medical benefits recommended by the Jacobs Pain Centre in the amounts of:

i. $3,187.90 for physiotherapy services in a treatment plan dated October 8, 2015, denied by the respondent on February 3, 2016?

ii. $2,000.00 for a chronic pain assessment in a treatment plan dated April 3, 2017, denied by the respondent on June 2, 2017?

(b) Is the applicant entitled to receive a medical benefit in the amount of $2,313.30 for physiotherapy services, recommended by the Pro Active Health Group, in a treatment plan dated February 21, 2016, denied by the respondent on May 3, 2016?

(c) Is the applicant entitled to receive a medical benefit in the amount of $2,960.26, partially approved in the amount of $2,314.54 and partially denied in the amount of $645.72, for psychological services, recommended by the Elite Specialist Group, in a treatment plan dated December 16, 2016, denied by the respondent on February 16, 2017?

(d) Is the applicant entitled to interest for the overdue payment of benefits?

(e) Is either party entitled to costs?

RESULT

[5] The applicant is entitled to all of the disputed treatment plans. As the benefits are payable, interest is owing on any incurred expenses for which payment is overdue.

[6] Neither party is entitled to costs.

ANALYSIS

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

[8] The applicant's clinical notes and records from her family doctor, Dr. Aujla, were submitted as evidence in support of her position that the treatment plans are reasonable and necessary. Overall, I found Dr. Aujla's notes and recommendations to be comprehensive and persuasive with respect to the disputed treatment plans.

[9] Dr. Aujla has been the primary care physician for the applicant for the past few years, including at the time of the accident. Dr. Aujla referred the applicant for an MRI, recommended that she use a back brace during back-loading activities, engage in modified duties at work and on August 3, 2017 diagnosed the applicant as suffering from chronic pain.

[10] The respondent agrees with the physical observations made by Dr. Aujla as they are similar to those made by its medical assessor, Dr. Khan. However, the respondent disagrees with the conclusions of Dr. Aujla. The respondent disagrees that the applicant's physical impairments warrant continued active treatment and that the applicant suffers from chronic pain. The respondent also raises issues with the credibility of the treatment providers who completed the physiotherapy treatment plans as the applicant works as a massage therapist at the same clinics.

[11] On balance, I find the conclusions of Dr. Aujla with respect to the applicant's injuries to be more persuasive than those of Dr. Khan. Dr. Aujla's observations, recommendations and conclusions span several years. Dr. Aujla is aware of the applicant's occupation, her physical limitations and psychological impairments. I

am persuaded that Dr. Aujla found the physiotherapy treatment beneficial for the applicant, including the need for a back brace to alleviate the applicant's pain.

[12] With respect to the applicant working at the same clinics as the treatment providers, I agree with the applicant that the respondent has not provided adequate explanation as to how the treatment providers' credibility is called into question because the applicant works at the same clinics. I am not persuaded by the respondent's submission that there are a "number of inconsistencies in the treatment plan in relation to noted injuries versus actual documented entries". I agree with the applicant's submission that a treatment provider may list the complaints and impairments that an applicant is experiencing even if those complaints and impairments are not listed in the applicant's other medical records.

[13] With respect to psychological treatment, the respondent's position is that the treatment plan is partially reasonable and necessary. The respondent relies on the assessment of Dr. Cobrin, psychologist, in denying the $645.72 balance. Dr. Pilowsky requested 4 hours of funding to complete the formal reassessment and discharge report. Dr. Cobrin finds that two hours are reasonable and necessary for that purpose. Finally, Dr. Pilowsky requests 12PR[1], payable at a rate of $21 per session, to complete writing session notes at the end of each of the 12 psychotherapy sessions. Dr. Cobrin finds that these 12PR are not reasonable and necessary as it common practice that the last 10 minutes of a 60 minute psychotherapy session to be allotted to writing session notes.

[14] I find that Dr. Pilowsky's notes and report demonstrate that the psychological treatment the applicant received was helpful. The applicant's ongoing symptoms, including difficulty managing her emotions and using alcohol to cope, provided a basis for the therapy. The applicant benefited from supportive counselling and cognitive behavioural therapy. The applicant was engaged during the sessions. The psychological assessment provided in support of the treatment was detailed and provided a reasonable basis for the respondent to, at least partially, approve the treatment plan.

[15] Therefore, I find that it is undisputed that the applicant has demonstrated the reasonableness and necessity of psychological treatment. The respondent submitted that four hours instead of two hours for the formal reassessment and discharge report is unreasonable and that the applicant did not benefit from the

[1] PR stands for "Procedure" – Unit measure for a service for which there is a standardized process of delivery which neither varies in application or time; i.e. x-ray, manipulation, missed appointment, etc. http://www.hcaiinfo.ca/Health-Care-Facility/documents/Codes/Unit-Measures.pdf

full 60 minutes of the psychological sessions. I am not persuaded by this submission. As indicated above, I find that the applicant's psychological assessment in support of the disputed psychological treatment plan was sufficiently detailed and demonstrated the reasonableness and necessity for the psychological treatment. I am persuaded that Dr. Pilowsky required four hours for the formal reassessment and discharge report and that the applicant did benefit from the full 60 minute psychological sessions.

[16] With respect to issue [4](a)(i) regarding physiotherapy services for the treatment plan dated October 8, 2015, the applicant raised concerns about the respondent's alleged non-compliance with s. 38(8) of the *Schedule* requiring notice of what the insurer agrees or refuses to pay for and why. As I have already found the applicant to be entitled to the disputed benefits, it is unnecessary to conduct this analysis.

[17] With respect to the claims for costs, Rule 19 of the Common Rules of Practice & Procedure requires that the party claiming costs demonstrate that the other party's conduct was unreasonable, frivolous, vexatious or in bad faith. The only submission made by the applicant with respect to Rule 19 is that the respondent did not attempt to resolve the issues in dispute despite the clear medical evidence. I do not find that this conduct reaches the threshold required by Rule 19. Other than this submission, no other submissions were provided by either party with respect to Rule 19. As such, I do not find that there is a basis to award costs to either party.

ORDER

[18] The applicant is entitled to the medical benefits in dispute and the relevant treatment plans are payable with interest owing in accordance with section 51 of the *Schedule*.

Released: November 13, 2018

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Anita Goela
Adjudicator