LICENCE APPEAL TRIBUNAL

Safety, Licensing Appeals and Standards
Tribunals Ontario

Ontario

Date: **October 26, 2016**
Tribunal File Number: **16-000087/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:

Clement Subramaniyam

Applicant

and

Unifund Assurance Company

Respondent

DECISION

Adjudicator: **Lan An**

Written Submissions By:

For the Applicant: David Levy, Counsel

For the Respondent: Gina Nardella, Counsel

Hearing in Writing on: **September 8, 2016**

REASONS FOR DECISION AND ORDER

OVERVIEW

1. The Applicant, Clement Subramaniyam, was injured in a motor vehicle accident on May 6, 2013. He applied for and received benefits under the *Statutory Accident Benefits Schedule – Effective after September 1, 2010* (the "*Schedule*").

2. The Respondent, Unifund Assurance Company, denied the Applicant's claim for medical benefits on four treatment plans. The Respondent also claims that two of these four treatment plans are statute barred. I have found that one of these two treatment plans is statute barred because the Applicant has brought it outside the limitation period.

3. The dispute over the medical benefit centres on the nature and extent of the Applicant's injuries. The Applicant submits that his injuries are extensive and that he is entitled to access a maximum of $50,000 of medical and rehabilitation benefits pursuant to s. 18(3) of the *Schedule*. The Respondent takes the position that his injuries are predominately minor and that s. 18(1) caps medical and rehabilitation benefits at $3,500 for predominantly minor injuries. As there is $0.77 left in the $3,500 limit, the Respondent takes the position that it has no further liability to the Applicant. The resolution of this matter depends on the sufficiency of the medical evidence put forward by the Applicant in support of his position.

ISSUES TO BE DECIDED

4. Of the four treatment plans in issue, the Respondent raises the following preliminary issues with respect to two of them:

    a. Is the Applicant prevented from pursuing a medical benefit in the amount of $200.00, the balance on a Treatment and Assessment Plan (OCF-18) dated August 30, 2013 (the "First Treatment Plan"), because he brought this proceeding more than two years after the Respondent denied his claim?

    b. Is the Applicant prevented from pursuing a medical benefit in the amount of $3,874.28, on a Treatment and Assessment Plan (OCF-18) dated November 7, 2013 (the "Second Treatment Plan"), because he brought this proceeding more than two years after the Respondent denied his claim?

5. The following are the main issues in dispute:

   (1) Did the Applicant suffer predominantly minor injuries in the May 6, 2013 motor vehicle accident?

   (2) If the answer to question (1) above is no,

      (a) Is the Respondent liable to pay the following medical benefits:

         i. The First Treatment Plan,
         ii. The Second Treatment Plan,
         iii. $2,941.80 for physiotherapy services, the balance on a Treatment and Assessment Plan (OCF-18) dated February 3, 2014 (the "Third Treatment Plan"), and
         iv. $3,364.05 for physiotherapy services, the balance on a Treatment and Assessment Plan (OCF-18) dated August 11, 2014 (the "Fourth Treatment Plan").

   (3) Is the Applicant or the Respondent entitled to its costs of this proceeding?

RESULT

6. The Tribunal finds on all of the evidence that the Applicant suffered predominantly minor injuries. However, there is compelling evidence of a pre-existing medical condition preventing the Applicant from recovering within the minor injury treatment cost limits.

7. The Tribunal has declined ordering costs against either party.

ANALYSIS

Preliminary Issue – Limitation Periods

8. Section 56 of the *Schedule* states the following:

   Time limit for proceedings

   An application under subsection 280 (2) of the Act in respect of a benefit shall be commenced within two years after the insurer's refusal to pay the amount claimed.

9. The Respondent denied the First Treatment Plan on September 23, 2013 and denied the Second Treatment Plan on December 20, 2013.

10. The Applicant applied to this Tribunal for dispute resolution on April 25, 2016. Clearly this is more than two years from the two dates of denial. However, in order for the Respondent to rely on the expiration of the limitation period, it must demonstrate that the Applicant failed to apply for mediation at the Financial Services Commission of Ontario (FSCO) before two years had elapsed and, if he did apply within two years, that he applied to this Tribunal no later than 90 days from receiving the FSCO Mediator's Report.

11. The Applicant submitted an Application for Mediation, listing the First Treatment Plan and the Second Treatment Plan as issues in dispute, at FSCO on November 9, 2015, which was received via facsimile on the same day (see Applicant's Written Submissions dated August 30, 2016).

12. The Tribunal finds that the First Treatment Plan is statute barred as it was submitted to FSCO more than two years after the Respondent denied it. However, the Tribunal finds that the Second Treatment Plan is not statute barred as it was submitted within the two year period after the Respondent denied it. The Mediator's Report was issued on April 7, 2016, and the Applicant applied to this Tribunal 18 days later on April 25, 2016. The Tribunal finds that the Applicant applied to this Tribunal within 90 days from the date of issuance of the Report of Mediator.

SUBSTANTIVE ISSUES

The Minor Injury Issue

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

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

15. In *Scarlett v. Belair Insurance*, 2015 ONSC 3635 ("*Scarlett*"), the Divisional Court reviewed the minor injury provisions in the *Schedule*, finding that they were a limit on an insurer's liability, not an exclusion from coverage, and that the onus of establishing entitlement beyond the cap rests with the claimant. Applying *Scarlett*, the Applicant must establish his entitlement to a higher level of coverage than the $3,500 for minor injuries.

16. The evidence provided by both parties at the hearing was documentary. The Tribunal has considered all of the documents submitted by each party.

17. From the Applicant's submissions and evidence, it appears that he accepts that his injuries sustained in the motor vehicle accident, resulting in neck pain and lower back pain, fall within the definition of minor injuries as defined in the *Schedule*. However, he asserts that he has a pre-existing medical condition, chronic disc disease at L5-S1, that prevent him from achieving maximal recovery from the minor injuries if he is subject to the $3,500 limit. In other words, he is asserting that the motor vehicle accident aggravated his pre-existing lower back condition and is unable to achieve maximal recovery if he is subject to the $3,500 limit.

18. As such, I will focus my enquiry on the question of whether there is compelling evidence that the Applicant suffered from a pre-existing condition, documented by a healthcare practitioner before the accident, preventing him from achieving maximal recovery if subjected to the $3,500 limit?

Is There Evidence of Pre-Existing Medical Condition?

19. Prior to the motor vehicle accident, Dr. J. Chin reported that the x-ray (conducted on January 19, 2013) showed moderate to severe degenerative disc disease, (which means there is less space between vertebrae as the disc is becoming compressed) and spondylolisthesis at the L5-S1. I note that this is often consistent with lower back pain.

20. This imaging corresponds with the clinical notes of the Applicant's family physician, Dr. Vaithianathan. In his clinical note for January 19, 2013, Dr. Vaithianathan noted that the Applicant complained of having back pain for over three years with pain radiating down the right leg (sciatica). In his clinical note for March 23, 2013, Dr. Vaithianathan reported the results from the x-ray of January 19, 2013 as degenerative disc disease and spondylolisthesis at the L5-S1.

21. Two days after the motor vehicle accident, Dr. Vaithianathan noted that the Applicant had increased musculoskeletal and sciatica pain

22. Subsequently, Dr. J. Chin reported that the x-ray (conducted on June 6, 2015) now shows severe degenerative disc disease at the L5-S1 and a grade 2 anterolisthesis with no obvious spondylolysis seen at the L5.

23. In an MRI, conducted on November 7, 2015, Dr. M. Prieditis reported and confirmed the grade 2 spondylolisthesis and broad-based disc bulging. He raised questions as to the presence of a spondylolysis at the L5-S1 level.

24. I find Dr. Vaithianathan's clinical notes (prior to the motor vehicle accident) and Dr. Chin's x-ray report of January 19, 2013 to be compelling evidence of a pre-existing medical condition because they show that the Applicant does not have a simple soft tissue condition but one that is substantiated on imaging by presence of structural degenerative changes and alignment problems due to the grade 2 spondylothesis. This is consistent with the chronic lower back pain symptoms reported by the Applicant prior to the motor vehicle accident. I must now consider if the Applicant's pre-existing lumbar spine condition prevents him from achieving maximal recovery if subjected to the $3,500 limit.

25. In his report, dated August 10, 2015, Dr. R. Wilson, the Applicant's neurologist and sleep consultant, stated that due to his lower back pain "he has had difficulty initiating and maintaining sleep" which has resulted in his energy being poor.

26. In his report, dated January 6, 2016, Dr. Wilson noted that the Applicant's leg pain has increased in severity, along with his lower back pain. Dr. Wilson pointed out that (due to his leg problem) he advised the Applicant to stop driving a motor vehicle as he was involved in two recent motor vehicle accidents because of loss of control of his right leg due to the altered feeling involving the right leg.

27. In his report, dated April 20, 2016, Dr. Wilson stated: "…this man presents with chronic recurring central lower back pain which I feel reflects the effects of the mechanical disturbances of the lumbar spine identified by the MRI of the lumbar

spine." He also states: "The altered feeling involved his feet and legs could reflect the effects of S1 nerve root irritation due to the degenerative changes involving the lumbar spine, myelopathy, or the restless leg syndrome…" Furthermore, Dr. Wilson noted that the Applicant reported that his lower back pain interfered with bending, lifting and twisting movements.

28. I find that the "mechanical disturbances" mentioned in Dr. Wilson's report of April 20, 2016 are due to the motor vehicle accident.

29. Based on Dr. Wilson's reports, I find that the Applicant is unable to achieve maximal recovery if subjected to the $3,500 limit due to his pre-existing lumbar spine condition.

30. The Respondent objects to Dr. Wilson's reports because they do not meet the requirement of section 4 of the MIG, which requires that documentation of a pre-existing medical condition must itself pre-date the accident. However, section 4 of the MIG does not state that the health practitioner's opinion about the pre-existing medical condition must pre-date the motor vehicle accident. It simply states that the medical condition must pre-date the motor vehicle accident.

31. I note that the Respondent relies heavily on Dr. E. Urovitz's report of May 11, 2016 and addendum of August 11, 2016. Although Dr. Urovitz was not provided with any of the Applicant's medical records prior to the motor vehicle accident (except for the OHIP summary for the period of February 8, 2009 to June 13, 2015) for the May 11, 2016 report, he was subsequently provided with the pre-accident medical records for the August 11, 2016 addendum. However, I prefer Dr. Wilson's reports over Dr. Urovitz's reports and Dr. Mascarenhas's report as Dr. Wilson conducted EMG and nerve conduction tests, while Dr. Urovitz and Dr. Mascarenhas did not do any testing. Furthermore, Dr. Wilson examined the Applicant on an ongoing basis which affords him the advantage of assessing and evaluating the Applicant's condition over time.

32. Although I have reviewed Dr. L. Mascarenhas's report of February 5, 2014, I have placed little weight on it as his report does not address the issue of a pre-existing medical condition. As stated earlier, it appears that the Applicant has conceded that his injuries fall within the definition of a minor injury as defined in the Schedule but he has a pre-existing condition which would him from achieving maximal recovery from the accident if limited to the $3,500.

33. Based on the evidence before me, I conclude that the Applicant has satisfied his onus to show there is compelling evidence that he cannot achieve maximal recovery within the MIG because of a pre-existing medical condition.

Are the Treatment Plans Reasonable and Necessary?

34. The onus is on the Applicant, to prove, on a balance of probabilities, that the Second Treatment Plan, the Third Treatment Plan and the Fourth Treatment Plan are reasonable and necessary. I note that the Applicant's counsel has not made any submissions with respect to whether these treatment plans are reasonable and necessary. As such, I decline to make a determination on this issue.

Costs

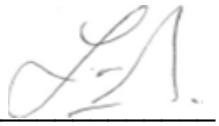
35. The *Licence Appeal Tribunal Rules of Practice and Procedure* (the "*Rules*") include a provision in Rule 19.1 for parties to request costs of the proceeding, if they believe that the other party has acted unreasonably, frivolously, vexatiously, or in bad faith. Rule 19.4 further sets out the requirements for that request, which must include the reasons for the request and the particulars of the alleged conduct.

36. Both parties have asked for costs in this proceeding. However, neither party has alleged the other party's conduct to be unreasonable, frivolous, vexatious, or in bad faith. Furthermore, neither party has set out the reasons for the request or the particulars of the other party's conduct. Both parties have failed to meet the threshold and requirements for costs set out in Rule 19. There is insufficient evidence of conduct that is unreasonable, frivolous, vexatious, or in bad faith before me, so I cannot make an order for costs in this matter. Therefore, no costs will be awarded.

Conclusion

37. In light of the foregoing, I find that the Applicant suffered predominantly minor injuries but there is compelling evidence of a pre-existing medical condition that would prevent recovery if limited to the $3,500 cap for medical and rehabilitation benefits. I also finds that the Applicant is not entitled to payment on the Second Treatment Plan, the Third Treatment Plan and the Fourth Treatment Plan because he failed to show that they were reasonable and necessary.

Released: October 26, 2016



Lan An,
Adjudicator