

**LICENCE APPEAL
TRIBUNAL**

**Safety, Licensing Appeals and
Standards Tribunals Ontario**

**TRIBUNAL D'APPEL EN MATIÈRE
DE PERMIS**

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



Citation: Huseyin Ok vs. Aviva General Insurance, 2020 ONLAT 19-002362/AABS

Released Date: 04/01/2020 File Number: 19-002362/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:

Huseyin Ok

Applicant

and

Aviva General Insurance

Respondent

PRELIMINARY ISSUE DECISION

VICE-CHAIR:

D. Gregory Flude

APPEARANCES:

For the Applicant:

Huseyin Ok, Applicant
Gary Mazin and Sarah Kun, Counsel

For the Respondent:

Lucy Carlos, Claims Representative
Nestor E. Kostyniuk and Serena Sud, Counsel

Interpreter

Hwand Gokcen, Interpreter in the Turkish language

Court Reporter:

Bruce Porter

HEARD: In-Person:

**November 25 through November 29, 2019 and
January 10, 2020**

REASONS FOR DECISION

OVERVIEW

- [1] Huseyin Ok does not consider himself to be the man he once was. The man he once was played recreational soccer, played with his grandchildren, did gardening and home maintenance, and worked at a physically demanding job as a steel man in high rise construction. He now walks with a cane, suffers pain in his legs and lower back, is irritable with his loved ones and does not have energy. He attributes the changes to injuries sustained in an automobile accident on June 8, 2016. The respondent, Aviva General Insurance ("Aviva"), attributes the changes to a degenerative condition in his spine due to the hard, physical labour he performed during his working life.
- [2] Mr. Ok sought and was paid benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010*, O. Reg 34/10 (the "Schedule"). His entitlement to benefits has now been exhausted unless he is found to have been catastrophically impaired as a result of the accident. In this preliminary issue hearing, he seeks a finding that he has been catastrophically impaired.
- [3] Catastrophic impairment is a defined term under the Schedule. If Mr. Ok is found to be catastrophically impaired, he will be entitled to access up to \$1 million in benefits. If he is not, counsel advise me that he has exhausted the policy limits available to him for treatment and Aviva will have no further obligation to pay for his treatment.

PRELIMINARY ISSUE

- [4] The preliminary issue I must decide is: Did Mr. Ok sustain a catastrophic impairment as defined under the Schedule?

RESULT

- [5] Mr. Ok did not sustain a catastrophic impairment as defined under the Schedule.

THE SPINE AND THE NATURE OF THE DISPUTE

- [6] To better understand the dispute between the parties, it is necessary to understand, at a basic level, the nature of the spine. Not to be over simplistic, it is generally known that the spine is made up of vertebrae and vertebrae are separated by discs. The spine is further divided into areas: the upper spine, known as the cervical spine with seven cervical vertebrae; the largest area from which the ribs radiate, known as the thoracic spine with twelve thoracic

vertebrae; a lower area, known as the lumbar spine with five lumbar vertebrae, and the bottom of the spine known as the sacrum. The vertebrae of the sacrum usually fuse together but in a small percentage of the population the sacrum may be mobile. On the evidence outlined below, I accept that Mr. Ok has a mobile sacrum.

- [7] Each vertebra has a hollow channel for the spinal cord, the central pathway for nerve impulses to travel to and from the brain. Nerves radiate out from the spinal cord and exit the spine at thirty-seven places to serve specific areas of the body through exit channels, each channel known as a foramen. Damage or irritation of the nerves at the foramen may be felt as pain, muscle weakness, and numbness in the area served by that nerve path. Since the damage is at the nerve root, it is known as radiculopathy, from the Latin word for root.
- [8] The spinal cord is generally solid in appearance but at its lower end it divides into individual nerve fibres which, in appearance, look like a horse tail. This area is known as the *cauda equina*, literally horse tail in Latin.
- [9] Radiculopathy may be caused by injury to the spine. As will be discussed below, Mr. Ok suffered a burst fracture at his first lumbar vertebra causing radiculopathy originating from compression at the nerve root impacting the hips. He also asserts that the accident caused him to suffer damage to the *cauda equina*. Damage to the *cauda equina* might include a host of nerve related symptoms to areas that are served by nerves that exit the spine below the point of damage.
- [10] Alternatively, radiculopathy may be caused by degenerative changes in the spine, narrowing discs or osteoarthritic narrowing of the foramen, for example. The degeneration may become sufficiently severe that it impinges on the nerve as it exits through the foramen. Mr. Ok suffers from such degeneration. The changes were identified before the accident. Aviva asserts that Mr. Ok's current complaints are related to his degenerative condition.
- [11] The dispute between the parties focusses on the cause the symptoms that Mr. Ok is suffering in his lower extremities. He asserts that it originates in the *cauda equina* and was caused by the accident. Aviva asserts that it originates at the foramina in the lumbar spine and is caused by degenerative changes unrelated to the accident.

APPLICABLE DEFINITION OF CATASTROPHIC IMPAIRMENT

- [12] The definition of a catastrophic impairment is set out in s. 3.1 of the Schedule. It includes clearly defined impairments such a loss of sight in both eyes, loss of a

limb, paraplegia or tetraplegia, or severe cognitive impairment. For the purposes of this analysis, however, it has one criterion which considers the accumulative effect of physical, mental, and behavioural impairments, none of which on their own is sufficient to trigger the designation. Using a guideline set out in the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 ("AMA Guides"), there are test protocols and values to be assigned based on the test results for each impairment. The scores for the various impairments are added together in a non-linear manner to result in a Whole Person Impairment score ("WPI") using tables in the AMA Guides. If a person's WPI is 55% or more then the person is catastrophically impaired. If less, then the person is not. Since scores are rounded up or down to the nearest 5%, effectively a person is catastrophically impaired if the WPI is 53%.

- [13] Catastrophic impairment assessments of WPI are, by their nature, multidisciplinary. Each practitioner assesses impairment in their discipline, be it psychological, neurological, behavioural, etc. and assigns a score within the range set out in the AMA Guides. Those scores are then amassed and the WPI is calculated by someone qualified in doing the calculations.

THE FOCUS OF THE DISPUTE IN THIS CASE

- [14] In their opening statements, both parties commented on the similarity between Mr. Ok's assessors' scores and scores levied by the assessors for Aviva, with one major exception, the cause of Mr. Ok's lower back problems. My focus, then, will be on the area from the last thoracic vertebra, T12, to the sacrum, including the whole lumbar spine, L1 to L5. The parties agree that if I accept Mr. Ok's assessors' opinion then he meets the test for catastrophic impairment. If I do not, then he does not meet the test. On the evidence before me, I find that Mr. Ok has failed to show, on a balance of probabilities, that he meets the catastrophic impairment test.
- [15] As stated above, Mr. Ok sustained a burst fracture of one vertebra. Mr. Ok's assessors place that vertebra in the thoracolumbar spine and assigned a 20% WPI score for that injury. They have then assigned a further 40% WPI for accident-related impairment to the *cauda equina*. Aviva's assessors agree with the assignment of 20% to the fracture, although they take the position that the fractured vertebra is the first lumbar vertebra, L1. They deny any involvement of the *cauda equina*, taking the position that Mr. Ok has well-documented degenerative disc disease in his lower lumbar spine that causes nerve root impingement and radiculopathy requiring surgical intervention.

The Location of the Fracture

- [16] There is a conflict in the medical evidence over the location of the fracture. The location of the fracture is important in the WPI calculation because if a single area of the spine is injured in more than one location, then, in calculating the WPI, only the highest-rated injury is counted. Thus, if Mr. Ok's fracture is in the thoracic spine at the twelfth vertebra (T12), then his score would include the 20% the parties agree should be assigned for this injury, plus a rating for damage he may have sustained in the lumbar spine. If the damage is the first lumbar vertebra (L1), then he would be assessed the higher of the 20% for the fracture or the rating for any other damage to the lumbar spine. On the evidence before me, I find that Mr. Ok sustained an L1 fracture.
- [17] The confusion surrounding the location of the fracture stems from an apparent misidentification by the radiologist who examined the first x-rays of Mr. Ok's spine after the accident and identified the fracture as occurring at T12. What marks the thoracic vertebrae is that they have ribs attached. To address the fact that there were no ribs emanating from the fractured vertebra, the radiologist purported to find vestigial ribs.
- [18] In assessing Mr. Ok and preparing a catastrophic assessment report on his behalf, Dr. Sangha, a physiatrist, accepted that Mr. Ok suffered a T12 fracture and assigned a 20% WPI to that injury. Aviva's assessor, Dr. Bruce Paitich, an orthopaedic surgeon, identified the fractured vertebra as L1. He also identified the error that led to the initial wrong diagnosis. Mr. Ok is one of a minority of people whose sacrum is mobile and not fixed. One technique of identifying vertebra, and that apparently used by the radiologist, is to count the bottom five mobile vertebra and consider them to be the lumbar spine. In this case, because Mr. Ok has six mobile lower vertebrae, the radiologist mistakenly counted the first sacral vertebra as the lumbar spine. For Dr. Paitich, the lack of ribs clearly indicates the fractured vertebra is L1.
- [19] I accept Dr. Paitich's explanation. While there was an initial misdiagnosis, subsequent treating physicians identified L1 as the damaged vertebra and treated that location.
- [20] In his evidence, Dr. Sangha testified that, for the purposes of the AMA Guides, whether it is T12 or L1 does affect the outcome. In his view, transitional areas like the thoracolumbar area are treated clinically separately from the rest of the spine and should be given their own rating. He conceded that Dr. Paitich's interpretation followed a literal interpretation of the AMA Guides but, in his view, the approach should be more flexible to recognize that this area is one of

transition. He cited no authority from the AMA Guides for this proposition except to state that the AMA Guides encourage the use of clinical judgment. Given Dr. Sangha's concession that Dr. Paitich's interpretation accords with the AMA Guides, I accept that the WPI for this injury should be counted as part of the lumbar spine. I fail to see how clinical judgment can override the clear division of the spine into discrete areas set out in the AMA Guides.

- [21] The result of my finding that Mr. Ok suffered a fractured L1 vertebra is that he is entitled to either a 20% WPI score for the fracture or such higher number that might arise from injury elsewhere in the lumbar spine.

Other Lumbar Spine Issues

- [22] In preparing his assessment, Dr. Sangha assessed 40% WPI for "cauda equina-like syndrome without bowel or bladder involvement." As stated above, there is agreement between the parties that if Mr. Ok does not have this condition, he does not meet the catastrophic impairment threshold.
- [23] In Dr. Sangha's view, the accident caused damage to the nerves in the spine. That damage then caused a cascade of symptoms from the point below the site of the damage, which he identifies as bilateral numbness, loss of strength, loss of reaction and pain in the lower extremities.
- [24] Aviva takes the position that the symptoms Dr. Sangha points to in support of his diagnosis are symptoms that arise from Mr. Ok's degenerative disc disease, particularly at the fourth and fifth lumbar vertebrae, L4 and L5. I find Aviva's position has more support in Mr. Ok's medical history. I will briefly outline Mr. Ok's medical history.

Prior Medical History

- [25] Mr. Ok left school after grade five and began working in construction. He had six siblings and needed to earn money to support the family. He worked at heavy physical labour all his working life. He moved to Canada and worked as a steel man in high rise construction – a physically demanding job. As he aged, he began to develop several medical conditions. Pre-accident, he was diagnosed with osteoporosis and takes medication to address it. He suffered from low back pain and knee pain. He testified that these complaints had no impact on his ability to work. Commencing in November 2014, he had bouts of vertigo that continued until the date of the accident on June 8, 2016.

- [26] In April 2016, Mr. Ok suffered from bilateral foot pain from standing for prolonged periods. His doctor recommended orthotics. The orthotics made him more comfortable. He was also diagnosed with high cholesterol and prescribed a statin drug to control it.
- [27] Of note with respect to the issues in dispute in this matter is the fact that Mr. Ok was diagnosed with LUTS (lower urinary tract symptoms). He had impaired urine flow and had to get up during the night to go the washroom. The source of these problems was diagnosed as an enlarged prostate. Thus, while damage to the *cauda equina* may impact bladder function, the bladder difficulties suffered by Mr. Ok are prostate related and not the result of *cauda equina* issues.
- [28] Between 2012, when Mr. Ok's family physician's clinical notes and records first mention lower back pain, and the accident on June 8, 2016, Mr. Ok saw his family doctor complaining of back pain, bilateral leg pain and cramping at night. He also complained of vertigo, especially through early 2016. In May 2016, Mr. Ok's doctor referred him for an MRI of his back. The results of the MRI were discussed with Mr. Ok on June 2, 2016. Mr. Ok suffered from degenerative disc disease.
- [29] From the above review it is clear that Mr. Ok was already beginning to manifest many of the lower extremity issues of which he now complains.

Treatment after the Accident

- [30] Mr. Ok was taken from the accident scene to the hospital. Since he had suffered a serious spinal injury, his treating physicians tested extensively for the neurological impact of the accident. In particular, he was tested on approximately five occasions for the muscle tone of his anal muscles. Lack of tone in these muscles would indicate damage to the *cauda equina*. His emergency room treating physicians ruled out *cauda equina* involvement from the accident. His fractured vertebra was treated conservatively, medical speak for the fact that the fracture was allowed to heal without surgical intervention.
- [31] He attended the fracture clinic following his release from hospital. His release report from the fracture clinic specifically notes that he is suffering no neurological deficit as a result of the accident.
- [32] Approximately 14 months following the accident, in August 2017, Mr. Ok began to experience increased pain in his lower back with radiculopathy symptoms. In October of that year he attended an assessment where he reported that while his back had been sore since the accident, it became worse two months earlier. The

October assessment led to a chain of events that ended with Mr. Ok undergoing decompression surgery on his back to relieve pressure on the nerve roots at the L4-L5, causing radiculopathy in his lower right extremities. His treating surgeon makes no finding of *cauda equina* involvement in the radiculopathy.

Expert Evidence

- [33] As stated above, both Mr. Ok and Aviva put forward medical expert opinions, Dr. Sangha on behalf of Mr. Ok and Dr. Paitich on behalf of Aviva. In preferring Dr. Paitich's opinion that Mr. Ok's symptoms do not involve the *cauda equina* and are not accident related, I note that, in addition to Dr. Paitich, Mr. Ok's treating physicians, both in the emergency room and hospital and again regarding the decompression surgery, specifically ruled out *cauda equina* involvement. It was an area of concern and they took steps to eliminate damage to it as a possibility.
- [34] I also note Dr. Paitich's description of *cauda equina* symptoms. He stated that damage in that area would involve the urinary tract, bowel, and vagina or penis. He notes the Mr. Ok shows none of these symptoms that are not related to his prostate issues. Dr. Paitich notes that while Mr. Ok may complain of erectile dysfunction, he can achieve an erection.
- [35] In addressing the 14-month delay between the accident and the onset of more severe back pain, Dr. Paitich pointed out that if this pain was accident-related, it would manifest in approximately the first 6 weeks from the date of the accident. The 14 month delay, in Dr. Paitich's opinion, indicates that the cause of the pain is not accident related.
- [36] Dr. Sangha supports his position by stating the Mr. Ok's *cauda equina* condition is without bladder or bowel involvement. In other words, it is his position that, despite the fact the *cauda equina* damage was higher in the lumbar spine such that it impacted the nerves exiting at L3-L4 and L4-L5, it did not impact the nerves preventing bowel and urinary incontinence. The AMA Guides specifically define *cauda equina* syndrome to include bowel and bladder involvement. There is no mention in the AMA Guides of "*cauda equina* like syndrome." Nor is "*cauda equina* like syndrome" mention by any treating neurologist or surgeon. It appears that Dr. Sangha stands alone in identifying a new condition that is not endorsed by his peers. I do not accept his characterization.
- [37] Finally, Dr. Sangha justifies his position that the *cauda equina* damage warrants a 40% WPI by addressing the bilateral nature of the radiculopathy. Dr. Paitich notes weakness on the right lower leg and ankle, consistent with foraminal narrowing at L4-L5. Similarly, the test results Dr. Sangha sets out in his report do

not support bilateral radiculopathy. He notes weakness, numbness and muscle atrophy on the right, but notes only a very minor reduction in Achilles tendon reaction on the left.

- [38] Overall, I find the evidence supports the conclusion that there is no *cauda equina* damage resulting from the accident and that the progress of Mr. Ok's degenerative condition explains his current symptoms. It flows from this finding that he cannot include 40% for "*cauda equina* like syndrome without bowel or bladder involvement" in his WPI calculation. By his own admission, he does not achieve a 55% WPI in the absence of this 40%

ORDER

- [39] I find that Mr. Ok did not sustain a catastrophic impairment in the accident. His motion for a finding that he is catastrophically impaired is dismissed.

Released: April 1, 2020



D. Gregory Flude
Vice-Chair