Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A15-005751

BETWEEN:

CINDEE MILAN

Applicant

and

AVIVA CANADA INC.

Insurer

REASON FOR DECISION

Before: Arbitrator Charles Matheson

Heard: In person in Kitchener on September 26-28, 2017, with written submissions on October 31, 2017

Appearances: Mr. R. Knight, lawyer, for Ms. Cindee Milan

Mr. D. Greenside, lawyer, for Aviva Canada Inc.

Issues:

The Applicant, Ms. Cindee Milan, was injured in a motor vehicle accident on May 17, 2011. She applied for and received statutory accident benefits from Aviva Canada Inc. ("Aviva"), payable under the *Schedule*.[1] The parties were unable to resolve their disputes through mediation, and

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[1] Effective September 1, 2010, the *Statutory Accident Benefits Schedule – Effective September 1, 2010* (the "new SABS") came into force. The transition rules in the new SABS provide that, subject to certain exceptions, benefits that would have been available pursuant to the *Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996* (the "old SABS") shall be paid under the new SABS, but in amounts determined under the old SABS.

Ms. Milan applied for arbitration at the Financial Services Commission of Ontario, through her attorney, under the *Insurance Act*, R.S.O. 1990, c. I.8, as amended.

The issues in this Hearing are:

1. Is the Applicant entitled to receive a weekly income replacement benefit in the amount of $325.00 from July 3, 2013 to date and on-going?
2. Is the Applicant entitled to receive the following medical benefits:

    a) $680.71 for Occupational Therapy Re-Assessment, service provider Sherry Kettyle, dated March 7, 2014;
    b) $3,048.20 for Physical rehabilitation, service provider Jason Vander Veen, Wellington Ortho & Rehab, dated December 19, 2013;
    c) $379.77 for physical rehabilitation, service provider Mark Guker, ReAlign Health, dated July 8, 2013;
    d) $1,100.00 for orthotics devices, service provider Healthy Step, dated July 26, 2013;
    e) $1,766.25 for physical rehabilitation and assessment, service provider Jason Vander Veen, Wellington Ortho & Rehab, dated February 13, 2015;
    f) $2,683.26 for vocational assessment, service provider Ashok Jain, dated February 20, 2015?

3. Is the Applicant entitled to interest for the overdue payment of benefits?
4. Is Aviva liable to pay a special award to the Applicant?
5. Is either party entitled to its expenses in respect to the Hearing?

Result:

1. I find the Applicant is not entitled to receive a weekly income replacement benefit in the amount of $325.00 from July 3, 2013 to date and on-going.

2. Is the Applicant entitled to receive the following medical benefits?
    a) I find that the Applicant is entitled to the treatment plan of $680.71 for Occupational Therapy Re-Assessment, dated March 7, 2014.
    b) I find that the Applicant is not entitled to $3,048.20 for Physical rehabilitation, dated December 19, 2013.
    c) I find that the Applicant is entitled to $379.77 for physical rehabilitation, dated July 8, 2013.
    d) I find that the Applicant is not entitled to $1,100.00 for orthotics devices, dated July 26, 2013.
    e) I find that the Applicant is not entitled to the treatment plan of $1,766.25 for physical rehabilitation and assessment, dated February 13, 2015.
    f) I find that the Applicant is entitled to the assessment plan of $2,683.26 for a vocational assessment dated February 20, 2015.
3. I find that the Insurer is not liable to pay a special award to the Applicant.
4. I find that the Applicant is entitled to interest for these overdue amounts, at the rate of 2% compounded monthly in accordance with the *Schedule*.
5. Should the parties become unable to resolve this issue, they shall subsequently schedule an Expense Hearing before me in accordance with Rules 75 to 79 of the provisions of the *Dispute Resolution Practice Code.*

Background

The Applicant was crossing a road at a crosswalk when she was struck by a vehicle on the left side of her body. The Applicant was working as a personal support worker at the time of the accident.

The Applicant had immigrated to Canada in 2008 after spending two years as a nanny in Norway.

The Applicant was born in the Philippines and received all her formal education in English until she moved to Norway.

The Applicant gave birth to her son on July 31, 2012. She raises her son with help from the biological father, who resides outside of her home. The Applicant has had a second motor vehicle accident on June 19, 2014.

EVIDENCE

Applicant's Testimony:

The Applicant worked as a full time live-in nanny for a family in Elora, with two young boys, from 2008 until March 2011. She did all household chores for the whole family, while going to school to upgrade her English skills. The Applicant moved to Guelph when she received her Permanent Residence status, and started to work at a manufacturing facility, until a Norwegian elderly couple required a PSW to support for Mrs. C. This was a full-time position so she quit the manufacturing facility.

The Applicant testified that while she was crossing a street in Guelph, after leaving a city transit bus, she was struck by a car, hitting her on her left thigh and hip area. She did not believe that she lost consciousness. At the time of the accident she was working as an unlicensed Personal Support Worker ("PSW") for Mister and Mrs. C. who also lived in Guelph.

The career goals of the Applicant were to work in the health care industry as a licenced PSW and eventually as a Registered Nurse.

The Applicant went to the hospital in an ambulance. She found out the injury she sustained was a torn meniscus ligament in her left knee. This was verified by an x-ray. The Applicant testified to the pain in her hip, her knee, and lower back. The Applicant testified that she has continued to

suffer from aches and pain in her arms and shoulders with pins and needles in her arms and hands. An MRI confirmed that she suffered from a pinched nerve in her spine.

The Applicant returned to work, approximately 5 weeks after the accident, to look after Mrs. C., despite that fact that she returned to work with the use of crutches and later on a knee brace. The Applicant was accommodated due to her injuries, and restricted to lighter duties. The Applicant continued to work for Mr. C. after Mrs. C. passed away, until she needed a leave from her employment for a maternity leave as she gave birth to her son on July 31, 2012. In June 2013 the Applicant was told her position working for Mr. C. was no longer available. Her first attempt to return to work was at a local Tim Horton's where she found the pain from standing and bending too much. She quit after a week.

The Applicant testified that she started to work for a PSW placement agency "Right-At-Home" in 2014. This was for modified positions only, as she was limited to light duty positions, which resulted in infrequent opportunities with limited hours and pay. The Applicant explained she tried to augment her income by participating in several on-line business opportunities which did not produce the successful results she wanted. She stated that she is not a great salesperson and her income was dependant on sales commissions. The Applicant also started working for a second PSW placement agency known as "Enhancing Lives" in 2016.

The Applicant testified that she went back to Cornerstone College, during her maternity leave (January 2013 to June 2013) for her certification as a PSW, which she successfully completed, despite the constant pain while sitting or standing for long periods. This is the same pain the Applicant testified to, which continues to impede her progress at the gym, and prevents her loss of weight.

The Applicant explained that she then went to Conestoga College in 2014, for up-grading her math and biology courses so she may pursue a registered nurse degree. During her upgrading and resulting academic assessments the Applicant decided to change her focus to Human Resources.

The Applicant started her diploma program in September 2016 in an expedited program where she tried to complete a two-year program in a single year. The Applicant admitted this was too ambitious and had to drop 2 courses, where she went on to complete the other 5 courses. The Applicant has not attended school since.

In regards to her weight, the Applicant wants to lose weight in order to reduce her pain in her knees and back. Bariatric surgery is her next step in order to reduce her weight and ultimately reduce her pain from the accident. The Applicant confirms that every health professional she has seen since the accident has recommended weight loss to ease the pain she is experiencing.
In regards to her work experiences prior to 2006 when she moved to Norway to work as a nanny, the Applicant verified that she worked at a family grocery store until she attended college, working as a shelf stocker, and cashier.

The Applicant also confirmed on cross-examination that she spoke and was verbally fluent in the 4 major dialects of the Philippine language. The Applicant attended St. Peter's College and attained a Bachelor of Commerce degree in business management in 2001. The Applicant confirmed that her education was in English, and that she worked for the National Oil Company as a receptionist while moving on to work at Globe Telecommunications in English, where she was in client services until she was promoted to an assistant to the sales manager for commercial and residential sales until 2003. The Applicant also confirmed that she worked full-time for a medical clinic where she booked appointments until 2004 when she moved to another company, Xribris, where she worked with aspiring authors as an "Author Service Representative" until moving to Norway in 2006.

The Applicant confirmed that she was in a second accident on June 19, 2014, where she was a passenger in someone else's vehicle. She confirms she has received medical benefits from a second insurer as a result of this accident.

The Applicant confirmed that she relied upon her son's biological father for child care when she attended her education classes until her subsidised childcare was approved.

The Applicant confirmed that she declined cortisone shots for her left knee as well as orthoscopic surgery to repair her tear, as she was unable to get assurances of 100% success of these procedures. Further, she confirms that she has been in counselling in her past as she has attempted suicide as a teenager and has continued to seek counselling to assist her in her relationships with a partner (December 2013 – April 2014), and in dealing with the loss of her father (May 2011).

Dr. Lydia Hatcher's (Medical Doctor) Testimony

Dr. Hatcher testified on behalf of the assessment team. This chronic pain assessment team's report was authored by Kathleen Gallagher, Occupational Therapist, Dr. Lydia Hatcher, MD and Dr. Hapidou, Psychologist. Dr. Hatcher testified to the veracity of the report and the diagnoses contained therein. Dr. Hatcher confirmed that the Applicant was diagnosed with "Persistent Depressive Disorder (dysthymia). With anxious distress. Late onset, and with persistent major depressive episode, with current episode, Moderate", and "myofascial pain in her back and neck with overlying probable fibromyalgia."[2] The Applicant was also diagnosed with "Somatic Symptoms Disorder with predominant pain. Persistent, moderate."[3] Dr. Hatcher expands on this diagnosis and states the Applicant suffers from "myofascial pain in her back and neck with overlying probable fibromyalgia,"[4] as of the date of her report.

The doctor testified that at the point in time she saw the Applicant, her treatments would only allow the Applicant to have better function within her activities of daily living and social life activities. Her treatment is not a cure for the pain; it is a pain management program.

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[2] Pages 15 and 16 of Michael G. DeGroote Pain Clinic Interdisciplinary Initial Assessment Report.
[3] *Ibid.*
[4] Michael G. DeGroote Pain Clinic Interdisciplinary Initial Assessment, June 22, 2017, pg. 16.

Dr. Hatcher explained her diagnosis of Central Sensitized Syndrome is the typical trigger for fibromyalgia, where the patient experiences wide spread pain sensations in areas not related to the actual mechanism of injury by a traumatic event. This explains, in her opinion, the tingling and numbness in her arms and hands, as these are not part of the original accident symptoms as reported by the Applicant.

During cross-examination Dr. Hatcher acknowledged that the Applicant's weight issue was not accident related per se, however, her weight loss is recommended to improve function as it will decrease any comorbidity issues, which otherwise exacerbates the pain condition.

Mr. Jason Vander Veen (Occupational Therapist)

Mr. Vander Veen testified to his knowledge of the Applicant as he was initially the primary physiotherapist until she moved to a closer service provider.

Mr. Vander Veen's physiotherapy (within this treatment plan) would entail both active and passive components. He also testified that "it's not that simple to just teach someone an exercise and send them on their way". He suggested that the Applicant had not reached the point where she was able to perform exercises on her own safely and properly. He further testified, in his professional opinion, that the Applicant had not yet reached this plateau which is why he submitted the treatment plans. In general, all clients are treated so that they progress from passive to active treatment from a facility-based program to an at home exercise program.

Mr. Vander Veen suggested in his opinion, that physiotherapy goals are to help the client with pain reduction and maintenance, and that the resulting pain reduction and maintenance are legitimate goals of medical rehabilitation benefits.

Mr. Vander Veen confirmed, on cross-examination, that he would provide the Applicant with instructions concerning a home exercise program and that he had already taught the Applicant

the 30 to 40 minutes of home exercises. He agreed that the Applicant should have been able to continue performing those exercises on her own at the gym and/or at home.
Mr. Vander Veen testified that the most effective physiotherapy is the therapy within 6 months of an accident. Mr. Vander Veen also testified that, in general, clients can take a significant amount of time to move to a completely active at home exercise routine. Variables affecting the length of treatment depend on the person and injury, it could take up to a year to progress to this point.

Dr. Mohamed Khaled's (Family Physician) Testimony
Dr. Khaled authored two evidenced Insurer's Medical Examination Reports, April 17, 2014 and May 22, 2015, respectively. Dr. Khaled testified as to the veracity of his findings in each of his reports, and that he has not changed his opinions on those conclusions within each report.
In his first report Dr. Khaled summarized his findings that the Applicant had no significant abnormalities to report and was generally found to be normal, for a person who had suffered a grade 2 whiplash with the associated headaches and non-specific back pain. The doctor noted the derangement with ligamentous injuries to the left knee.

Dr. Khaled opined that more active exercise and/or therapy would be most beneficial to the Applicant seeing that his assessment is 3 years post-accident, and would help the Applicant lose weight and increase function while decreasing pain. Thus, he approved a gym membership rather than continued physiotherapy.

Dr. Khaled testified that during the second examination he noted that the Applicant had gained more weight since the last assessment. He opined that the on-going back pain and knee pain were related to her weight issue, as she was approaching a level of being morbidly obese, and the most effective way to lose weight is to reduce caloric intake, which is about 80% of weight reduction. Therefore, the doctor did not approve any further passive modalities as the Applicant had reached her maximum medical recovery.

The doctor opined under cross-examination that maintaining the status quo with passive therapy would not achieve any benefit to the Applicant in regards to on-going functioning improvement or pain reduction, especially four years post-accident. Dr. Khaled testified, in his professional opinion, that people should require 4 weeks, or 6-10 sessions of physiotherapy, in order to teach them all the exercises they should do at home.

The doctor also opined on the reviewed MRIs on the Applicant's back, and suggested that there were no abnormalities that would cause any disability. There were no impingements on any nerves and there were no significant orthopedic or neurological issues in the MRIs that would contribute to the pain being experienced.

Mr. Jeffery Cohen's (Vocational Assessor) Testimony

Mr. Cohen authored his evidenced Vocational Evaluation and Transferable Skills Analysis Report dated August 28, 2015. He defended his various conclusions and his assessment techniques as he walked this commission through his report.

Overall Mr. Cohen was guarded as to the prospects of employment for the Applicant, in part, because she was educated in her second language (at a level not compatible with Canadian standards) and because she required some accommodation as to her tolerance in sitting, standing and walking. He stated that all of her work experiences are stale or more than 5 years old. Mr. Cohen testified that he believes that further educational upgrading is required for the Applicant to pursue her aspirations of meaningful and sustainable work in Canada as her restrictions put her at a disadvantage in a competitive workplace, thus her options are very narrow.

Dr. Alrick Daugherty's (Chiropractor) Testimony

Dr. Daugherty testified to his authored Insurer's Examination Chiropractic Assessment dated August 6, 2013. The doctor revealed that the Applicant during his assessment had disclosed that previous physiotherapy was not helping her. His report was in response to an OCF-18 proposed by Dr. Guker dated July 8, 2013. The doctor approved seven weeks of active therapy instead of

the treatment recommended by Dr. Guker. The doctor was not persuaded to change his opinion after cross-examination.

Dr. Daugherty opined that active therapy "only" was the best fit for this Applicant. Under cross-examination the doctor advised that he did recommend passive therapy as adjustments and manipulations of the neck and upper back are considered passive in nature. Dr. Daugherty opined that diet was equally important in weight reduction.

Dr. Daugherty opined on orthoscopic surgery on knees and its success rates in his experience, in that only one patient had a partial negative outcome, as one of the two knees operated on completely healed without complications.

Issues

1. *Is Ms. Milan entitled to receive a weekly income replacement benefit in the amount of $325.00 from July 4, 2013 to date and on-going?*

The Applicant is seeking post-104 weekly Income Replacement Benefits ("IRBs"), from July 4, 2013 to date and on-going.

The parties agree that it is the burden of the Applicant to prove that she is entitled to this benefit as she is claiming she is "suffering a complete inability to engage in any employment or self-employment for which she is reasonably suited by education, training or experience".

The applicable section of the *Schedule* for the IRB is Part II s. 6, which reads as follows:

> **Period of benefit**
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> 6. (1) Subject to subsection (2), an income replacement benefit is payable for the period in which the Insured person suffers a substantial inability to perform the essential tasks of his or her employment or self-employment.

(2) The Insurer is not required to pay an income replacement benefit,

(a) for the first week of the disability; or

(b) after the first 104 weeks of disability, unless, as a result of the accident, the Insured person is suffering a complete inability to engage in any employment or self-employment for which he or she is reasonably suited by education, training or experience.

Arguments

The Applicant argues that she has not been able to return to her pre-accident level of employment because of her disabilities and pain, which are the direct result of the 2011 motor vehicle accident.

The Applicant submits that the Supreme Court in *Martin v. Nova Scotia (Worker's Compensation Board)* 2003 SCC 54, has stated that chronic pain in and of itself is a *bona fide* disability. The Applicant also submits that all the evidence shows that the Applicant suffered injuries in the subject accident and that she suffers from chronic pain. The Applicant argues that the evidence shows that the Insurer's Drs. Khaled, MD, Lewis, Psychologist and Daugherty, Chiropractor agree that the Applicant suffered injuries, and continues to suffer from chronic pain.

The Applicant respectfully submits that she suffers from a complete inability to engage in any employment for which she is reasonably suited within her training, education, and experience due to her injuries and chronic pain.

The Applicant submits that the uncontested evidence shows that she was off work for approximately 5 weeks. A calculation of income was completed, and the Insurer paid her $325.00 per week for this period.

The Applicant argues that her IRB was not terminated by the Insurer at any time; therefore, there is no limitation period applicable in this case. This issue has not been disputed by the Insurer.

The disabilities the Applicant is relying upon, which have not been disputed by the Insurer, are listed in the Michael G. DeGroote Pain Clinic's Interdisciplinary Initial Assessment, dated June 22, 2017. This team assessment was authored by Kathleen Gallagher, Occupational Therapist, Dr. Lydia Hatcher, MD and Dr. Hapidou, Psychologist. Dr. Hatcher testified on behalf of the assessment team.

Dr. Hatcher confirmed that the Applicant was diagnosed with "Persistent Depressive Disorder (dysthymia). With anxious distress. Late onset, and with persistent major depressive episode, with current episode, Moderate", and "myofascial pain in her back and neck with overlying probable fibromyalgia."[5] The Applicant was also diagnosed with "Somatic Symptoms Disorder with predominant pain. Persistent, moderate."[6]

The Applicant also relies upon the Vocational Evaluation and Transferable Skills Analysis Report authored by Mr. Jeffery Cohen. Mr. Cohen is a professional Vocational Evaluation and Rehabilitation expert. Mr. Cohen testified and verified his findings of his report dated August 28, 2015.

After reviewing medical documentation, self-reporting questionnaires and test results from his own testing, Mr. Cohen came to the following conclusion:

> ...until such time that she completes the necessary upgrading process, Ms. Milan's work options, with the context of her injuries and diminished physical functioning, will remain severely restricted to (at best) elemental work that will be neither reflective of her reduced tolerances nor her aspirations for meaningful and sustained work in Canada.[7]

The Applicant submits that the *Schedule* and case law make it clear that the mere fact that the Applicant's return to work on very modified duties after the accident until her maternity leave,

[5] Pages 15 and 16 of Michael G. DeGroote Pain Clinic Interdisciplinary Initial Assessment Report.
[6] *Ibid.*
[7] Vocational Evaluation and Transferable Skills Analysis Report page 31 of 32, August 28, 2015.

followed by periodic and sporadic employment and/or schooling after that, does not disentitle the Applicant to IRBs. They submit that the total hours of worked and level of remuneration factor into the determination. I agree.

The Insurer submits that the Applicant's involvement in a subsequent motor vehicle accident, on June 19, 2014, should be taken into account when considering her recovery from the earlier 2011 accident and her demonstrated abilities prior to her involvement in the 2014 accident; an event about which she did not inform Dr. Hatcher or Mr. Cohen.

The Insurer argues, in part, that the Applicant has not established her entitlement under the post-104 week disability test contained in section 6(2)(b) of the *Schedule* which requires evidence to support a conclusion that she has and continues to suffer a complete inability to engage in any employment or self-employment for which she is reasonably suited by education, training or experience.

The Insurer argues that Mr. Cohen's report makes conflicting findings in that the assessor finds that the Applicant is able to perform sedentary (to perhaps) light work, positions such as quality assurance, editing photos, operating a cash register, filling out requisition forms and/or preparing sales slips. The Insurer implies, in part, that the evidence does not show that any of these vocations have even been attempted by the Applicant, let alone what the enumeration and status these positions have or may have.

Decision

First, I find and agree that the Applicant suffers from chronic pain. I also accept Dr. Hatcher's diagnosis of "myofascial pain in her back and neck with overlying probable fibromyalgia,"[8] as of the date of her report.

[8] Michael G. DeGroote Pain Clinic Interdisciplinary Initial Assessment, June 22, 2017, pg. 16.

Second, I note that the Insurer did not assess the Applicant with any Insurer's examinations for post-104 weekly IRBs, and I agree that the Applicant was not denied any IRBs at any time by the Insurer, as argued by the Applicant. I find that the Insurer simply did not pay more than the $0.00 per week as her accommodated employment income was greater than the weekly IRB of $325.00. Therefore, by extension, I also agree there are no applicable limitation periods for this benefit, as argued by the Applicant.

Third, I find that the evidence before me supports the findings that the Insurer did not adjust the file once the Applicant went on maternity leave. On this point I note that the disputed IRB before me is only about post-104 weekly benefits and not about the actions or inactions of the Insurer during the first 104 weeks post-accident. Therefore, I find that I have no jurisdiction to comment on any events within the first 104 weeks of the accident.

Fourth, I find that my jurisdiction to make a decision on the post-104 week IRB issue derives from the Report of Mediator,[9] which clearly checks off the box denoted as "weekly benefits" in this deemed failed mediation report. Therefore, I find that I am restricted to make a finding on the post-104 IRB only, as defined by the parties in the application of arbitration as well as per the issues listed within the pre-hearing letter.

Finally, I am unable to be persuaded, on the preponderance of all the evidence, that the chronic pain is such that it rises to the point that would prevent the Applicant from working on a "complete inability" level. This does not mean that I do not believe the Applicant does not suffer pain from her disability; the opposite is true. In my view, the Applicant's actions during the first four years post 2011 accident combined with the findings of her own health professionals suggest to me that she suffered a "substantial inability" but not "a complete inability" to work as a result of the 2011 accident due to her disability.

[9] Report of Mediator dated July 29, 2015.

I point to the fact that the Applicant testified to and self-reported to several evidenced assessors that she has been able to complete all of her own house and self-care requirements of her daily living including those specific requirements of her son since his birth in 2012, independently with little or no outside help.

I also point to the fact that the Applicant successfully pursued post-secondary education on at least two occasions, while maintaining her home and while meeting her young child's needs up to and beyond the 2014 accident. The first occasion was when she attended Cornerstone College and completed her Personal Support Workers certificate, and then attended Conestoga College where she started a two-year program and successfully completed 5 courses in the first year for a Human Resources Management Diploma.

The evidence shows that Dr. Hatcher's report supported the Applicant in attending their pain management clinic, as well as rendering a diagnosis of her present condition in June 22, 2017. The doctor was unaware of the 2014 accident but reviewed and used post-2014 accident medical records to come to her conclusions. Further, Dr. Hatcher testified that she believed and maintained that the Applicant lost consciousness despite evidence of the Applicant to the contrary.

Dr. Hatcher writes in her summary the following:

> She [the Applicant] seems to have provided largely consistent data during the structured interview and psychometric portion of the psychological assessment. In terms of her psychometric findings, Ms. Milan endorsed average levels of depressed mood, catastrophizing, pain traumatization, anxiety, three stages of change, and acceptance of pain. Her score on pain related interference was below average.[10]

I note the following excerpt from Mr. Cohen's vocational report which reads as follows:

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[10] Michael G. DeGroote Pain Clinic Interdisciplinary Initial Assessment, June 22, 2017, pg. 14 and 15.

> In the absence of any observable functional impairments with using her arms/hands at desk level in the course of this assessment, Ms. Milan's motor coordination and dexterity skills are considered to be intact and commensurate with the potential to, for example, perform mechanical assembly tasks, operate equipment, mix and bake pastries, stock shelves and sort mail.[11]

I understand that Mr. Cohen simply discards the Applicant's previous work history and education as being foreign in origin and stale for the Canadian marketplace, but Mr. Cohen did not opine or explain why the Applicant's physical disabilities prevent her from finding entry level positions within the sedentary or light work vocations that fall within her physical abilities.

Further I note that the Applicant has evidenced that she possesses language skills in five languages. The evidence shows that the Applicant and Mr. Cohen have not turned their minds to vocations using these skills, which fall into the light or sedentary vocational slot. The evidence shows that the Applicant has only pursued or tried to pursue full-time accommodated versions of her pre-accident job as a personal support worker. To this point, the totality of the Applicant's own testimony shows that her only attempt at finding employment other than that of a personal support worker is when she attempted to be an on-line sales person for several pyramid-type schemes, where she was unsuccessful. The Applicant testified that she failed in these on-line ventures because of her inability to sell or to be an influencer, not because of her disabilities.

I note the Applicant's physical presentation when she was assessed by Dr. Khaled on March 27, 2014, in an Insurer's examination for a disputed treatment plan.[12] The doctor describes his findings of his physical examination as follows:

> The examination lasted 50 minutes. She had a stated height of 4'11" and a stated weight of 230 pounds.[13]

[11] Vocational Evaluation and Transferable Skills Analysis Report page 29 of 32, August 28, 2015.
[12] Insurer's Examination Medical Physician Assessment dated April 17, 2014.

> Examination of the arms shows that they are normally developed and symmetrical. There was no tenderness on palpation of the soft tissues or bony landmarks of either arm. Both arms displayed a full functional range of motion.[14]
> There was normal muscle tone and normal reflexes in the upper and lower extremities bilaterally.[15]

In fairness to the Applicant the doctor did verify her earlier complaints and found tenderness on palpation at the base of the lumbosacral and pelvis areas, and the patient was noted as not being able to walk on her left tiptoes as there was evidence of ligamentous derangement on examination of the knee.[16]

In totality, my view is that Dr. Khaled, Dr. Hatcher and Mr. Cohen agree that the Applicant can, in essence, do work within the sedentary or light work sphere of vocations.

For the above reasons I find that the Applicant has failed to prove on a balance of probabilities that she, beyond the first 104 weeks of the accident, is suffering a complete inability to engage in any employment or self-employment for which she is reasonably suited by education, training or experience. Therefore, I find that the Applicant is not entitled to receive a weekly IRB in the amount of $325.00 from July 3, 2013 to date and on-going.

2a) Is Ms. Milan entitled to receive medical benefits for $680.71 for Occupational Therapy Re-Assessment, service provider Sherry Kettyle, dated March 7, 2014?

The Applicant is claiming the benefit in the amount of $680.71 for an Occupational Therapy Re-Assessment, and that this treatment and assessment plan was reasonable and necessary in that the Applicant reported ongoing difficulties, which required the Occupational Therapist's guidance,

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[13] *Ibid.*, Paragraph 5 on page 6 of 11.
[14] *Ibid.*, Paragraph 7 on page 6 of 11.
[15] *Ibid.*, Paragraph two on page 7 of 11.
[16] *Ibid.*, page 6 and 7 of 11.

assistance, and education with regard to assistive devices, education regarding pacing, body mechanics, and energy conservation, assisting the Applicant with regard to resuming housekeeping, community referrals as required, and the Occupational Therapist ("OT") would be able to liaise with other treatment providers as well.

Arguments

The Applicant also submits that she was unable to do these things on her own and required the OT services. Furthermore, this assessment was not validly or properly denied. The Insurer's stated medical reason for denying this treatment plan was that "The frequency of care does not generally diminish". It is submitted that this is not a valid reason, medical or otherwise.

The Applicant argues that this treatment plan was not denied by way of Insurer's Examination ("IE") despite Aviva's response to an Application for Arbitration. The letter of explanation of benefits ("OCF-9") states that it will be dealt with via IE on March 27, 2014 but it was not; Dr. Khaled did not opine on this Treatment Plan and it was never denied by him. Therefore, because this was actually incurred or, should be deemed incurred by s. 3(8), the Insurer was required to pay for this treatment plan after the 11th day as there was and never has been notice in accordance with subsection 38(8) and therefore subsection 38(11) applies.

The Insurer argues that it corresponded with the Applicant's counsel on March 28, 2014 requesting a completed OCF-3 ("Disability Certificate") because the Applicant had returned to work. Further, the Insurer argues that Applicant's counsel did not reply to this request until February 24, 2015 when it requested further clarification for the denial of this benefit. The Insurer submits that it responded to this inquiry on April 21, 2015 confirming that it required a second opinion for this treatment plan and also required a completed OCF-3.

The applicable sections of the *Schedule* read as follows:

s. 3(8) If in a dispute to which sections 279 to 283 of the Act apply, a Court or arbitrator finds that an expense was not incurred because the Insurer unreasonably withheld or delayed payment of a benefit in respect of the expense, the Court or arbitrator may, for the purpose of determining an Insured person's entitlement to the benefit, deem the expense to have been incurred.

s. 33. (1) An Applicant shall, within 10 business days after receiving a request from the Insurer, provide the Insurer with the following:

1. Any information reasonably required to assist the Insurer in determining the Applicant's entitlement to a benefit.

(6) The Insurer is not liable to pay a benefit in respect of any period during which the Insured person fails to comply with subsection (1) or (2).

s. 38(8) Within 10 business days after it receives the treatment and assessment plan, the Insurer shall give the Insured person a notice that identifies the goods, services, assessments and examinations described in the treatment and assessment plan that the Insurer agrees to pay for, any the Insurer does not agree to pay for and the medical reasons and all of the other reasons why the Insurer considers any goods, services, assessments and examinations, or the proposed costs of them, not to be reasonable and necessary.

s. 38(11) If the Insurer fails to give a notice in accordance with subsection (8) in connection with a treatment and assessment plan, the following rules apply:

2. The Insurer shall pay for all goods, services, assessments and examinations described in the treatment and assessment plan that relate to the period starting on the 11th business day after the day the Insurer received the application and ending on the day the Insurer gives a notice described in subsection (8).

s. 44(5) If the Insurer requires an examination under this section, the Insurer shall arrange for the examination at its expense and shall give the Insured person a notice setting out,

(a) the medical and any other reasons for the examination;

Decision

After reading the applicable sections of the *Schedule*, as argued by the parties, and after reviewing the evidenced timeline, I agree that a proper denial did not occur.

In my view, the OCF-9, dated March 28, 2014, states in the column under medical reason "The frequency of care does not generally diminish over time". This is not a medical reason in my view and violates s. 44(5)(a). Later in this OCF-9 it states the Insurer is scheduling a s. 44 assessment.

The OCF-9, dated March 21, 2014, clearly articulates that the March 7, 2014 In-Home Reassessment is one of the two plans being assessed on March 27, 2014. In my view the Insurer's intentions were clear.

After carefully reading Dr. Khaled's assessment,[17] which was attended by the Applicant, I find that he did not speak to or deny this assessment. Clearly the Insurer failed to properly assess the plan as it led the Applicant to believe. As a result I give little weight to the Insurer's OCF-3 argument for denying the disputed treatment plan. The OCF-3 request was made a day after the IE took place, the Insurer did not know the results or findings of Dr. Khaled at the time of the letter. There is no evidence before me that the Applicant received the evidenced OCF-3 request letter. The evidenced timeline by the parties shows that this OCF-3 request letter issue arose in another context years after the fact, when Applicant's counsel requested clarity on the denial of this benefit. Had the OCF-3 request been followed by a proper assessment, a different light would be cast on these events.

For the reasons above, I find that the treatment plan was reasonable and necessary, and I find that s. 3(8) also applies in that this March 7, 2014 treatment plan is deemed incurred, therefore the Insurer is liable to pay the claimed benefit.

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[17] Insurer's Examination Medical Physician Assessment dated April 17, 2014.

Therefore, I find that the Applicant is entitled to the treatment plan of $680.71 for Occupational Therapy Re-Assessment, dated March 7, 2014.

2b) Is Ms. Milan entitled to receive medical benefits for $3,048.20 for Physical rehabilitation, service provider Jason Vander Veen, Wellington Ortho & Rehab, dated December 19, 2013?

On December 19, 2013, Dr. Jason Vander Veen proposed that the Applicant should have massage therapy, physiotherapy and a gym membership. The total cost associated with these benefits was $4,044.75.

Dr. Khaled completed his IE assessment on March 27, 2014 to provide an opinion on whether this treatment was reasonable and necessary and determined that the physiotherapy and massages would provide no benefit. However, Dr. Khaled did recommend a gym membership at $926.55, which included childcare. This left a balance in dispute of $3,048.20. As noted above Dr. Khaled did testify as to the veracity of his report's findings and conclusions.

Arguments

The Applicant argues, in part, that Dr. Khaled's IE reports only denied passive therapies because further passive physiotherapy won't improve her state. This was verified during his testimony. Dr. Khaled did not deny physiotherapy treatment because it would not maintain the status quo or because it would not reduce pain. It is respectfully submitted that he was either unaware of or failed to apply the correct test when he denied these physiotherapy treatment plans.

The Applicant respectfully submits that Dr. Khaled's position that the Applicant requires no further facility-based treatment for her physical pain should be rejected. It is submitted that care which relieves physical pain, and therefore improves function, is a legitimate medical and rehabilitative goal. It appears that Dr. Khaled is of a different view or did not turn his mind to this treatment goal when he authored his report. It is submitted that further facility-based treatment is and was reasonable for her.

The Applicant argues and submits that Dr. Daugherty's testimony in support of his evidenced report, from a chiropractic view, was that exercise and diet play equal parts of the weight-loss picture. Dr. Daugherty highly recommended exercise and active therapy and testified that the Applicant's injuries would affect her ability to exercise and lose weight.

Further, the Applicant argues Mr. Vander Veen, the treating physiotherapist, testified that the Applicant's physiotherapy (within this treatment plan) would entail both active and passive components. Regarding passive physiotherapy, he also testified that "it's not that simple to just teach someone an exercise and send them on their way". He suggests that the Applicant had not reached the point where she was able to perform these exercises on her own. In his opinion, the Applicant required monitoring to ensure she performed the recommended exercises safely and properly. He further testified, in his professional opinion, that the Applicant had not yet reached this plateau which is why he submitted the treatment plans.

Finally, the Applicant submits that the preponderance of the evidence supports the position that she required and still requires further physiotherapy, which would either be active or passive exercise to help her and to teach her to exercise safely and properly which would improve her function by reducing pain. In that physiotherapy helps with pain reduction and maintenance, then pain reduction and maintenance are legitimate goals of medical rehabilitation benefits under the *Schedule* which renders the physiotherapy treatment plans reasonable and necessary. The Applicant submits that Dr. Khaled's position that the Applicant requires no further facility-based treatment for her physical pain should be rejected. Therefore, it is submitted that further facility-based treatment is and was reasonable for the Applicant.

The Insurer relies, in part, on the fact that Dr. Khaled testified, in his professional opinion, that people should require 4 weeks, or 6-10 sessions of physiotherapy in order to teach them all the exercises they should do at home.

Further, the Insurer also relies, in part, on the testimony of Jason Vander Veen, who confirmed, on cross-examination, that he would provide the Applicant with instructions concerning a home exercise program when she attended for her treatments. He also agreed that the idea was to graduate a patient from a passive exercise to an active exercise program and then to a self-directed home exercise program. Mr. Vander Veen confirmed that he had already taught the Applicant the 30 to 40 minutes of home exercise (he recommended she continue to perform at home on her own) by the time she completed his approved treatment plans, dated June 21, 2011, October 10, 2011 and December 6, 2011. As such the Applicant has received 32 fifty-minute sessions by the time those treatment plans were completed in December 2011. He agreed that the Applicant should have been able to continue performing those exercises on her own at the gym and/or at home.

Decision

In my view, both components of the "reasonable and necessary" test must be passed before I can find entitlement for same. In this instance I am unable to be persuaded that the treatment plan passes both tests. I believe that the subject treatment plan passes the "reasonableness" test, however, I am unable to conclude that the "necessary" component is also true.

Although Dr. Khaled's testimony might have been a narrow view of this particular circumstance, or on patients in general, I also believe that a person of the Applicant's demonstrated abilities should have graduated to the level of being able to perform her specific exercises some 30 months post-accident and after almost 32 hours' worth of physiotherapy. I give considerable weight to Mr. Vander Veen's testimony when he explains that the goal is to graduate the client to being able to do her in home exercises, unsupervised. The question is: how long does graduation take?

I note that Dr. Khaled writes in his report the following:[18]

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[18] Insurer's Examination Medical Physician Assessment Report, assessment date March 27, 2014, completion date April 17, 2014, page 9 of 11.

> I note however that the accident is over three years ago and the claimant is likely now at maximum medical recovery relative to any expected benefit from passive physiotherapy treatments. Further benefit may require cortisone injection to reduce inflammation or surgical repair. I don't expect that ongoing physiotherapy treatments will significantly benefit this claimant.

Further, I note that the Applicant testified that she refused cortisone treatments as well as surgery for her knee. I also note that the evidence shows that the Applicant doesn't use crutches or any other assistive devises anymore.

In my view, with the preponderance of all the evidence, I am unconvinced that the proposed treatment plan meets the "necessary" component of the reasonable and necessary test.

Therefore, I find that the Applicant is not entitled to $3,048.20 for Physical rehabilitation, dated December 19, 2013.

2c) Is Ms. Milan entitled to the medical benefit of $379.77 for physical rehabilitation, service provider Mark Guker, ReAlign Health, dated July 8, 2013?

On July 8, 2013, Dr. Mark Guker, Chiropractor issued a treatment plan which proposed the following for the Applicant:

- Manipulation of multiple regions (x18)
- Release-muscles of head and neck (x18)
- Therapy-multiple regions (x5)
- Exercise-multiple regions (x5)

The cost associated with this treatment was $1,969.75.

The evidence shows that the Insurer then arranged for an IE assessment. Dr. Alrick Daugherty completed the assessment on August 6, 2013 to provide an opinion whether this treatment was

reasonable and necessary. The doctor determined that the proposed treatment was partially reasonable and necessary. Dr. Daugherty determined:

- 7 x manipulations-multiple regions (instead of the 18 proposed) were reasonable and necessary.
- 14 x exercise-multiple regions (instead of the 5 proposed) were reasonable and necessary.

The cost associated with this treatment was $1,589.98, leaving a balance in dispute of $379.77.

Arguments

The Applicant argues that Dr. Daugherty's report and his testimony at the Hearing did not explain why he only approved 7 of the 18 manipulation sessions submitted. His report and his testimony supported more manipulations and he testified that he has had patients for which years of chiropractic treatments were required. His report's conclusion and his testimony are inconsistent. Furthermore, the Applicant argues that Dr. Daugherty's testimony was he was not focussed on maintenance or pain relief; his focus was on "improvement" only. The Applicant submits that this is not the correct test. Maintenance and pain relief are equally as important when it comes to the necessity and reasonableness of medical rehabilitation benefits under the *Schedule* as they are legitimate medical and rehabilitative goals. Dr. Daugherty's testimony is that he did not focus on the treatment goals as stated on the OCF-18, Part 9a),[19] when he authored his report.

The Applicant also relies on the family doctor's clinical notes and records of Dr. Librach. The evidence shows that the doctor continued to recommend more chiropractic treatments as late as September 26, 2016.

[19] Part 9 a) on page 4 of 5 of OCF-18 dated July 8, 2013.

The Insurer argues that Dr. Daugherty stated, when giving evidence at the arbitration Hearing, that the passive treatment that was being proposed would be of no benefit given the length of time that had transpired since the accident. He also confirmed that the Applicant had informed him that the prior treatment she had received was not beneficial. He also stated that the treatment which had been proposed would have "maintained the status quo" but would not have resulted in any improvement. Consequently, Dr. Daugherty altered Dr. Guker's treatment plan and recommended adjustments and active strengthening exercises which were more likely to provide benefit.

Decision

It is my view that removing segments of a comprehensive treatment plan must be done carefully. This specific alteration, in my view, goes against the stated goals of the plan.[20] In my view the removal of the passive treatment that was to balance the active treatments and adjustments was unreasonable. In consideration of the specifics of this case and the timing of this treatment plan, the Applicant has proven on the balance of probabilities that the passive components of the proposed treatment plan were reasonable and necessary under these circumstances.

For the reasons above, I find that the complete treatment plan inclusive of the denied $379.77 portion for physical rehabilitation, dated July 8, 2013, was reasonable and necessary. Therefore, I find that the Applicant is entitled to the $379.77 for physical rehabilitation, dated July 8, 2013.

2d) Is Ms. Milan entitled to the medical benefit of $1,100.00 for orthotics devices, service provider Healthy Step, dated July 26, 2013?

The evidence shows the sequence of events in that the Applicant submitted an OCF-18 completed by Dr. Mark Guker, dated May 10, 2013, proposing orthotics at a cost of $500.00. This was approved by the Insurer. The Applicant then submitted an OCF-18 for orthotics and orthotic devices on July 26, 2013. The Insurer subsequently requested an explanation for the

[20] Treatment and Assessment Plan (OCF-18) dated July 8, 2013, Part 9 a), page 4 of 5.

duplication. The Insurer has not received an answer to its duplication question. Only the second treatment plan is in dispute and before me.

Arguments

The Applicant argues that her testimony was that she did not receive the approved orthotics and that she was unaware that the previous treatment plan was approved.

The Applicant argued that the Insurer should now pay the $1,100.00 on the newer treatment plan in dispute because the first treatment plan that they did approve for $500.00 was never incurred or paid out, as she still does not have orthotic devices. The Applicant submits that this treatment plan was reasonable and necessary, and the Applicant should have received $1,100.00 worth of orthotics and orthotic devices. There is ample evidence to support her need for orthotics and there has been no evidence submitted to dispute this treatment plan.

The Applicant submits that this disputed treatment plan for orthotics and orthotic devices submitted by Dr. Tomines was never sent to an IE nor was it ever denied. The Insurer merely questioned why there was a duplication of a previous treatment plan submitted by Dr. Guker that was approved.

The Insurer argues, in part, the requested information was reasonably required to assist the Insurer in its decision as the Insurer had already approved an OCF-18 for the Applicant to receive orthotics, and reasonably required an explanation as to why the Applicant needed another set of orthotics.

The Insurer relies upon the recent Licensing and Appeals Tribunal ("LAT") decision of *16-002373 v. Aviva Insurance Canada 2017 CarswellOnt 14362*, which it argues has confirmed that if an applicant fails to provide information reasonably required to assist an insurer with its decision, section 33(6) of the *Schedule* will apply, and an insurer will not be liable to pay the

claimed benefit. The Insurer submits that this matter is analogous to *16-002373*, and it is the Insurer's position that it is not liable to pay the Applicant the $1,100.00 for the orthotics devices.

The relevant sections of section 33 of the *Schedule* read as follows:

> *Duty of Applicant to provide information*
>
> 33. (1) An Applicant shall, within 10 business days after receiving a request from the Insurer, provide the Insurer with the following:
>
> 1. Any information reasonably required to assist the Insurer in determining the Applicant's entitlement to a benefit.
>
> 33 (6) The Insurer is not liable to pay a benefit in respect of any period during which the Insured person fails to comply with subsection (1) or (2).

Decision

There is no evidence before me which provides for and explains why the Applicant was unable to speak to her treating chiropractor about the approval of the first orthotics treatment plan. There is no evidence as to why the disputed treatment plan duplicated the first approved plan some 60 days later. There is no evidence that the Insurer has rescinded the approval for the first treatment plan. There is no evidence that the Applicant or Applicant's counsel did not receive the confirmation letter for the approved orthotics.

I note it has been four years since the first treatment plan was approved and the Applicant still has not obtained said orthotics.

In my view, the Insurer is correct in making a reasonable request as to the reason for the duplication of the orthotics portion of the disputed OCF-18 of $1,100.00.

For the reasons above, I find that the Applicant failed to answer a reasonable question, and as a result s. 33(6) of the *Schedule* shall apply and the Insurer is not liable to pay the claimed benefit

of $1,100.00 for orthotics devices, dated July 26, 2013. Therefore, I find that the Applicant is not entitled to the claimed benefit of $1,100.00 for orthotics devices, dated July 26, 2013.

2e) Is Ms. Milan entitled to the medical benefit of $1,766.25 for physical rehabilitation and assessment, service provider Jason Vander Veen, Wellington Ortho & Rehab, dated February 13, 2015?

The Applicant submits that she has gained a significant amount of weight since the subject car accident, that she needs to lose weight, that weight loss would help with her pain, and that exercise plays an important role in weight loss.

Arguments

The Applicant argues that the evidence shows that her ability to lose that weight and not gain more weight was severely affected by the injuries she suffered from the car accident.

The Applicant submits that her ability to exercise was greatly impacted both from a physical and psychological standpoint because of the subject motor vehicle accident. It is respectfully submitted that the subject car accident caused or materially contributed to her weight gain.

The Insurer argues, in part, Dr. Khaled authored a second IE assessment report of May 22, 2015, about a year after the Applicant's second accident (June 19, 2014). Thus, the evidence shows the Applicant has or is receiving treatments from another insurer as a result of that accident. The Insurer notes the Applicant failed to notify Dr. Khaled of the second accident for his second report. Other significant factors and findings which are clearly articulated in Dr. Khaled's report read as follows:

> The treatment plan proposes the services of a physiotherapist entailing assessment; 15 sessions of physical rehabilitation; and a document fee, altogether totaling $1,766.25.[21]

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[21] Insurer's Examination Medical Physician Assessment dated May 22, 2015, paragraph 4 page 1.

> Presently my findings are unchanged. I also note that the majority of the claimant's symptoms remain unchanged and unimproved.[22]
>
> I also note that she continues to be overweight and has in fact increased her weight by 20 pounds since I last assessment about a year ago. The present BMI is over 50 well into the morbidity obese category. This in itself will significantly increase symptoms of pain and dysfunction at the left knee and back.[23]
>
> This treatment plan is for ongoing sessions of passive and active facility-based physiotherapy rehab. I note however that the Insured has had four years of regular treatment of this nature with no significant improvement in her symptoms. Based on the results of her recent MRI she has clear internal derangement at the left knee and likely requires surgical repair or at least further consultation. I expect there is limited on-going benefit with more physiotherapy treatments of this nature. The claimant does continue to have impairment at the left knee caused by the accident. Her headache and back pain are likely at maximum medical recovery as these were soft tissue injuries only do not require further treatment.[24]

The Insurer argues Dr. Khaled determined that the proposed treatment was not reasonable and necessary because it would provide a limited ongoing benefit. The Insurer submits that the Applicant provided no evidence after Dr. Khaled's IE to prove the necessity or efficacy of the proposed treatment. The Insurer relies on a recent LAT decision in *16-003333 v. Wawanesa Mutual Insurance Company* 2017 Carswell Ont 14364. The Insurer argues that this award confirms that if the Applicant has not met her onus of proof to prove that the benefit claimed was reasonable and necessary, then the Insurer is not liable to pay the claimed benefit.

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[22] *Ibid.*, paragraph 6, page 8 of 11.
[23] *Ibid.*, paragraph 6, page 8 of 11.
[24] *Ibid.*, paragraph 3, page 9 of 11.

Decision

In this instance I agree with the Insurer. The Applicant has not adduced evidence that these additional 15 physiotherapy treatments, after nearly four years of physiotherapy training and treatments and a gym membership will help resolve the Applicant's post-accident issues. The Applicant has not shown that this treatment would address the weight issue or the resulting psychological issues, which the Applicant is arguing. The Applicant has not shown that she is unable to motivate herself or otherwise go to a gym or continue with her in-home exercise program. In fact, the Applicant testified in cross-examination that she continually works out with a large rubber ball at home.

I note that Mr. Vander Veen testified that the most effective physiotherapy is the therapy within 6 months of an accident, and that he continues to submit treatment plans based solely on the fact that the Applicant has unresolved pain. Mr. Vander Veen also testified that clients can take a significant amount of time to move to a completely active exercise routine; depending on the person and injury it could take up to a year (not four years) to progress to this point.

Finally, I take into consideration Dr. Hatcher's testimony in regards to the Applicant's weight which verifies Dr. Khaled's findings listed above. Her testimony was that weight loss would lead to a significant decrease in comorbidity disorders and that she understood that the Applicant was obese prior to the accident and her obesity issue is not accident related. I note the family doctor's clinical notes and records show that the Applicant was 190 pounds just prior to the accident, the Applicant self-reports that she is 270 pounds as of the date of Dr. Hatcher's report.

For the reasons above, I find that this treatment plan of $1,766.25 for physical rehabilitation and assessment, dated February 13, 2015 is not reasonable or necessary. Therefore, I find that the Applicant is not entitled to the treatment plan of $1,766.25 for physical rehabilitation and assessment, dated February 13, 2015.

2f) Is Ms. Milan entitled to the medical benefit of $2,683.26 for a vocational assessment, service provider Ashok Jain, dated February 20, 2015?

The Applicant is claiming $2,683.26 for a vocational assessment and claims that she did not attend the IE as requested by the Insurer because the Insurer's request was not reasonable.

Arguments

The Applicant argues that the Insurer was invited, and had every opportunity to have this assessed by way of a paper review. The Applicant argues and maintains that the explanation of benefits letter dated April 9, 2015 was not a reasonable s. 44 request as the Insurer provided no valid medical or other reasons for the denial, or why it required the IE.

The Applicant submits that the evidence shows that the Insurer's stated medical reason displayed on the explanation of benefits letter clearly states: "the type(s) of treatment does not appear consistent with the patient's diagnosis". The Applicant argues that this phrase was clearly standard, not specific to the Applicant, boilerplate, and/or is not a valid reason, medical or otherwise, as to why the Insurer required an IE. Further, the Applicant argues that this disputed treatment plan was for a Vocational Assessment not treatment, and the Insurer did not explain or provide evidence as to why a Vocational Assessment did not appear consistent in this case. The Applicant submits it is unclear what diagnosis the Insurer was referring to and why it referred to the Applicant as a "patient".

The Applicant argues that the Insurer did not have an absolute or unqualified right to the IE under s. 44 of the *Schedule*, however, should the Insurer request an IE, the medical reasons for the examination are mandatory. The Applicant relies, in part, upon *Augustin v. Unifund Assurance Co.* (2013), 2013 CarswellOnt 15809 (F.S.C.O. Arb.) where Arbitrator Sapin finds and writes the following at paragraph 48-60:

> 48 The requirement to include medical reasons in an IE notice, as distinct

from "other" reasons, is also new to the SABS-2010. The previous s. 42(4)(a) required only that an IE notice include "the reasons for the examination."

49 As stated above, I find s. 38 and s. 44 must be read together, as the right to an IE is founded in s. 38(10) and arises from the Insurer's right under s. 38(8) to refuse a claim for treatment. I have already identified that the "medical reasons and all of the other reasons" in the refusal notice should include, at a minimum, a statement that the claims adjuster has reviewed the MIG and the treating health practitioner's medical opinion, and has concluded that the health practitioner has not provided compelling evidence that the person's injuries are outside the MIG, or that the treatment claimed is reasonable or necessary. The "medical and other reasons for the examination" in the Notice of Examination under s. 44(5) should contain substantially similar information.

50 Unifund's IE notice, above, does not reflect these additional requirements and so does not comply with the *Schedule*.

58 The second reason I do not agree with Unifund's interpretation is that it is too broad. If it were correct, Insurers could require any number or type of IEs they liked, no matter how often, or how unreasonable, without oversight or consequence, and Insured persons would be forced to attend on pain of permanently jeopardizing their benefits and any right to dispute the reasonableness of the IE, without any recourse at all.

59 Such an interpretation strays too far from an Insurer's obligation of utmost good faith in a first party system and the standard of consumer protection set by cases such as *Smith v. Co-operators General Insurance Co.* and years of court and arbitral jurisprudence. It is not tenable.

> 60 I find in this case that Ms. Augustin's failure to attend an IE does not preclude her from a determination of whether the IE requested by Unifund was reasonably necessary.

Therefore, the Applicant submits that the Insurer's Notice of Examinations for both the Occupational Therapy and Vocational Assessments do not reflect any of the required information, by analogy, identified by Arbitrator Sapin above. Thus, these denials and notices contained standard, boilerplate language not specific to the Applicant and there is every indication that the adjuster did not review any relevant documents pertaining to the Applicant's claims to these assessments.

Finally, the Applicant argues that because this was actually incurred, and it is respectfully submitted, it should be deemed incurred by s. 3(8). It is respectfully submitted that the Insurer was required to pay for this treatment and assessment plan after the 11th day under subsection 38(11) because it failed to give a notice in accordance with s. 38(8) and has never provided notice in accordance with s. 38(8).

The Insurer argues that section 37(7)(a) and (b) confirm that if an insured person fails to attend an examination which they are required to attend, the insurer may make a determination that the applicant is not entitled to any expenses recommended under their treatment plan, unless the applicant has reasonable cause for not attending the IE. Here, the Applicant has failed to attend an IE which she was required to attend and further failed to provide an acceptable reason for her failure to attend and/or complete the required examinations. Hence, Aviva had the discretion to make a determination that the Applicant is not entitled to the expenses claimed for and that it is not liable to pay $2,683.26 for the vocational assessment by service provider Ashok Jain, dated February 20, 2015.

The Insurer continues to submit that s. 15(1)(h) of the *Schedule* states that the Insurer shall pay for all reasonable and necessary expenses incurred by or on behalf of the Insured person as a

result of the accident for "other goods and services of a medical nature that the Insurer agrees are essential for the treatment of the Insured person, and for which a benefit is not otherwise provided in this Regulation". Section 3(7)(e) defines "incurred", for purposes of the *Schedule*, as follows:

> An expense in respect of goods or services referred to in this Regulation is not incurred by an Insured person unless
>
> (i) the Insured person has received the goods or services to which the expense relates;
> (ii) the Insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and;
> (iii) the person who provided the goods or services;
>
> (A) did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or
> (B) sustained an economic loss as a result of providing the goods or services to the Insured person.

On this point the Insurer argues that Arbitrator Anne Sone addressed the issue of "incurred expense" in *Barnes and the Motor Vehicle Accident Claims Fund* (FSCO A13-005372) and concluded that the claimant must prove that the expense has been incurred and that the claimant has received the claimed services. The Insurer submits the Applicant has not received any of the treatment which is currently in dispute in this Application and has not incurred the expense associated with the proposed treatment. There was no evidence presented to prove that she paid for the treatment in dispute, which she is contractually liable to pay for, or that she has promised to pay for it. Consequently, even if the proposed treatment was found to be reasonable and necessary, the Insurer has no obligations to pay as it has not been incurred.

Decision

First, I note that the vocational assessment OCF-18 was completed by Ashok Jain for Vocational Alternatives Inc. on February 20, 2015. On page 6 of 7 of the OCF-18 it clearly states that Mr. Cohen is the actual vocational evaluator/consultant who will be overseeing the plan. As this completed assessment is within the body of evidence and Mr. Cohen testified to its veracity it does in my view satisfy the *Schedule* in regards to an "incurred expense".

In regards to the question of whether or not the Insurer's medical reasons are in fact medical reasons in its notice of assessment letter, I agree with the Applicant and find that this notice is invalid and/or improper. Therefore, the Insurer is required to pay for this assessment plan after the 11th day under s. 38(11) because it failed to give notice in accordance with s. 38(8) and has not provided notice in accordance with s. 38(8)

For the above reasons I find that the Applicant is entitled to the assessment plan of $2,683.26 for a vocational assessment dated February 20, 2015.

1) ***Is the Applicant entitled to interest for the overdue payment of benefits?***

The Applicant submits that her entitlements and the amounts thereof were crystallized under a "transitional policy" on the date the insurance contract was entered into which is why the Applicant has $100,000.00 available in medical and rehabilitation benefits. It is submitted that it makes no difference that it was not her own policy but the policy of the defendant driver that is responsible; that policy covers the Applicant in the same way as if it was her own and the amounts, which includes interest, are determined under the "*Old Schedule*", known as *Ontario Regulation 403/96: Statutory Accident Benefits after November 1, 1996*, therefore it is submitted that the interest rate for outstanding amounts owing is 2% compounded monthly.

I note that the Insurer did not argue or contest this point.

I find the Applicant as a result of the above decisions, in regards to the three OCF-18s listed above, is entitled to interest for these overdue amounts, at the rate of 2% compounded monthly in accordance with the *Old Schedule*.

2) Is Aviva liable to pay a special award to the Applicant?

The Applicant submits that if it is found that she is entitled to overdue payments and that these payments were unreasonably withheld by the Insurer, a special award should be granted.

The Applicant argues through her counsel, she advised the Insurer's counsel on August 28, 2017 that having not claimed a special award on the Application for Arbitration was an oversight. The Applicant argues that this constituted advance notice. Additionally, the Insurer knew or ought to have known that Arbitrators have special award jurisdiction and thus it ran the risk of exposure to a special award despite it not being specifically claimed on the Application for Arbitration.

To this point, the Applicant continues to argue that an Arbitrator's special award jurisdiction arises from s. 282(10) of the *Insurance Act*,[25] which notes the following:

> If the arbitrator finds that an Insurer has unreasonably withheld or delayed payments, the arbitrator, in addition to awarding the benefits and interest to which an Insured person is entitled under the *Statutory Accident Benefits Schedule*, shall award a lump sum of up to 50 per cent of the amount to which the person was entitled at the time of the award together with interest on all amounts then owing to the Insured (including unpaid interest) at the rate of 2 per cent per month, compounded monthly, from the time the benefits first became payable under the *Schedule*.

[25] Section 283 of the *Insurance Act*, R.S.O. 1990 c. I.8 as it read immediately before being amended by Schedule 3 to the *Fighting Fraud and Reducing Automobile Insurance Rates Act, 2014*, and Regulation 664, R.R.O. 1990.

The Applicant submits that the Insurer's conduct in refusing to pay her IRBs as well as its denial of funding for the disputed physical treatments and examinations constitutes an unreasonable delay. Furthermore, it is respectfully submitted that the Insurer failed in its duty to administer the file in a fair and even-handed manner, thus fulfilling the requirements for granting a special award.

Further, the Applicant argues that all of the Insurer's failures constitute unfair and deceptive practices as found in the *Insurance Act - Ontario Regulation 7/00 Unfair or Deceptive Acts or Practices*.

Decision

I note the Insurer did not argue against any of the merits for a special award as argued by the Applicant.

I agree with the Applicant that constant misstatements within an explanation of benefits letters are more than an inconvenience to an applicant, and as such the passive-aggressive actions of a "sophisticated party" strays too far from an insurer's obligation of utmost good faith in a first party system and the standard of consumer protection as set out by cases such as *Smith v. Co-operators General Insurance Co.*[26] It is quite distasteful and should not happen. However, regarding the circumstances in this case, I am unable to hold the Insurer to a level of perfection, and as such the discrepancies do not rise to the level of an unfair or deceptive practice.

Therefore, I find that the Insurer is not liable to pay a special award to the Applicant.

3) Expenses

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[26] *Smith v. Co-operators General Insurance Co.*, (2002), 2002 SCC 30 (SCC).

Neither party made submissions on expenses. Should the parties become unable to resolve this issue, they shall subsequently schedule an expense hearing before me in accordance with Rules 75 to 79 of the *Dispute Resolution Practice Code*.

Charles Matheson
Arbitrator

January 4, 2018
Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A15-005751

BETWEEN:

CINDEE MILAN

Applicant

and

AVIVA Canada Inc.

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c. I.8, as it read immediately before being amended by Schedule 3 to the *Fighting Fraud and Reducing Automobile Insurance Rates Act*, 2014, and Ontario *Regulation 664*, as amended, it is ordered that:

1. I find the Applicant is not entitled to receive a weekly income replacement benefit in the amount of $325.00 from July 3, 2013 to date and on-going.
2. Is the Applicant entitled to receive the following medical benefits?
    a. I find that the Applicant is entitled to the treatment plan of $680.71 for Occupational Therapy Re-Assessment, dated March 7, 2014.
    b. I find that the Applicant is not entitled to $3,048.20 for Physical rehabilitation, dated December 19, 2013.
    c. I find that the Applicant is entitled to $379.77 for physical rehabilitation, dated July 8, 2013.
    d. I find that the Applicant is not entitled to $1,100.00 for orthotics devices, dated July 26, 2013.
    e. I find that the Applicant is not entitled to the treatment plan of $1,766.25 for physical rehabilitation and assessment, dated February 13, 2015.

f. I find that the Applicant is entitled to the assessment plan of $2,683.26 for a vocational assessment dated February 20, 2015.

3. I find that the Insurer is not liable to pay a special award to the Applicant.
4. I find that the Applicant is entitled to interest for these overdue amounts, at the rate of 2% compounded monthly in accordance with the *Schedule*.
5. Should the parties become unable to resolve this issue, they shall subsequently schedule an Expense Hearing before me in accordance with Rules 75 to 79 of the provisions of the *Dispute Resolution Practice Code*.

Charles Matheson
Arbitrator

January 4, 2018
Date