RECONSIDERATION DECISION

Citation: S.W. v. Aviva Insurance Company, 2021 ONLAT 18-006517/AABS – R

Before: Craig Mazerolle

Date: February 3, 2021

File Number: 18-006517/AABS

Case Name: S.W. vs. Aviva Insurance Company

Written Reconsideration Submissions by:

For the Applicant: Rajwant Singh Bamel, Counsel

For the Respondent: Geoffrey Keating, Counsel

OVERVIEW

[1] Due to injuries sustained from an accident on May 2, 2016, the applicant sought medical benefits from the respondent, pursuant to the *Statutory Accident Benefits Schedule* (the "*Schedule*").[1] The respondent denied some of these benefits, so an application was filed with the Tribunal.

[2] After reviewing the parties' written submissions, I awarded the applicant some of the disputed medical benefits (i.e., the "Original Decision", dated April 7, 2020).[2] Briefly, I found the applicant was entitled to "the two physiotherapy treatment plans, the neurological assessment, the disability certificate, the chronic pain assessment, the chronic pain program, and $1,200.00 of the shockwave therapy treatment plan".[3] In addition to the other half of the shockwave therapy treatment plan, I denied the disputed psychological assessment and the outstanding amount under the psychological services plan.

[3] The respondent took issue with the Original Decision, so it filed a Request for Reconsideration on April 28, 2020. In this Request, the respondent alleged several factual and legal errors. Specifically, the Tribunal is alleged to have:

(a) Incorrectly found the applicant ceased physical treatment in May 2018;

(b) Incorrectly referred to the physical therapy in dispute as "physiotherapy";

(c) Failed to consider the assessments the applicant had already completed in approving the chronic pain assessment;

(d) Either did not consider or incorrectly interpreted the opinions of the respondent's physiatry assessor, Dr. Alborz Oshidari;

(e) Did not address the respondent's concerns about the psychological assessment conducted by Dr. Andrew Shaul and Helen Ilios;

(f) Applied the wrong test when it approved the chronic pain program;

(g) Incorrectly found that shockwave therapy formed a part of the chronic pain program; and,

[1] *Effective September 1, 2010*, O. Reg. 34/10.
[2] *S.W. v. Aviva General Insurance*, 2020 CanLII 34434 (ON LAT).
[3] Original Decision at para. 56. The total amount requested under the shockwave therapy plan was $2,400.00.

(h) Incorrectly found the disability certificate to be payable.

[4] The applicant asked the Tribunal to dismiss the respondent's Request in full. While the applicant conceded that there were several "clerical errors" in the Original Decision, she argued that the respondent did not provide an explanation provided to justify why these errors reached the high standard needed for granting a reconsideration.

[5] For the reasons to follow, I will dismiss the respondent's Request for Reconsideration in full.

ANALYSIS

[6] The Tribunal does not grant reconsideration requests lightly. As described by then Associate Chair Batty in *J.R. v. Coachman Insurance Company*, reconsiderations are meant to remedy "serious breaches of procedural fairness or errors that materially affect decisions."[4] Therefore, "[m]inor or inconsequential procedural or substantive mistakes do not qualify" for the "broad remedial powers" afforded to the Tribunal through this process.[5]

[7] The grounds for granting a reconsideration are enumerated in Rule 18.2 of the Tribunal's *Common Rules of Practice and Procedure*:

(a) The Tribunal acted outside its jurisdiction or violated the rules of procedural fairness;

(b) The Tribunal made an error of law or fact such that the Tribunal would likely have reached a different result had the error not been made;

(c) The Tribunal heard false evidence from a party or witness, which was discovered only after the hearing and likely affected the result; or

(d) There is evidence that was not before the Tribunal when rendering its decision, could not have been obtained previously by the party now seeking to introduce it, and would likely have affected the result.

[8] Of relevance is subsection (b), as—while I accept that there are several minor errors in the Original Decision—I am not satisfied that I would have reached a different conclusion on any of the disputed benefits had I not made these errors.

[4] 2018 CanLII 39372 (ON LAT) at para. 30.
[5] *Ibid* at paras. 31-32.

Ceasing Physical Therapy

[9] As explained in the Original Decision, applicants must demonstrate—on a balance of probabilities—that the medical or rehabilitation services listed in a treatment plan are reasonable and necessary as a result of injuries caused by the accident.

[10] In the Original Decision, I concluded at paragraph 18 that:

> the applicant continued with physiotherapy until May 2018, at which point these services were no longer approved by the respondent. This longstanding reliance on physical therapy not only speaks to its efficacy at dealing with her condition, but—as detailed in the assessment with [the respondent's psychological assessor, Dr. Monique Costa El-Hage—the applicant's pain worsened after she stopped receiving this treatment. Therefore, while Dr. Oshidari may have concluded that physical therapy would no longer be of assistance, this timeline of recovery and subsequent deterioration suggests otherwise.

[11] The respondent took issue with this finding for two reasons. First, by pointing to references in assessments with the applicant from 2019, it argued that she did, in fact, continue with physical therapy after May 2018. According to the respondent, if this error had not been made, the Tribunal would have had no reason to then disregard the opinion of Dr. Oshidari. The respondent also submitted that I erred in concluding the applicant ceased this physical therapy due to its denial of this funding. The respondent argued that I ignored how the applicant discontinued this therapy "voluntarily" and, had I not made this error, I would have reached a different conclusion.

[12] The applicant countered this argument by submitting that "if the treatment was found to be ongoing after May of 2018, it would only reiterate the learned Adjudicator's finding that the Applicant had continuous ongoing reliance on physical therapy speaking to its efficacy and its reasonableness and necessity moving forward." I agree.

[13] Again, the basis of my finding that this physical therapy is reasonable and necessary can be summed up in the aforementioned passage from the Original Decision: "This longstanding reliance on physical therapy not only speaks to its efficacy at dealing with her condition, but—as detailed in the assessment with Dr. El-Hage—the applicant's pain worsened after she stopped receiving this treatment."

[14] Therefore, if the applicant continued with treatment past May 2018, this fact would strengthen the conclusion that she has long relied on this treatment due to its efficacy. Moreover, even if I accept the respondent's contention that the applicant ended this therapy voluntarily, it does not change the statement she made to Dr. El-Hage (report dated August 8, 2019) that her condition worsened when she stopped attending the treatment—a statement I chose to accept in my reasoning.

[15] Either way, I do not see how reaching a different factual finding on either or both of the respondent's points would have changed the conclusion that the physical therapy in dispute is reasonable and necessary.

"Physiotherapy" vs. Physical Therapy

[16] In the Original Decision, I occasionally labelled the physical therapy treatment plans in dispute as requests for "physiotherapy", even though the practitioners slated to perform these services did not include a physiotherapist. The respondent, therefore, took issue with the use of the term "physiotherapy", as it argued that it suggests I did not understand the nature of the services at issue.

[17] I fail to see how changing the word used to describe these services would have led to a different conclusion. That is, in spite of this catch-all term, the Original Decision demonstrates an appreciation of the applicant's accident-related impairments and the need for physical therapy.

[18] Further, the use of the term "physiotherapy" in the Tribunal's orders preceding the original written hearing suggests that the parties put little weight on this word. That is, in both the order setting up the original hearing (dated November 1, 2018), as well as the later motion order that added the second of the two physical therapy treatment plans to the list of issues (dated May 13, 2019), these disputed services were referred to as "physiotherapy". If any significance attached to this label, the parties had an opportunity to amend these orders.

Chronic Pain Assessment

[19] In the Original Decision, I awarded the disputed chronic pain assessment for the following reasons:

> Evidence of significant, post-accident changes to the applicant's well-being can be found throughout the medical records, including: a reduction in pre-accident, social activities; functional limitations (e.g., lifting, carrying, caregiving, etc.); and, while she has returned

> to full time work as a nurse, she has required help with the job's physical tasks.
>
> Therefore, considering both the length of time since the accident, as well as the functional changes during this period, it was reasonable for the applicant to explore the possibility that her pain had developed into a chronic condition. As such, I find the chronic pain assessment to be reasonable and necessary.[6]

[20] The respondent challenged this reasoning, as the applicant already had "the opportunity to explore the issue of chronic pain, through attendances at assessments with Dr. [Michael] Gofeld and Ms. Ilios/Dr. Shaul." Since none of these assessors diagnosed the applicant with a chronic pain condition, the respondent argues, it was a factual error to approve further testing.

[21] I do not accept this argument. First, I fail to see how this proposed chronic pain assessment was duplicative of the testing performed by Ms. Ilios and Dr. Shaul, as these assessors conducted a psychological assessment. Second, the testing the respondent cites from Dr. Gofeld was the proposed chronic pain assessment that the applicant sought payment for in this disputed treatment plan. Beyond the fact that the focus of the reasonable and necessary analysis for assessments should be limited to the evidence available at the time of said plan's submission, there is no obligation for testing to reveal a diagnosable condition to find that an assessment is payable. Indeed, such a requirement would largely, if not completely, obviate the need for the assessment itself.

[22] Taken together, I do not put any weight on this argument.

Dr. Oshidari's Expert Reports

[23] The respondent also claims that I did not "consider" the paper review of Dr. Oshidari (dated August 8, 2019) in the Original Decision, a failure that amounts to "a violation of procedural fairness." The respondent then claims that "[t]he Tribunal had criticized Dr. Oshidari's report, on the basis that it ran contrary to the Applicant's timeline of recovery and subsequent deterioration." I believe this second argument relates to Dr. Oshidari's initial report (dated May 8, 2019).

[24] First, I do not find merit in the argument that I breached the respondent's right to procedural fairness, as this paper review was referenced in the Original Decision (albeit when summarizing the parties' positions on the evidence):

[6] Original Decision at paras. 39-40.

> Then, in regard to the chronic pain treatment, the applicant submitted that not only would it assist with this longstanding issue, but the paper review conducted for the respondent by Dr. Oshidari is flawed (dated August 8, 2019). That is, Dr. Oshidari allegedly failed to consider the clinical notes of the applicant's physician, as well as the "ultra sound findings of Dr. Gofeld" (namely, the findings of supraspinatus and labral tears).[7]

While the Original Decision did not specifically reference the conclusions made in this paper review, it cannot be said that it was not considered in my deliberations.

[25] Then, concerning the claim that I incorrectly analyzed Dr. Oshidari's initial expert report, the respondent may disagree with my findings on this point, but a reconsideration will not be granted on the sole basis of a disagreement with a factual finding that is based on a weighing of the evidence.

Arguments About the Applicant's Psychological Assessment

[26] The respondent also alleged that the Tribunal committed a legal error by not referencing its arguments about the applicant's psychological assessment from Dr. Shaul and Ms. Ilios. Briefly, the respondent alleged during the original written hearing that this report ignored contradictory evidence when making determinations about the applicant's functional limitations (e.g., the applicant had returned to her pre-accident role as a nurse, yet the report stated she had difficulty with less physical tasks like household chores). The respondent also noted that both Dr. Shaul and Ms. Ilios signed the report, yet there was no indication as to what sections were completed by each assessor.

[27] Even if these concerns had been specifically addressed in the Original Decision, I fail to see how it would have affected my findings.

[28] First, many of the respondent's concerns with this assessment during its original written submissions involved sections of the report that were not conclusions made by Dr. Shaul or Ms. Ilios, but rather self-reported symptomology from the applicant. For instance, though the respondent challenged a part of the report detailing physical tasks she could not complete, these limitations were subjective complaints from the applicant, not an opinion reached by the assessors.

[7] Original Decision at para. 34.

[29] As such, the following statement I made in the Original Decision about the other disputed report from the applicant is of importance: “The respondent raised concerns about Dr. Gofeld’s qualifications that will be discussed below, but—considering this psychological symptomology was self-reported—I am willing to accept this part of his report.”[8] Put another way, I was not concerned about issues the respondent may have had with an assessor if the information I gleaned from his or her report was limited to self-reported symptoms.

[30] Then, moving on to the respondent’s concern about the authorship of the report, the main reference to the actual conclusions made by these assessors in my Original Decision is limited to the following passage, wherein I provided my reasons for approving the disputed chronic pain program:

> Then, moving on to the proposed program, Dr. Shaul’s assessment provides a helpful explanation for why this program is needed, as he addressed the connection between the applicant’s physical and psychological conditions:
>
> > These psychological and emotional difficulties are in large part a direct consequence of her physical condition. As long as her physical condition, along with its pain and restrictions remain present, it is likely that [the applicant] will experience significant emotional distress.
>
> This need for treatment that covers both the applicant’s physical and psychological impairments is, therefore, why I find this chronic pain program to be reasonable and necessary. That is, the plan proposes a combination of physical and psychological modalities that, together, form a holistic, wraparound treatment regime that may finally provide the applicant with lasting pain relief.[9]

[31] I have highlighted this passage because, even if this specific conclusion had been reached solely by Ms. Ilios, I am satisfied that her status as a mental health professional would allow her to provide this kind of expert opinion, i.e., an explanation for why the psychological and physical impairments are connected.

[32] I would then note that, while the respondent also cited concerns that other adjudicators have expressed regarding the reports of Dr. Shaul, I do not place much weight on this argument. Each claim before the Tribunal must be evaluated on its own merits, and so concerns about a particular assessor must always be understood alongside the totality of the hearing record. In the present

[8] Original Decision at para. 28.
[9] Original Decision at paras. 41-42.

case, I see no reason why these concerns would affect my determinations, as the Original Decision demonstrates a reasonable weighing of the entire evidentiary record.

Test for Approving the Chronic Pain Program

[33] Beyond concerns about my reliance on the applicant's psychological assessment, the respondent also alleged that I used an incorrect legal test when I found the chronic pain program to be reasonable and necessary. Specifically, the respondent took issue with the use of the word "may" in the final sentence of the above cited passage, as it argued [citations removed]:

> The test requires that an Applicant show that a benefit is reasonable and necessary on a balance of probabilities. A finding that a proposed benefit "may" assist falls far short of this standard. It suggests that any benefit would be considered reasonable and necessary if there was a chance that it may result in improvement, despite how speculative that chance might be.

[34] The respondent may take issue with the use of the word "may", but the high standard needed to grant a reconsideration will generally not be met due to one or two questionable words. Rather, an adjudicator's reasoning and language must be understood in the context of the entire decision under review.

[35] Therefore, beyond the fact that the test for approving a medical benefit was clearly stated at outset of the Original Decision, there were a number of other medical and rehabilitation benefits considered throughout. There is no indication that an incorrect test was applied to these other determinations, and so—while the words "will likely" would have been a more accurate encapsulation of the test than "may"—it is not enough to extract a single word from an adjudicator's reasons. Rather, the Tribunal's overall rationale must be considered, and I am satisfied that, when seen as a whole, the justification for this finding is sound and in line with the statutory test.

Shockwave Therapy

[36] The respondent claimed in its Request for Reconsideration that there is no mention of shockwave therapy in the chronic pain program that was approved in the Original Decision. As such, it appears to take the position that the shockwave therapy approved in the separate, standalone shockwave therapy treatment plan should not be payable, due to the relationship between this approval and the approval of the chronic pain program.

[37] I do not accept this argument, as it ignores that shockwave therapy is listed as one of the modalities in the chronic pain program treatment plan.

Disability Certificate

[38] In the Original Decision, I found the disability certificate (signed December 9, 2017) was payable because:

> A significant amount of time had passed since the last disability certificate was signed on June 6, 2016, so it was reasonable for the applicant to seek out an updated summary of her medical condition, especially as it could have captured impairments that develop slowly over time.[10]

[39] While the respondent argued in its Request that a disability certificate is only payable when requested by an insurer to determine entitlement to a specified benefit, the applicant contended that this certificate was prepared for the purpose of determining her entitlement to specified benefits. In support of its position, the respondent cited the Tribunal's decision in *O.R.O. v. Aviva Insurance Company*, wherein Adjudicator Braun denied payment of a disability certificate as it did not meet the standard under s. 25(1) of the *Schedule*.[11]

[40] I conclude that I did not err in awarding the payment of this disability certificate. Section 25(1) clearly states that these expenses are payable when required under ss. 21, 36, or 37 of the *Schedule*. In the present case, the respondent alleged that, since the applicant had returned to work, there could be no specified benefits at that time. Beyond the reasoning I provided in the Original Decision regarding the length of time that had passed since the last certificate, the fact that an individual has returned to work does not foreclose the possibility of receiving the other specified benefits identified in s. 36 (e.g., housekeeping).

[41] I also do not accept the interpretation of s. 25(1) in *Aviva*, specifically where the adjudicator found insurers must request a certificate before it becomes payable. There is no mention of this requirement in s. 25(1), and requiring insurers to first request these records before they are payable is an unreasonable barrier for applicants attempting to access specified benefits. Such an interpretation would run counter to the consumer protection mandate of the *Schedule*.

[10] Original Decision at para. 49.
[11] 2019 CanLII 101441 (ON LAT) at para. 30 ("*Aviva*").

ORDER

[42] The respondent's Request for Reconsideration is dismissed in full.

Released: February 3, 2021

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Craig Mazerolle
Adjudicator