FSCO A99–000849

BETWEEN:

MARY GLINKA

Applicant

and

DUFFERIN MUTUAL INSURANCE COMPANY

Insurer

REASONS FOR DECISION

Before: M. Kaye Joachim

Heard: July 18, 19, 20, 2000, at the Offices of the Financial Services Commission of Ontario in Toronto.
Written submissions were received on August 22, September 21 and October 12, 2000.

Appearances: Roland Spiegel for Ms. Glinka
Eric K. Grossman for Dufferin Mutual Insurance Company

Issues:

The Applicant, Mary Glinka, was injured in a motor vehicle accident on September 2, 1998. She applied for and received statutory accident benefits from Dufferin Mutual Insurance Company ("Dufferin"), payable under the *Schedule*.[1] The parties were unable to resolve their disputes through

[1]The *Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996*, Ontario Regulation 403/96, as amended by Ontario Regulations 462/96, 505/96, 551/96 and 303/98.

mediation, and Ms. Glinka applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

The issues in this hearing are:

1. Is Ms. Glinka entitled to receive a medical benefit for treatment provided by Success Rehabilitation Clinic in the amount of $14,129.95 and ongoing claimed pursuant to section 14 of the *Schedule*?

2. Is Ms. Glinka entitled to payments for the cost of examinations by Deahy Medical Assessments Inc. ($2,514.50), Homereach Community Inc. ($1,272.95), and Dr. Harris ($1,125), pursuant to section 24 of the *Schedule*?

3. Is Dufferin liable to pay a special award pursuant to subsection 282(10) of the *Insurance Act* because it unreasonably withhold or delayed payments to Ms. Glinka?

4. Dufferin claims reimbursement of the cost of missed insurer's examinations.

5. Is Dufferin liable to pay Ms. Glinka's expenses in respect of the arbitration under section 282(11) of the *Insurance Act*, R.S.O. 1990?

6. Is. Ms. Glinka liable to pay Dufferin's expenses in respect of the arbitration under section 282(11) of the *Insurance Act*, R.S.O. 1990?

7. Is Ms. Glinka liable to pay Dufferin an award under section 282(11.2)of the *Insurance Act*, R.S.O. 1990?

Result:

1. Ms. Glinka is entitled to some chiropractic, physiotherapy, and massage expenses incurred at Success Rehabilitation Clinic, in accordance with this decision.

2. Ms. Glinka is entitled to $2514 in respect of the Deahy account and $933 in respect of the Homereach account, plus interest.

3. Dufferin is not liable to pay a special award.

4. Dufferin is not entitled to cancellation fees.

5. Ms. Glinka is not entitled to her arbitration expenses.

6. Dufferin is entitled to its reasonable arbitration expenses in respect of Dr. Bereznick's second attendance on July 20, 2000.
7. Dufferin is not entitled to an award under section 282(11.2) the *Insurance Act*, R.S.O. 1990.

8. Dufferin is not entitled to the cost of missed insurer's examinations.Ms. Glinka is not entitled to her arbitration expenses.

9. Dufferin is entitled to its reasonable expenses related to the second attendance of Dr. Bereznick.

EVIDENCE AND ANALYSIS:

Mary Glinka was 40 years old at the time of the accident. She was living in Feversham (near Stayner/Collingwood) and commuting to work on Airport Road in Toronto. Ms. Glinka was employed as a Counsellor/Officer Assistant with Citizenship and Immigration. Her duties included processing immigration applications, making referrals for clients, and inputting information on citizenship and immigration files. She worked four days per week, seven and a half hours per day.

Ms. Glinka suffered a whiplash injury in a motor vehicle accident on September 2, 1998. Her initial symptoms included stiffness in the neck and back, headache and mild dizziness, left knee pain, and bruising. She has not returned to work since. Initially she reported difficulties with household chores, but over time, gradually resumed most of these activities.

Ms. Glinka was immediately referred to Success Rehabilitation Clinic, a clinic owned by Dr. Judy Silverman, a chiropractor. She began chiropractic, physiotherapy, and massage treatments, which have continued uninterrupted until the date of the hearing.

Dr. Silverman submitted a treatment plan proposing 20 chiropractic sessions, 25 active rehabilitation sessions and eight half-hour massage sessions over six weeks at a proposed cost of $3,280. Dufferin agreed to pay for the proposed treatment plan and in fact paid $4,200.45 in respect of services, assessments and reports.

On October 21, 1998, Dr. Silverman submitted a second treatment plan proposing another 15 chiropractic sessions, 20 active exercise sessions and five half-hour massage sessions over the next four weeks. Dufferin declined to pay for the proposed services and attempted to set up a Medical and Rehabilitation DAC Assessment in respect of the proposed treatments. For reasons which will be explained in greater detail later, this did not take place until August 1999.

Meanwhile, Dr. Silverman continued to treat Ms. Glinka and submitted further treatment plans on November 13 1998, December 2, 1998, January 20, 1999 and March 26, 1999 recommending further chiropractic, rehabilitation exercises, and massage treatments. Dufferin continued to refuse to pay for these services.

The issue before me is whether the ongoing chiropractic, physiotherapy, and massage treatments as recommended in the October 21, 1998 treatment plan and subsequent treatment plans were reasonable and necessary expenses incurred as a result of the accident.

Dr. Lew Pliamm, Ms. Glinka's family physician, confirmed that immediately after the accident Ms. Glinka began complaining of neck pain, back pain, left knee pain, insomnia, anxiety and distress. He advised that he had previously treated Ms. Glinka for left knee pain and anxiety and stress, but that these conditions had been aggravated by the accident. The evidence did not demonstrate any serious complaints of neck and back pain prior to the accident.[2] Dr. Pliamm diagnosed WAD grade II, back

[2]The OHIP records disclose one visit to Dr. Silverman in January 1998, but Ms. Glinka did not recall visiting Dr. Silverman prior to the accident. I am not satisfied that this isolated OHIP billing record indicates significant pre-existing neck or back problems. Dr. Pliamm's clinical notes and records are the best evidence of Ms. Glinka's pre-accident health complaints, and his records do not disclose complaints of neck and back pain prior to the accident.

pain, insomnia and anxiety. He recommended passive therapy, followed by active treatment, but suggested no time frames. There are no other reports from Dr. Pliamm explaining Ms. Glinka's ongoing need for chiropractic, physiotherapy or massage.

Dr. Silverman also described Ms. Glinka's injuries as a WAD grade II, upper back strain and lower back strain. She initially recommended 20 chiropractic treatments, 25 physiotherapy treatments and eight massage treatments over six weeks. The short term goal was to increase range of motion and decrease pain, and the long term goal was to restore normal function.

Ms. Glinka initially attended at the clinic four times per week. This necessitated significant travelling. Sometimes she had a ride from Feversham to the clinic at Yonge and Finch. Other times she was driven to Bramalea, where she took the Go Bus and then the subway. She waited at a friend's place until she could make the return trip home.

The chiropractic therapy, which has remained relatively unchanged throughout consists of chiropractic manipulation, the use of TENS machine, and the application of heat/cold. Initially, ultrasound was also applied. The chiropractic portion lasts approximately 30 minutes. The physiotherapy consists of walking on a treadmill, stretching exercises, free weights, and machine weights, under the supervision of the clinic's physiotherapist. Additionally, she receives occasional half hour massages, to ease her pain.

On October 22, 1998, Dr. Silverman re-examined Ms. Glinka[3] and noted that she continued to suffer from flexion extension injuries to her lumbar and cervical spine. Dr. Silverman recommended another five to six weeks of treatment, followed by a further re-evaluation at that time.

There is no indication that any further examinations, re-evaluations, or reports were conducted or provided to Dufferin. There were no progress reports indicating any improvement or deterioration and

[3] I place no weight on the October 21, 1998 report, as it was identical to the September 4, 1998 report and was based on the September 3, 1998 examination.

no indication whether the treatment would ever end. Dr. Silverman did not provide any report explaining the necessity for ongoing treatment.

In November 1998, Ms. Glinka was referred to Deahy Medical Assessments Inc. ("Deahy")for a multi-disciplinary assessment. Ms. Glinka testified that Roland Spiegel discussed this referral with Dr. Pliamm and Dr. Silverman. Although Dr. Silverman signed the referral slip to Deahy, the evidence established that it was Mr. Spiegel who organized the various assessments and examinations. Mr. Spiegel appears to have a personal interest in Deahy. On the application for mediation seeking the cost of the Deahy assessment, Mr. Spiegel identifies himself as an ADR Specialist with the "firm" of Deahy Medical Assessments Inc. He is similarly identified on the Application for Arbitration. Ms. Glinka faxed correspondence to Mr. Spiegel at the fax number of Deahy.[4] I recognize that there is no obligation to identify potential conflicts of interest in respect of assessments. However, this may affect the weight to be given to the assessment. Mr. Spiegel has referred his client to an assessment centre in which he himself has an interest, in order to obtain a supposedly neutral assessment of her condition. Deahy benefits from the referral by reaping the fees associated with the assessment. Ms. Glinka may benefit from a sympathetic assessment performed by her own advocate's organization. I have taken this factor into account in weighing the objectivity of the multi-disciplinary assessment.

The multi-disciplinary assessment included a medical pain assessment, a physiotherapist assessment, and an Arcon functional assessment. The pain assessment was conducted by Dr. B. Alpert, a pain management specialist and a consulting orthopaedic surgeon. In his report, Dr. Alpert recorded the following diagnostic impression:

> cervical spine, trapezial, and lumbar spine musculoligamentous strains and zygapophyseal joint pain...post-traumatic cervicogenic headaches..left knee patellofemoral pain syndrome, associated with contusion.

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[4]Exhibit 19.

His report included the following discussion:

> This patient appears to have sustained a number of soft tissue impairments...The supporting muscles and ligaments in the cervical spine, trapezii and lumbar spine, appear to have undergone overstretching with partial tearing and strain together with the capsules of the zygapophyseal (facet) joints. Acutely, this is associated with local capillary hemorrhage, inflammatory exudate, and local swelling within the dep soft tissues as well as irritative increase in muscle tone and spasm. ... Cervicogenic headaches result from the damage to the upper cervical spine facets particularly at C2-3, where the roots of the greater occipital nerve are located...Her left knee appears to have been deeply contused, with damage to the articular cartilaginous surface at the back of the knee cap, leading to patellofemoral pain syndrome.

It is not clear to me how Dr. Alpert determined that Ms. Glinka's muscles and ligaments were overstretched, that the local capillaries had haemorrhaged, that the cervical spine facets were damaged or that the articular cartilaginous surface at the back of the knee cap was damaged, based on an *external* physical examination. Essentially, Dr. Alpert is confirming that Ms. Glinka has soft tissue injuries and that she is still complaining of pain.

Dr. Alpert concluded that Ms. Glinka required an additional six weeks rehabilitative physical therapy, including stretching and active graduated conditioning and strengthening. He recommended a "multimodality approach" to help relieve her pain and facilitate further active conditioning exercise. He recommended she be reassessed at that time by her own physician and chiropractor. He also suggested that she be instructed on appropriate home exercises and pain management.

The physiotherapist noted limited range of motion in the neck and back and full range of motion in the knee. The physiotherapist concluded that Ms. Glinka would continue to benefit from an "active exercise therapy program designed to improve symptoms of pain and decreased range of motion." Since Ms. Glinka was doing quite well with her current regime, no change was recommended: "Emphasis should

be on an active exercise program. She should continue to be involved in some passive modalities to ameliorate symptoms of pain."

The ARCON functional assessment was conducted by a certified kinesiologist to assess strength and range of motion. Static strength testing demonstrated that Ms. Glinka was at a sedentary industry strength rating. She had a decreased range of motion in her cervical spine for all movements by approximately 9 percent of the norm. She demonstrated full range of motion in her lumbar spine for all movements. Based on the test results, the kinesiologist concluded that Ms. Glinka was unable to perform the duties of her pre-accident position due to decreased cervical range of motion, insufficient lifting and carrying strength, and decreased postural tolerances with respect to reaching, stooping, crouching and twisting. She is also unable to adequately perform her pre-accident activities of daily living. The kinesiologist strongly recommended that she continue her physiotherapy treatment to progressively improve her strengths and tolerances.

Dufferin was unable to offer any contemporaneous medical evidence about Ms. Glinka's physical condition at this time, as Mr. Spiegel effectively thwarted its attempts to have Ms. Glinka assessed by a medical practitioner of its choice or by a Designated Assessment Centre. This will be discussed later.

Eventually, Ms. Glinka was assessed by a Medical Rehabilitation DAC in mid-August 1999. The physiotherapist noted that by this time, the physiotherapy portion of the treatment was entirely active, including scapular retraction, free weights, shoulder abduction exercises, bicep curls and tricep extensions, lower extremity stretches, treadmill and cervical spine retraction exercises. Ms. Glinka also reported doing some exercises at home, but was not able to replicate all the exercises performed at the facility. At this stage, Ms. Glinka reported 80 percent improvement since the accident. The physiotherapist concluded that Ms. Glinka's ongoing symptoms were not consistent with the normal healing process and that her impairments likely did not originate from any physical cause. The

physiotherapist concluded that further physiotherapy and massage were not reasonable and necessary, although active range of motion and stretching exercises at home would be beneficial.
The functional abilities evaluation was conducted jointly by an occupational therapist and the physiotherapist. They concluded that Ms. Glinka put forth a consistent effort and that the results were reliable. Their testing revealed that Ms Glinka was able to perform all activities of daily living and occupational activities.

The chiropractic assessment was done by Dr. D. Bereznick. He concluded that there were no objective indicators of injury and that continued treatment fell outside the recommendations of the Ontario Chiropractic Association's clinical guidelines. In his report, Dr. Bereznick stated,

> It is my opinion that providing passive care well outside the natural history of an injury creates an environment whereby the risk of developing physician dependancy and pain focussing behaviour outweighs the likelihood of acquiring therapeutic gain.

Dr. Bereznick also testified at the hearing. In his view, in order for treatment to be considered reasonable and necessary there must be some therapeutic benefit greater than if the treatment did not take place. Dr. Bereznick agreed that, even in the absence of any objective findings, it is reasonable to have a trial of six to eights weeks of chiropractic therapy to see if there is any benefit. He testified that the Clinical Guidelines of the Chiropractic College recommend a maximum of 16 weeks of chiropractic care, even in cases of chronic pain. Dr. Bereznick did not question the sincerity of Ms. Glinka's pain; however, he questioned the therapeutic benefit of continued chiropractic care. He testified that chronic manipulation can cause micro injury. He also explained that Ms. Glinka's perception that the treatments made her feel better may be a psychological reaction. He noted that although Ms. Glinka claimed that the treatments made her feel better, when he examined her in 1999 she was extremely stiff, guarded, and in pain.

Ms. Glinka testified that she views the therapy as helpful. It makes her feel better for a day or a couple of days and helps her feel "more mobile." At the time of the hearing in July 2000, one year and ten months post-accident, she felt 65 percent recovered. She felt she was slowly improving. That was the extent of her testimony. Ms. Glinka did not explain how the therapy helped, whether it relieved pain or improved function. Since she had never tried a trial period without therapy, it is unclear whether she would feel any differently without it. She has not returned to work, although she has resumed most of her household chores. Her only activity seems to consist of travelling three days per week for therapy. She finds the travel quite tiring.

Entitlement to Treatments at Success Rehabilitation Clinic:

Ms. Glinka suffered a Grade II Whiplash-Associated Disorder, which is described in the Financial Services Commission's Guidelines On The Management of Claims Involving Whiplash-Associated Disorders, Commissioner's Guidelines No. 5/96 as "neck complaint and musculoskeletal signs including decreased range of motion and point tenderness." Her ongoing pain complaints do not have their origin in a physical problem. However, I accept that she suffers from chronic pain, fatigue and depression.

Chiropractic Treatment:

Ms. Glinka began chiropractic treatment on September 3, 1998 at a rate of four times per week. In accordance with the first treatment plan, she received 20 chiropractic sessions. By October 22, 1996, Dr. Silverman noted some improvement in Ms. Glinka's condition. Although she still had limited cervical range of motion, straight leg raising had increased from 75 degrees on the left and 60 degrees on the right to 90 degrees bilaterally. Her left knee pain had resolved. Accordingly, I accept that the combined treatments (including chiropractic) provided by Success Rehabilitation appeared to be having a therapeutic effect. Accordingly, I find that the further 15 chiropractic treatments over four weeks as

recommended by Dr. Silverman in the October 21, 1998 treatment plan were reasonable and necessary.

The Commission's Guideline on The Management of Claims Involving Whiplash-Associated Disorders contemplates a "short-term regimen of manipulation can be used for WAD." While this is only a guideline, I would expect some explanation after 35 chiropractic treatments for the reasonableness and justification of ongoing benefits. However, after that time, Dr. Silverman did not present any explanation for ongoing chiropractic treatment. She did not submit any further examination results, indicating whether the treatment was having any therapeutic benefit, improving range of motion, reducing pain, or having any effect at all. There are no other medical reports supporting or explaining the beneficial effect of ongoing chiropractic treatment to the neck and back.

Ms. Glinka testified that the *combined* treatments from Success make her feel better and improved her mobility. However, Ms. Glinka was not able to identify which parts of the treatment made her feel better. Was it the chiropractic treatment, the physiotherapy or the massage?

Ms. Glinka's report that the therapy helped her feel better must be viewed with caution. Although she reported feeling 80% improved during the DAC assessment of August 1999, she was very stiff and guarded. By the hearing in July 2000 she was only 65 percent improved, but still claimed gradual improvement.

Even if I accepted that Ms. Glinka perceived a subjective benefit from the chiropractic treatments, this, in and of itself, does not justify ongoing, endless chiropractic treatment. I accept the principle that pain relief, in and of itself, may be a legitimate treatment goal, provided that it does not encourage inappropriate or indefinite dependency or interfere with other aspects of rehabilitation.[5] However, the

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[5] *Amoa-Williams and Allstate Insurance Company* (FSCO A97-001864, June 5, 2000),*Violi and General Accident Assurance Company of Canada* (FSCO P99-00047, September 27, 2000)

evidence in this case does not support that the treatments were reasonable and necessary to achieve that goal. *Violi and General Accident Assurance Company Of Canada*[6] does not stand for the proposition that if a patient claims she feels better, the treatment is reasonable and necessary. That standard would amount to a blank cheque to the service industry for unlimited treatment. In *Violi* there was evidence from the family doctor, chiropractor, massage therapist and orthopaedic surgeon supporting the ongoing treatment as a means of pain relief. This case is distinguishable from the *Violi* case by the absence in this case of convincing medical evidence supporting the beneficial effects of continued chiropractic treatment.

In *Alves and Commercial Union Assurance Company,*[7] Director's Delegate Naylor stated:

> I do not view the arbitrator's reasons as imposing set requirements of proof. Rather, he was assessing the strength of the evidence before him. He acknowledged that an applicant could recover expenses for palliative therapy affording pain relief. However, he was not satisfied in this case, given the amount of treatment Mr. Alves had received and the outcome of the DAC review, that generalised assertions on the part of Mr. Alves and his treating practitioner that the therapy was of benefit were of sufficient weight to justify continued payment. I do not find any basis to interfere in his assessment.

I am not satisfied that the totality of the evidence establishes that continued chiropractic treatments were reasonable and necessary beyond the first 35 sessions. Despite disputing the October treatment plan, Dufferin appeared to have paid for some chiropractic sessions beyond the initial 20 sessions.[8] I leave it to the parties to calculate the number of sessions already paid.

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[6](FSCO A98-00670, August 20, 1999)

[7](FSCO P99-00028, August 25, 2000)

[8]Exhibit 6 shows that the chiropractic accounts appear to have been paid to November 16, 1998.

With respect to the cost of the sessions, there was no evidence presented in this case to suggest that the rate of $35 to $44.65 (once the OHIP contribution expired) per session was not reasonable. Dufferin urged me to consider the evidence presented in the case of *Amoa-Williams and Allstate Insurance*.[9] In that case, Arbitrator Sapin considered a similar situation where the chiropractor charged a block fee for sessions which included assessment, manipulation, electrical current therapy and/or myofascial therapy. She found that it was not reasonable to include so many therapies in a single chiropractic session, and concluded that a fee of $40 per visit, inclusive of OHIP was reasonable. As tempting as it is simply to adopt her reasoning, there was insufficient evidence before me to reach similar conclusions. I am not prepared to make a finding that the chiropractic fee charged was unreasonable in the absence of any evidence. Accordingly, I find that Ms. Glinka is entitled to payment of the first 35 chiropractic sessions at $44.65 (once the OHIP contribution expired) less the payments which have already been made by Dufferin and Sun Life.

Physiotherapy:

Dr. Silverman's October 22, 1998 report indicating slow improvement similarly justified ongoing physiotherapy treatment. Also, the Deahy physiotherapy conducted on November 4, 1998 indicated a 25 percent limitation in cervical range of motion and some limited lumbar range of motion. The ARCON functional Assessment was more precise, and noted full lumbar range of motion and only a 9 percent limitation in the cervical range of motion. These assessments indicate continued measurable progress. Both assessors recommended further physiotherapy. The physiotherapist specified that this should be "an active exercise program" although passive modalities could be used to relieve pain symptoms. Neither of these assessors specified a time frame for the ongoing physiotherapy. On November 10, 1998, Dr. Alpert of Deahy also recommended an additional six weeks rehabilitative physical therapy, with re-assessment after that. Six weeks beyond November 10, 1998 is December

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[9] *Supra*, see note #5.

22, 1998. I note that these recommendations are consistent with the Commissions's Physiotherapy Utilization Guidelines for Soft Tissue Disorders of the Spine[10] Those Guidelines indicate that after the sub-acute phase, which could last up to 12 weeks after the accident, a specialized assessment including an examination and a functional assessment are recommended. That took place at the Deahy multi-disciplinary assessment. After that point, a further 12-week chronic pain management program may be justified. The physiotherapy treatment until December 22, 1998 falls within those time frames.

After that point there is no convincing medical evidence indicating a continued need for physiotherapy, apart from Dr. Silverman's treatment plans. As indicated earlier, Dr. Silverman did not submit any further reports detailing the results of any further examinations, indicating any clinical findings, or noting any improvements in range of motion or function.

Mr. Spiegel pointed out that Dr. G. Conn, an orthopaedic surgeon who examined Ms. Glinka in December 1998, stated that "an active program of mobilization is far more important than the passive modalities that she has been receiving to date." However, I am not satisfied that Dr. Conn was aware that Ms. Glinka had in fact been receiving active physiotherapy for some time. He only saw Ms. Glinka once, and was not aware of the progress of her rehabilitation.

Again, while Ms. Glinka reported subjective relief from the exercises, there was no indication why she could not continue with some home-based exercise program. Indeed, Ms. Glinka reported being fatigued by the length of time spent travelling to and from the clinic.
I am not satisfied that the evidence in this case demonstrates that continued physiotherapy treatment was reasonable and necessary beyond December 22, 1998. Accordingly, I find that Ms. Glinka is entitled to reasonable expenses incurred in respect of physiotherapy expenses until December 22, 1998.

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[10]FSCO Bulletin NO. A-12/97

Success charged a fee of $85 per physiotherapy session. The Commission's Professional Fees Guideline for Physiotherapists[11] sets a maximum rate of $95 to $120 per hour for direct (one-on one) treatment time. The hourly rate charged by Success is less that the lower range of $95, but the service provided was not direct one-on-one treatment. Ms. Glinka testified that each session lasted approximately one hour and that there were two to three other patients present. While there was some guidance provided by the physiotherapist, this was not one-on-one physiotherapy for the entire hour. In a similar situation, Arbitrator Sapin determined that this type of physiotherapy supervision generally justified a fee of $50 per hour.[12] I agree with her reasoning and similarly find that $50 per physiotherapy session is a reasonable fee.

Ms. Glinka submitted that the Insurer is estopped from raising the reasonableness of the cost of the treatments because it has never raised such issue before mediation. On the contrary, in a letter dated November 24, 1998, Dufferin advised Ms. Glinka that Dr. Silverman's treatment plans were being refused, in part because the amounts being charged were excessive.[13]

Dufferin appears to have paid for some physiotherapy expenses beyond the first treatment plan at the rate of $85 per session.[14] The reasonableness of the fees already paid is not before me.[15]

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[11]FSCO Bulletin No. A-12/97 Property & Casualty - Auto

[12]*Amoa-Williams, Supra,* see note #5.

[13]Exhibit 2, Correspondence section.

[14]Exhibit 6.

[15]In other words, Dufferin is not entitled to repayment of the amount in excess of $50 in respect of the paid expenses, nor is it entitled to offset the excess against the further physiotherapy expenses I have ordered in this decision.

Ms. Glinka is entitled to payment of physiotherapy sessions not already paid, at the rate of $50 per session, until December 22, 1998 . Any payments by Sun Life in respect of these sessions must be taken into account.

Massage Therapy:

Dr. Silverman's reports explained that the purpose of the massage treatments was to reduce pain and increase blood circulation. Dr. Alpert and the physiotherapist from Deahy specifically recommended other modalities to relieve pain while Ms. Glinka was engaged in an active exercise program. I interpret this as support for massage therapy in conjunction with the active physiotherapy.[16] Ms. Glinka was receiving a moderate number of half-hour massage treatments while she engaged in her active physiotherapy. I find that the massage treatments were reasonable and necessary to relieve pain while she was engaged in the active physiotherapy treatments until December 22, 1998. Dufferin did not dispute the reasonableness of the $35 fee per session.

Accordingly, Ms. Glinka is entitled to $35 per massage session until December 22, 1998, less payments already made by Dufferin or Sun Life in respect of these massage sessions.[17]

Collateral Benefits:

It appears that since the rejection of the October 1998 treatment plan, Ms. Glinka has first submitted her expense claims to her collateral insurer, Sun Life. Success has deducted the amounts received from Sun Life. Accordingly, there is no issue with respect to collateral benefits regarding the Success expenses after October 1998.

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[16] I did not similarly interpret this reference to passive modalities as support for chiropractic treatment because neither Dr. Alpert nor the physiotherapist were qualified to comment on the ongoing need for chiropractic care.

[17] Exhibit 6 indicates that Dufferin made payments for massage after the first treatment plan.

Interest on Medical Benefits:

Section 46(2) provides that interest is payable on overdue amounts. Subsection 46(1) provides that an amount payable in respect of a benefit is overdue if the insurer fails to pay the benefit within the time required under this Part. "This Part" is Part X — Procedures for Claiming Benefits. Disputed medical benefits are not payable when the Medical Rehabilitation DAC Assessment Centre does not state that the disputed medical benefit is reasonable and necessary.[18] Until the dispute is resolved, interest is not payable.[19] In this case, the Medical and Rehabilitation DAC did not state that the disputed benefits were payable. I have now determined that some of the medical benefits are payable. The benefits were not payable or due until this decision and interest is not payable until after this decision.

Entitlement to Cost of Examinations:

Ms. Glinka seeks reimbursement in respect of various assessments under section 24(1) of the *Schedule*. Section 24(1) provides:

> The insurer shall pay for all reasonable expenses incurred by or on behalf of an insured person for the purpose of this Regulation in obtaining and attending an examination or assessment or in obtaining a certificate, report or treatment plan, including....

In order to establish entitlement to the cost of the assessment, the insured must demonstrate that the assessment was conducted "for the purposes of this Regulation." The purpose of the assessment may

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[18] Subsection 38(14)(b) of the *Schedule*.

[19] *Zacharias v. Allianz Insurance Company of Canada*, [1999] O.F.S.C.I.D. 139, (FSCO A97-001283, April 29, 1999) - Letter Decision.

be explained by the referring practitioner[20] or may be evident in the report itself.[21] I agree with Arbitrator McMahon that if " the report addresses issues found in the Regulation, such as disability and the need for treatment and rehabilitation, it is fair to draw an inference linking the two."[22]

The nsured must also demonstrate that it was reasonable to undertake the assessment, in light of the benefits in dispute at the time, and in light of information available from other sources.[23]

Finally, the insured must show that the fees charged for the assessments were reasonable in light of the time, care and expertise that went into the conduct of the assessment and the preparation of the report.[24]

Once the insured has made out a *prima facie* case for the reasonableness of the account, the secondary onus shifts to the insurer to disprove the reasonableness. The *Schedule* does not impose a heavy accounting onus on injured persons.[25]

Ms. Glinka submitted that Dufferin should be estopped from disputing the cost of the assessment since it did not formally refuse the expenses or provide reasons. There is no provision in the *Schedule* prohibiting an insurer from disputing claims under section 24 whether or not they have provided reasons for the refusal. Further, there has been no detrimental reliance by Ms. Glinka. She did not seek approval from Dufferin prior to incurring the cost of the assessments, nor did Dufferin represent in any

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[20] *Tsimidis and Liberty Mutual Insurance Company* (FSCO A98-000388, January 6, 1999)

[21] *Tesfai and Allstate Insurance Company of Canada* (FSCO A99-000321, July 26, 2000).

[22] *Ibid.*

[23] *Ibid.*

[24] *Tesfai*, *supra* note #20, (FSCO appeal P99-00013, August 28, 2000)

[25] *Gaba and Allstate Insurance Company* (OIC A-000624, August 21, 1992)

way to her that the assessments would be paid. On the contrary, Ms. Glinka arranged and attended the assessments and then requested payment. In those circumstances, she chose to bear the risk whether the insurer and ultimately, myself, would find that the assessments were reasonable expenses under the *Schedule*.

Deahy Assessment:

The evidence demonstrated that Ms. Glinka's representative organized the referral to Deahy and that Dr. Silverman signed the referral slip. The referral slip is a pre-printed form on Deahy stationery containing the following paragraph: "My patient was involved in a Motor Vehicle Accident as dated __ ad despite my intervention, the patient continues to have ongoing problems that include..." The boxes for neck pain, headache, back pain, difficulty in activities of daily living, and difficulty in returning to work are checked off. The referral slip also contains the pre-printed statement "I require this assessment, which I feel is reasonable and necessary, to assist me in further management and treatment of my patient."

I do not find this form of standardized referral slip, prepared by the assessment centre, very persuasive evidence of the true purpose of the assessment. I am not satisfied that Dr. Silverman actually turned her mind to how the requested assessment would help her in her treatment. There is no indication in the clinical notes and records or in any report from Success whether or how Dr. Silverman used the results. Thus, I do not find that the referral form, in and of itself, establishes that the multi-disciplinary assessment was for the purpose of the Regulation or that it was a reasonable referral.

I find that the referral from Dr. Silverman was made simply and solely at the request of Ms. Glinka's representative. That being said, I see no impropriety in an insured's representative directly referring an insured to assessments for the purpose of determining entitlement to benefits under the *Schedule*, although co-ordination with and the concurrence of the treating practitioners should be encouraged.

I will consider the multi-disciplinary report itself to determine whether it is for the purpose of the Regulation. The multi-disciplinary assessment included a medical examination by a pain specialist and consulting orthopaedic surgeon, a physiotherapy assessment and an ARCON functional assessment. Each assessor did an examination or assessment, commented on Ms. Glinka's current condition, her ability to return to work and the activities of daily living, and made recommendations with respect to the future medical treatment required. Thus, the multi-disciplinary assessments directly address entitlement tests under the *Schedule* for income replacement benefits and medical benefits. It also addresses potential housekeeping needs. Ms. Glinka was receiving income replacement benefits at the time of the assessment. After the referral, but around the time of the assessments, Dufferin indicated its intention to terminate weekly income benefits effective November 9, 1998. Also around this time, Dufferin had declined to fund further medical benefits at Success.

I also note that the Commission Physiotherapy Utilization Guidelines for Soft Tissue Disorders of the Spine recommend an examination and functional capacity evaluation after the sub-acute phase (up to 12 weeks post accident), before embarking on a chronic pain management program. By November 1998, Ms. Glinka was eight weeks post-accident and continuing to experience pain.

Dr. Pliamm had made other referrals for Ms. Glinka to investigate various complaints, but there were no other orthopaedic assessments available at that time. While Dr. Silverman's clinic was providing physiotherapy treatment and could potentially have provided an in-depth physiotherapy assessment and functional assessment, it had not done so.

For all the above reasons, I find that the multi-disciplinary assessments were for the purpose of the Regulation, related to issues in dispute, and were reasonable in light of the information available at the time.

The cost of the medical assessment was $950, the cost of the physiotherapy assessment was $450 and the cost of ARCON functional abilities evaluation was $950. The total, including GST is $2,514.50.The medical assessment and the physiotherapy assessment involved a history taking, a physical examination and a written report outlining the results of the examinations and future recommendations. The kinesiologist conducting the functional assessment did a detailed job description and intake interview. Six tests were conducted and a detailed report was produced. There is no indication how long any of these assessments took. The fees charged were within the range of fees for similar assessments which other arbitrators have found reasonable.[26] I find that the cost of the multi-disciplinary assessment is reasonable.

Dufferin submitted that the medical assessment ought to have been recovered from OHIP rather than the insurer. Ms. Glinka relied upon a letter from W. Novak, Service Manager, Ministry of Health dated April 29, 1999, which stated:

> A patient that is referred to a medical assessment unit that does multi-disciplinary assessments including a medical assessment to obtain information for insurance purposes is considered third party billing and is not payable by OHIP.

Dufferin relied upon a letter dated August 20, 1999 written by Dr. G. L. Ollson, Manager, Monitoring & Control, Health Insurance & Related Program, Ministry of Health:

> I am writing in response to your letter regarding charges for services rendered to your client by Dr. Brian Alpert. As we discussed on the telephone this morning neither the medical service nor the report to the referring physician, Dr. Beharry, can be charged to the patient either directly or through you as his insurer. Both services are benefits under the Ontario Health Insurance Plan.

However, Dr. Ollson subsequently wrote directly to Dr. Alpert on the same subject:

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[26] *Tesfai, supra,* see note #21 and *Tsimidis , supra,* see note #24.

> Thank you for your letter of September 27, 1999 concerning the service to [edited by myself to preserve confidentiality of patient] on August 20, 1999. While it is not clear to me who initiated the request for the medical evaluation and treatment plan, you explained that the service was rendered for the purpose of determining entitlement to rehabilitation services for injuries suffered as a result of a motor vehicle accident. Under those circumstances, the service would not be a benefit under OHIP.[27]

In my view, the evidence does not demonstrate that any part of the Deahy assessment could be recovered from OHIP.

Psychological Assessment:

Ms. Glinka testified that Dr. Pliamm recommended that she see a psychologist, that Mr. Spiegel recommended Dr. Harris, and that Dr. Pliamm agreed to the referral. There are notations in Dr. Pliamm's clinical notes and records that he discussed the issue of a psychological referral for her in respect of her fear of driving.

Ms. Glinka was assessed by Dr. R. J. Harris, a clinical psychologist on November 6, 1998. In his report Dr. Harris explains that the referral was prompted by Ms. Glinka's driving fears since the accident. He states the purpose of the psychological examination is to determine if psychological treatment would be reasonable and necessary, and, if so, to prepare a treatment plan.

Dr. Harris conducted a clinical interview. A series of six psychological tests were also administered. A report detailing the results of the interview and the tests was prepared. Dr. Harris concluded Ms.

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[27] Although this letter was submitted by Mr. Spiegel as part of his reply submissions I am prepared to consider it. Counsel for the insurer was not aware of the existence of this subsequent letter, as it was addressed to Dr. Alpert. I am satisfied that it would not be appropriate to rely on the incomplete correspondence with respect to this issue. In any event, even if I were to exclude consideration of the letter of October 21, 1999, my decision would remain the same. In light of the contradiction between Dr. Ollson's letter of August 20, 1999 and W. Novak's letter of April 29, 1999, I am not satisfied that the evidence convincingly demonstrates that these types of assessments and reports are covered by OHIP.

Glinka suffered from acute post-traumatic stress disorder, related to the accident. He suggested medication and clinical therapy to deal with her anxiety. He also identified that Ms. Glinka had a driving fear, manifested by her refusal to drive, her upset when riding in a car, and her dreams about the accident. He recommended further therapy directed at her driving fear.

Dufferin asserted that Ms. Glinka's anxiety pre-existed the accident and that Dr. Harris did not elicit this information upon his clinical interview. Dufferin relied upon the Medical Rehabilitation psychological DAC assessment to support its position that Ms. Glinka's anxiety was not related to the accident.

While Ms. Glinka clearly had some pre-accident anxiety, it was not disabling her from working prior to the accident. Further, she had no driving fears prior to the accident. While Ms. Glinka's failure to reveal her pre-accident anxiety will affect the weight to be given to Dr. Harris' report in future disputes, it does not undermine the reasonableness of the request for the assessment or the assessment process used by Dr. Harris who quite properly inquired into Ms. Glinka's pre-accident health status. Dr. Harris is not responsible for the reliability of the information provided by Ms. Glinka nor the adequacy of the background information provided by Dr. Pliamm. In some circumstances, the failure of the referring physician to provide adequate background information to the assessing doctor, might render the request for the assessment unreasonable. However, in this case, despite the pre-accident anxiety, there was an entirely new symptom, driving fear, which justified the referral and was clearly related to the accident.

I find that the purpose of Dr. Harris' psychological assessment was to identify any accident- related psychological condition and to prepare a treatment plan in respect of any identified conditions. The assessment was reasonable in light of Ms. Glinka's post-accident driving fears.

Dr. Harris charged $175 per hour for a two-hour clinical interview, one hour of test administration, one hour of test scoring and two hours of report writing. In addition, he charged $75 for the preparation of the treatment plan. Dufferin submitted that it was unreasonable to charge the full psychologist rate for

the test administration and scoring, since this was likely done by a psychometrist. However, I heard no evidence to that effect. I heard no evidence that the hourly rate of $175 was unreasonable. On the contrary, the evidence indicates that Ms. Glinka's disability insurer, Sun Life, considers $165 per hour a "reasonable and customary charge" for psychological counselling.

Under section 60(2) of the *Schedule*, Dufferin is not required to pay that portion of Dr. Harris' account for which payment is reasonably available to Ms. Glinka under any insurance plan. The onus is on Dufferin to establish that the payment for Dr. Harris account is reasonably available under the Sun Life plan. Sun Life has paid expenses relating to psychological treatment and indicated that it considers a rate of $165 per hour a reasonable and customary fee. I heard no evidence whether the completion of forms, such as treatment plans, was covered by the Sun Life policy. Ms. Glinka provided no explanation why Dr. Harris' account was not submitted to Sun Life. Indeed, although Sun Life is the primary carrier, she has repeatedly sought to obtain expenses from Dufferin first. I am satisfied that the evidence demonstrates that the Sun Life policy would have covered payment at the rate of $165 per hour for the assessment services provided by Dr. Harris. Accordingly, Dufferin is not required to pay for $990 (6 hours x $165) of Dr. Harris' account. The remaining fee of $135 ($60 plus $75 for the treatment plan) is payable by Dufferin.

Accordingly, I find that $135 of Dr. Harris' account is payable under section 24.

Homereach Community Inc.:

In January 1999, an occupational therapy in-home assessment was conducted by Homereach Community Inc. ("Homereach"). Although the report states that the referral came from Dr. Pliamm and that Ms. Glinka's representative, Roland Spiegel, "consented" to the referral, I find that it was Mr. Spiegel **who** initiated and organized the referral, and that Dr. Pliamm merely consented to

the referral. Ms. Glinka's evidence was to the effect that "Roland Spiegel gave me the referral. I went to Dr. Pliamm with it."

However, as stated earlier, the source of the referral is not definitive. The issue is whether the assessment is for the purpose of the Regulation and is otherwise reasonable, as defined above.

There appears to be some undisclosed relationship between Mr. Spiegel and Homereach Community Inc. Mr. Spiegel represented Ms. Glinka as a member of BIAB, Bodily Injury Accident Benefits Group. BIAB appears to have shared the same address, telephone number and fax number as Homereach at one time.[28] As I have stated previously, there is no obligation to declare a conflict of interest in respect of assessment. However, such conflicts may undermine the weight to be given to the assessment. It may also raise questions about the legitimacy of the need for the assessment.

The occupational therapy in-home assessment was prepared by Marika Paquin, a licensed occupational therapist. The stated purpose of the assessment was to establish the client's functional status related to her reported pre-accident essential activities of daily living and homemaking tasks and to do a worksite assessment. The therapist reviewed Dr. Silverman's treatment plan, Dr. Harris' report, Dr. Pliamm's Disability Certificate and the Deahy Medical Assessment. She reviewed Ms. Glinka's pre-accident functional status and completed a detailed activities of normal life form. She concluded that Ms. Glinka was partially impaired from some homemaking tasks and work tasks and required some assistive devices and occupational therapy. She also recommended driving therapy.

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[28]Exhibit 16 is a fax sent from BIAB. The letterhead from BIAB on this correspondence lists the following address, telephone and fax numbers: 27 Vanity Crescent, Richmond Hill, Ontario L4B 4E6 Tel: (905)889-6344, Fax: (905) 889-5590. The fax message across the top of the page read "FROM: Homereach Community Inc. PHONE no.: 905 889-5590." The letterhead of Homereach also indicates: 27 Vanity Crescent, Richmond Hill, Ont. L4B 4E6 Tel: (905) 889-5511 Fax: (905) 889-5590 (Exhibit 20C).

I find that the purpose of the assessment was to assess whether Ms. Glinka was impaired in any activities of normal life, with a view to identifying any need for assistive devices or housekeeping expenses under section 22 of the *Schedule*. There was no evidence on the record whether Ms. Glinka subsequently made a claim for housekeeping expenses, and therefore, these were not actually in dispute at the time. However, it appears to me to be reasonable to assess whether Ms. Glinka met the test for entitlement before actually submitting a claim. At the time, she was consistently complaining of difficulties with household tasks. Accordingly, I find that the occupational therapy in-home assessment was for the purpose of the Regulation, and was reasonable in light of the lack of detailed information on the extent of her impairment with respect to her activities of daily living.

Ms. Paquin billed 9.75 hours of time for the assessment, including 3 hours for the assessment, 2 hours for travel, 4.5 hours for the report and .25 for a phone call and fax. She charged $120 per hour for 9.75 hours, for a total of $1170. She also charged $.42/km for 150 kilometres ($63); $14.95 for a manual on activities of daily living and $25 for a medic-air back pillow.

The latter two expenses are not assessment fees and are not payable under section 24. There was no dispute raised with respect to the charge for mileage, and it is accordingly allowed. There is no dispute about travel time and that time is allowed. The time for the phone call and fax is not unreasonable.

I find that seven hours for the interview and the report is excessive. Based on my review of the report I would assess that five hours would be a reasonable amount of time to obtain the information, review the documents, and prepare the report.

The hourly rate of $120 appears somewhat high, considering that the maximum hourly rate for a physiotherapist providing direct one-on-one therapy is $120.[29] While the therapist was working one-

[29] Professional Fees Guideline - Physiotherapists, FSCO Bulletin, A-12/97 - Property & Casualty - Auto.

on-one, this was not the same type of direct, hands on interaction provided by a physiotherapist. Also, there was no equipment involved. However, there was no evidence presented about the qualifications of occupational therapists, or the usual fees charged by them. In the absence of evidence I am not prepared to conclude that the rate is unreasonable.

Accordingly, I find that the reasonable fees for the occupational therapist assessment is 7.25 hours @ $120/hour ($870), plus $63 (mileage) for a total of $933.

Interest on Costs of Examinations:

Dufferin suggested that assessment expenses are not "benefits" and do not attract interest. However, such expenses are specifically referred to as other "benefits" under section 41 of the *Schedule*. Section 41 provides that "benefits" under Part VI (which includes costs of examinations under section 24(1)) are payable within 30 days after the insurer receives the application for the benefit.

The Deahy invoice was submitted on December 14, 1998, the Harris invoice was submitted on November 12, 1998 and the Homereach invoice was submitted on January 22, 1999. Dufferin never requested an application in respect of those expenses, and I find that the benefits were overdue 30 days after receipt of the invoice, and interest is payable accordingly.

Special Award:

Mr. Spiegel seeks a special award in respect of Dufferin's refusal to pay the Success account and the cost of examinations. Section 282(10) of the *Insurance Act* provides that a special award is payable if the arbitrator finds that an insurer has unreasonably withheld or delayed payments.

Refusal to pay cost of examinations:

Dufferin did not even formally reply to these invoices. However, at the time those invoices were submitted, the jurisprudence supporting payment for insured's assessments was not clear. Also, as they were not submitted on formal "expense" claims, Dufferin did not view them as requiring a formal rejection. More significantly, I have found that Mr. Spiegel's handling of Ms. Glinka's claim was so aggravating that it sheds some light on Dufferin's refusal to pay for these assessments.

As discussed earlier, Mr. Spiegel arranged for Ms. Glinka to be assessed at Deahy and by Dr. Harris in early November 1998. Dufferin retained Remark Rehabilitation ("Remark") to arrange an insurer's examination in relation to her income replacement benefits and advised Ms. Glinka on November 24, 1998 that someone from Remark Rehabilitation would be contacting her. Remark wrote to Ms. Glinka on December 2,1998 advising of the assessments scheduled in Orangeville on December 17, 1998. The notice specifically requested 84 hours (approximately 3 ½ days) notice if she was unable to attend the evaluation.

On December 15, 1998, BIAB sent a fax to Dufferin advising that Ms. Glinka could not attend the assessments due to the short notice and previous arrangements. Ms. Glinka testified the previous engagement related to "estate issues" but provided no details of the nature of the prior arrangement, nor did she explain why it could not be changed. The clinical notes of Dr. Silverman indicate that Ms. Glinka attended at the Success clinic in Toronto around this time, on December 15, 16 and 18, 1998.

BIAB requested that the insurer's examination be rescheduled to mid-January 1999. Accordingly, Remark rescheduled the assessments for January 21 and January 25 in Orangeville. A letter was sent

out on January 6, 1999. Ms. Glinka was requested to advise them 84 hours prior to the assessments if she was unable to attend.

On January 19, 1999, two days before the first scheduled assessment, BIAB sent another fax advising that Ms. Glinka would not be able to attend the assessments "due to returning to work issues that she has to attend to. Please reschedule I.E. for mid February 1999." Ms. Glinka testified that she was "trying to work something out with my employer." Again there was no detailed explanation for why she could not attend. The employment file did not disclose any meetings with her employer on January 21 or January 25, 1999. Although Ms. Glinka refused to attend the insurer's examination, she was able to attend at Dr. Silverman's office in Toronto on January 20 and January 26, 1999.

I find that Ms. Glinka was being uncooperative in attending reasonable requests for insurer examinations.

Dufferin responded by terminating Ms. Glinka's income replacement benefits under subsection 42(8) of the *Schedule*, for failing to attend the insurer's examinations. At the same time, Dufferin advised that it was prepared to schedule a further examination in March and invited BIAB to consult with Remark on a convenient time and date.

In mid-February 1999, when all of Ms. Glinka's own assessments were complete, BIAB wrote to Dufferin advising that as Ms. Glinka had already undergone an occupational therapy assessment, a psychological assessment, a medical assessment, a physiotherapy assessment, and functional ability assessment, she would not be attending any insurer's examinations in the near future, as that would constitute a duplication of medical services.

At the same time as Ms. Glinka was being uncooperative in attending Dufferin's request for assessments, she was requesting payment for the costs of her assessments with Deahy, Dr. Harris and

Homereach. When viewed in this context, Dufferin's refusal to pay for the assessments was not unreasonable.

Refusal to pay Success account:

With respect to the Success account, I have found that most of the claimed expenses were not reasonable and necessary. It was not unreasonable for the Insurer to question the need for ongoing treatment after the expiration of the first treatment plan and attempt to initiate a medical rehabilitation DAC to determine the issue.

Following the rejection of the second treatment plan by Dr. Silverman and the treatment plan of Dr. Harris, Dufferin was required to request a Medical Rehabilitation DAC Assessment. On November 24, 1998 Dufferin wrote to Ms. Glinka asking her to complete an OCF-14 (Permission to Disclose Health Information to the Designated Assessment Centre). This request was repeated on December 8, 1998 and December 16, 1998.

Mr. Spiegel suggested that Dufferin was not entitled to require a signed OCF-14 before arranging for the medical rehabilitation DAC. He did not trouble to advise Dufferin of his view at the time, **nor** urge them to schedule the DAC without an OCF-14. He raised this issue for the first time during the hearing.

I note that the Commission's Guidelines for Designated Assessment Centres to Conduct Assessment for Accidents on of after November 1, 1996[30] states under the heading of Responsibilities of the Insurer:

> The Insurer must notify the DAC, in writing, to initiate an assessment request. As the first step in the assessment, this notification, in the form of a referral, sets the stage for the entire process. To ensure a successful outcome, the DAC must receive a complete

[30] As amended, June 1998.

> referral, including a signed Permission to Disclose Health Information to the Designated Assessment Centre (OCF-14) Form, and up to date medical documentation and reports.

Under the heading "Consent" it states:

> A Permission to Disclose Health Information to the Designated Assessment Centre (OCF-14) form, with an original signature by the claimant, must be submitted with the referral package. A DAC can not commence an assessment without receiving a completed and signed OCF-14 form.

In my view, Dufferin was acting reasonably in requesting an OCF -14, and Ms. Glinka was delaying the process by refusing to provide it and not even offering an explanation for the delay.

On January 5, 1998, Dufferin received a signed OCF-14. On January 11, 1999, Dufferin sent the referral and the disputed treatment plans to Work Able, a Designated Assessment Centre in Barrie and on January 20, 1998, requested Work Able to proceed with the assessment.

On January 22, 1999 Work Able sent a notice to BIAB, copied to Ms. Glinka advising that the psychological assessment was scheduled for February 1 and the chiropractic and physiotherapy assessments were scheduled for February 3, 1999 in Barrie.

On February 1, 1999 BIAB sent a fax to Dufferin advising that Ms. Glinka could not attend the DAC due to short notice. Dufferin was requested to reschedule the DAC as soon as possible, co-ordinate the schedule with Ms. Glinka, and arrange transportation to and from the assessment. Ms. Glinka did not offer any explanation for her non-attendance on February 1. It is difficult to understand how a notice sent out on January 22, 1999 for an appointment on February 1 is "short notice" when the DAC is expected to begin its assessment within two week of the request.[31]

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[31] Subsection 53(8) of the *Schedule*.

Dr. Silverman's clinical notes and records indicate that Ms. Glinka actually attended at her clinic in Toronto on February 1, 2 and 4, 1999. Also, I find that Ms. Glinka's demand for pre-paid transportation to and from the assessment in Barrie was not reasonable, when she was capable of arranging her own travel three days a week from Feversham, directly past Barrie, on her way to Toronto. While Ms. Glinka is entitled to reasonable transportation expenses, this does not necessarily dictate pre-paid transportation when the evidence suggests she has other, less expensive means of travel at **her** disposal.

On March 2, 1999 Workable sent a notice to BIAB, with a copy to Ms. Glinka advising of a rescheduled DAC assessment in Barrie on March 10 and 11, 1998. The evidence indicates that this letter was delivered on March 5, 1999, but Ms. Glinka testified that she did not pick up her mail from the post office until after the scheduled assessment. Dr. Silverman's clinical notes indicate that Ms. Glinka was sick for two weeks around this time. I accept that she likely did not pick up her mail prior to the assessment. However, there was no explanation why BIAB did not advise her of the dates or attempt to ensure her attendance.[32] Even if she was too ill to attend (and I note that Ms. Glinka did not assert this, although she complained about the late delivery of the notice), why did BIAB not alert the DAC to her inability to attend in sufficient time to avoid a cancellation fee?

At this point, Dufferin declined to schedule any further DAC until Ms. Glinka paid the DAC cancellation fees in the amount of $2,100. While Dufferin's frustration is understandable, there is no statutory basis for demanding the payment of cancellation fees.

Ms. Glinka sought to force Dufferin to schedule a further DAC assessment by filling an application for mediation with the Financial Services Commission, but **this** application was rejected.

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[32] Although Ms. Glinka wrote to Dufferin explaining that she had received the notice late, she did not assert that she was too ill to attend.

Eventually, during a mediation of other issues, Dufferin agreed to arrange a third Medical Rehabilitation DAC assessment in Barrie, provide two weeks notice and arrange pre-paid transportation.

In my view, the delay in arranging the Medical Rehabilitation DAC was due almost entirely to Ms. Glinka's lack of co-operation and unreasonable demands about notice and pre-paid transportation.

In all the circumstances I find that Dufferin's failure to pay the disputed medical benefits and cost of examinations was not unreasonable and no special award is payable.

Cancellation Fees:

Dufferin seeks reimbursement for the cancellations fees charged by Remark ($1,350 in respect of missed physiotherapy and chiropractic assessments on March 10 1999 and a psychological assessment on March 11, 1999) and Work Able ($750 in respect of psychological assessment on February 1 and $500 in respect of an orthopaedic examination on February 4,1999). In *Dinh and Pafco Insurance Company, Ltd* [33] Arbitrator Draper held that the insurer was not entitled to recoup cancellation fees by deducting them from ongoing weekly benefits and that an arbitrator has no authority to deal with "no-show" fees. I agree with that decision. I am not satisfied that there is any provision in the current *Schedule* which permits me to order the insured to pay such cancellation fees.

Dufferin submitted that the cancellation fees could be awarded as an expense under section 282(11)of the *Insurance Act*. Alternatively, Dufferin submitted that it was entitled to the return of its assessment fee under section 282(11.2) of the *Insurance Act*. These arguments are dealt with below.

Representation:

[33](OIC A-007053, October 5, 1994)

I feel compelled to comment on the poor quality of Mr. Spiegel's representation.
Mr. Spiegel failed to comply with the Commission's pre-hearing production and notice requirements. Despite repeated requests from Insurer's counsel, Mr. Spiegel did not advise the Insurer what documents he intended to rely upon at the hearing. Mr. Spiegel relied upon the Arbitration Brief by Dufferin and **repeatedly** sought to supplement those documents when he realized that documents he wanted to rely upon were not included in the Brief.

Mr. Spiegel did not advise of the witnesses he intended to call. He indicated that he wanted to question the claims adjuster, but made no arrangements to summons him, "assuming" that he would be there. Mr. Spiegel made no arrangements to call the family physician, Dr. Pliamm, relying instead on the Insurer's intention to call him for cross-examination, and intending to put his questions in-chief at that time. Mr. Spiegel made no arrangements for the attendance of Dr. Silverman, whose account was the subject of a large part of the hearing. Instead, midway during the hearing he sought to introduce a report prepared by Dr. Silverman at the last minute. This document had not been served on the other side prior to the hearing. When asked why he had not complied with the Commission's *Dispute Resolution Code*, Mr. Spiegel replied that he had been "busy."

Mr. Spiegel sought to give evidence as a rehabilitation expert as to his case management of the file, and the reasons for the referral to the various assessments. He brought along his curriculum vitae to demonstrate his expertise in that area. Needless to say, Mr. Spiegel did not advise Dufferin that he intended to call himself as a witness, did not provide a copy of **his** curriculum vitae in advance, nor provide any summary or clue of the expert evidence he was proposing to give. Neither did he perceive any impropriety in popping in and out of the witness box as an advocate/witness on the same case. I ruled that he would not be permitted to give evidence as an expert witness in light of the lack of notice.

Although he had been provided with a copy of the Arbitration Brief in advance of the hearing, Mr. Spiegel did not appear to have read it. He did not know where the documents were and wasted

considerable hearing time during examination and cross-examination of witnesses looking for documents in the brief. I specifically advised him to spend some time becoming familiar with the brief to avoid such a waste of time, to no avail.

Mr. Spiegel's cross-examination of Dr. Bereznick was incompetent. He persistently asked irrelevant questions; he made speeches to the witness; he asked lengthy, involved and incomprehensible questions. He sought to introduce medical articles to the witness which had not been previously disclosed, although he had been advised of Dr. Bereznick's proposed testimony. There was no explanation why he did not file these documents in advance of the hearing. His cross-examination of Dr. Bereznick was so extensive and irrelevant that it necessitated Dr. Bereznick's re-attendance on a second day. I repeatedly warned Mr. Spiegel to focus his cross examination so that Dr. Bereznick' testimony could be completed on the first day. I am satisfied that there was sufficient time on the first day for a thorough cross-examination. Nonetheless Mr. Spiegel insisted on recalling Dr. Bereznick to continue his cross-examination on a second day. I ruled during the hearing that the costs of Dr. Bereznick's attendance on the second day would be borne by his client and I am hereby confirming that ruling.

Mr. Spiegel sought to introduce medical articles which ought to have been introduced in-chief, as reply evidence. I excluded the evidence.

The parties were offered the opportunity to complete oral submissions within a four-hour period. Mr. Spiegel refused to commit to this time frame and threatened to resign as his client's representative if required to prepare written submissions.

In my view, Mr. Spiegel is not competent to represent clients before this Tribunal. As this hearing is over, it would useless to exclude Mr Spiegel from any further participation in this hearing. However,

Mr. Spiegel's conduct in the presentation of this case will be considered in my decision on expenses of this arbitration proceedings.

EXPENSES:

Ms. Glinka seeks her expenses of this arbitration proceeding. Dufferin seeks its expenses of the arbitration proceeding and an award under section 282(11.2) of the *Insurance Act*.

Section 282(11) of the *Insurance Act* now allows expenses to be awarded to either the insured person or the insurer:

> **282.—**(11) The arbitrator may award, according to the criteria prescribed by the regulations, to the insured person or the insurer, all or part of such expenses incurred in respect of an arbitration proceeding as may be prescribed in the regulations, to the maximum set out in the regulations.

The criteria for awarding expenses are found in section 12(2) of O.Reg. 464/96, which states as follows:

> 12.— (2) An arbitrator may award expenses to an insurer or insured person under subsection 282(11) of the *Act* if the arbitrator is satisfied that the award is justified, having regard to the following criteria:
>
> 1. Each party's degree of success in the outcome of the proceeding.
>
> 2. Conduct of the insurer or insured person that tended to shorten or facilitate the proceeding or that tended to prolong, obstruct, or hinder the proceeding, including failure to comply with undertakings or orders.
>
> 3. Whether the proceeding or any position taken by the insurer or the insured person during the proceeding was manifestly unfounded, frivolous, vexatious, fraudulent or an abuse of process.

4. The degree of complexity, novelty or significance of the factual or legal issues raised in the proceeding.

5. If the insurer or the insured person requests, any written offers to settle made after the conclusion of mediation and before the conclusion of the arbitration in accordance with the rules of practice and procedure applicable to the proceeding, including the terms of the offers, the timing of the offers and the responses to the offers, having regard to the result of the proceeding.

6. Any other matter related to the proceeding that the arbitrator considers relevant to the issue of whether an award of expenses is justified.

Arbitrators must consider these legislated criteria and apply them to both parties. Concern for insureds' access to the dispute resolution system continues to play a significant role in the exercise of arbitral discretion in deciding entitlement to expenses.

While Ms. Glinka has been partially successful in establishing entitlement to the cost of the examinations, Dufferin was largely successful in defeating an excessive claim for treatment expenses.

There were also indications that Ms. Glinka had initially claimed payment for expenses from Dufferin without properly accounting for Sun Life's contribution.

The overwhelming factor in this decision has been the conduct of Ms. Glinka's representative, Mr. Spiegel. I have already ruled that his excessive cross-examination of Dr. Bereznick justified an award of expenses in favour of Dufferin in respect of the half day spent on Dr. Bereznick's re-attendance.

For the reasons discussed above, under Representation, I find that Mr. Spiegel's conduct tended to prolong the hearing far in excess of what was required. He added very little to assist Ms. Glinka's claims. My findings favourable to her have been based primarily on the documentary evidence, which was submitted by Dufferin in its Arbitration Brief. The insurer has been put to the expense of three days of hearing, plus extensive written submissions.

Having regard to all the circumstances, I find that Ms. Glinka is not entitled to her expenses in respect of this arbitration. In light of Ms. Glinka's partial success and the financial imbalance between the parties' ability to bear the costs of this hearing, I have decided not to award Dufferin all its expenses of the hearing. Instead, as previously ordered, Ms. Glinka shall pay the insurer's expenses in respect of the half day of attendance required for Dr. Bereznick's second attendance.

Dufferin submitted that Ms. Glinka's deliberate failure to attend the insurer's examination and the delay in attending the DAC in violation of section 50 of the *Schedule*, amounted to an abuse of process. Dufferin submitted that this was an appropriate case to award Dufferin the amount of the assessment fee ($3000) under section 282(11.2) of the *Insurance Act*, as compensation for the cancellation fees ($2600) which are not otherwise recoverable.

> 282(11.2)If an insured person commences an arbitration that, in the opinion of the arbitrator, is frivolous, vexatious or an abuse of process, the arbitrator may award an amount to be paid by the insured person to the insurer that does not exceed the amount of assessment against the insurer in respect of the arbitration under section 14.

Section 50 provides serious consequences for the failure to make onself reasonably available for an insurer examination or a DAC assessment. The insured person is

precluded from proceeding to mediation, and hence arbitration. While Dufferin raised these issues at mediation, the matter was settled by Ms. Glinka's agreement to attend a DAC. Thus, the issue of whether there has been a breach of section 50 was not before me. I have merely found that Ms. Glinka was uncooperative. I have not made any specific finding of a breach of section 50.

Ms. Glinka filed the applications for mediation and arbitration to claim medical benefits under section 14 and recover the costs of examinations under section 24. That these were not frivolous claims is evidenced by her partial success in this proceeding. I am not persuaded that the commencement of the arbitration was frivolous, vexatious or an abuse of process.

It would not be appropriate to twist the meaning of section 282(11.2) of the *Insurance Act* to offset the cancellation fees which are not otherwise recoverable under the *Schedule*.

November 21, 2000

M. Kaye Joachim
Arbitrator

Date

FSCO A99–000849

BETWEEN:

MARY GLINKA

Applicant

and

DUFFERIN MUTUAL INSURANCE COMPANY

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. Dufferin shall pay Ms. Glinka the chiropractic, physiotherapy and massage expenses incurred at Success Rehabilitation Clinic as set out in this decision.

2. Dufferin shall pay $2,514 in respect of the account from Deahy Medical Assessments Inc., $135 in respect of Dr. Harris' account, and $933 in respect of the account of Homereach Community Inc., plus interest.

3. Ms. Glinka shall pay Dufferin's reasonable expenses in respect of the attendance of Dr. Bereznick on July 20, 2000.

November 21, 2000

M. Kaye Joachim
Arbitrator

Date