LICENCE APPEAL TRIBUNAL

Safety, Licensing Appeals and Standards Tribunals Ontario

TRIBUNAL D'APPEL EN MATIÈRE DE PERMIS

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

Citation: R.I. v. Aviva Insurance Company, 2020 ONLAT 19-006444/AABS

Released Date: 10/23/2020
File Number: 19-006444/AABS

In the matter of an Application pursuant to subsection 280(2) of the *Insurance Act*, RSO 1990, c I.8., in relation to statutory accident benefits.

Between:

Ragab Ibrahim

Applicant

and

Aviva Insurance Company

Respondent

DECISION AND ORDER

ADJUDICATOR: **Avril A. Farlam**

APPEARANCES:

For the Applicant: Steven Arie Glowinsky and Ned Bozalo, Counsel

For the Respondent: Leah Dick, Counsel

Heard by Way of Submissions in Writing

REASONS FOR DECISION AND ORDER

OVERVIEW

[1] Ragab Ibrahim ("applicant") was involved in a motor vehicle accident on October 22, 2018 ("accident") and sought benefits from Aviva Insurance Company ("respondent") pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010 (the "Schedule").*[1] The applicant was denied benefits by the respondent and submitted an application to the Licence Application Tribunal - Automobile Accident Benefits Service ("Tribunal").

PRELIMINARY ISSUE

[2] The respondent submits that its funding of attendant care benefits for the applicant has no bearing on the issues in dispute and requests that paragraph 14 be struck from the applicant's submissions. The applicant in reply submits that the funding of same reflects the severity of the applicant's accident-related injuries and should not be struck.

[3] I decline to strike paragraph 14 of the applicant's submissions because this paragraph addresses more than funding and includes a description of accident-related injuries as assessed by Ms. Yang, a registered nurse. The applicant's accident-related injuries are relevant to the issues in dispute before me. However, in making this ruling, I wish to make it clear that I do not express any opinion on whether the funding of attendant care services is an admission by the respondent that this assistance is both reasonable and necessary as argued by the applicant. The funding of attendant care services is not in issue before me and I express no opinion on it.

[4] In reply, the applicant submits that paragraph 43 of the respondent's submissions be struck because whether or not the College of Physicians and Surgeons of Ontario ("CPSO") has a remediation plan in effect for Dr. Alexander and past failures and successes with that plan have no bearing on the issues in dispute at this hearing.

[5] I decline to strike paragraph 43 of the respondent's submissions because the experience and expertise of a physician may be relevant, but I admit this evidence subject to weight.

[1] O. Reg. 34/10.

ISSUES

[6] The issues to be decided in this hearing are:

i. Is the applicant entitled to receive a medical benefit in the amount of $768.10 ($5,388.10 less $4,620.00 approved by the respondent) for physical treatment, recommended by In Motion Rehabilitation and Wellness Centre Inc. in a treatment plan dated November 15, 2018, and denied by the respondent on January 7, 2019?

ii. Is the applicant entitled to payments for the cost of examinations, in the amount of $2,813.13 for an orthopaedic assessment, recommended by TDI Chronic Pain and Medical Assessments Inc. in a treatment plan dated December 14, 2018 and denied by the respondent on January 3, 2019?

iii. Is the applicant entitled to payments for the cost of examinations, in the amount of $2,496.00 for a chronic pain assessment recommended by TDI Chronic Pain and Medical Assessments Inc., in a treatment plan dated June 7, 2019, and denied by the respondent on June 19, 2019?

iv. Is the respondent liable to pay an award under Regulation 664 because it unreasonably withheld or delayed payments to the applicant?

v. Is the applicant entitled to interest on any overdue payment of benefits?

RESULT

[7] The applicant's claims for the physical treatment balance of $768.10, for the orthopaedic assessment of $2,813.13 and for the chronic pain assessment of $2,496.00 are dismissed. There is no special award. There is no interest.

LAW

[8] Sections 14, 15 and 16 of the *Schedule* provide that an insurer is only liable to pay for medical and rehabilitation expenses that are reasonable and necessary as a result of the accident. The applicant bears the onus of proving on a balance of probabilities that any proposed treatment plan he or she seeks is reasonable and necessary.[2]

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[2] *Scarlett v. Belair,* 2015 ONSC 3635 (Div. Ct.)

ANALYSIS

Physical Treatment Balance of $768.10

[9] The respondent approved $4,620.00 for physical treatment recommended by In Motion Rehabilitation and Wellness ("In Motion") in a treatment plan dated November 15, 2018 but denied $768.10. The applicant concedes that $8.10 of the denial was appropriate. This leaves $760.00 in dispute, which the applicant submits is $380.00 for each of two assessments, one at the commencement of treatment and one at the conclusion.

[10] The applicant submits these assessments are commonplace, necessary and appropriate to allow treatment providers to determine the most appropriate treatment methods, duration and frequency and to apprise the respondent of these treatment strategies by way of written brief reports. Further, the applicant submits that the time and fee for each assessment and report, approximately 3.5 hours at the chiropractor's billable rate of $112.81 per hour (totalling $394.84), are reasonable and that the $200.00 maximum in the Guideline[3] does not govern treatment commencement or progress reports, which are proposed. Further, the applicant relies on the Tribunal decision's of *S.S. v. Northbridge Insurance*[4] for the proposition that if one of the goals of the treatment in question is to alleviate pain so that the injured party can engage in ordinary daily activities at a pre-accident level, as is the case here, then the treatment will be deemed reasonable and necessary.

[11] The respondent submits that $200.00 is the maximum for completing an OCF-18 and includes any assessment necessary for submitting the OCF-18.

[12] I find that the weight of the applicant's medical evidence is not sufficient to establish that this $760.00 is reasonable and necessary. The onus is on the applicant and he has not met it. In Motion's November 15, 2018 treatment plan was not filed by the applicant nor did he file any other evidence to establish that this cost is reasonable and necessary. The *S.S.* decision is not binding on me and, further, the goals of the disputed treatment plan here are not before me as they were before the Tribunal in the *S.S.* case. This claim is dismissed.

Orthopaedic Assessment of $2,813.13

[13] The applicant claims $2,813.13, being the cost of a December 14, 2018 treatment plan for an orthopaedic assessment recommended by TDI Chronic

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[3] *Superintendent's Guideline No. 03/14* (September 2014 Professional Services Guideline)
[4] *S.S. v. Northbridge Insurance,* 16-000960/AABS (ON LAT) at para 44.

Pain and Medical Assessments Inc. ("TDI"). The applicant submits that his right shoulder, left leg and hip injuries are orthopaedic in nature and that a comprehensive orthopaedic assessment is reasonable and necessary in order to evaluate the applicant, determine relevant treatment, to reduce his ongoing pain, to increase his strength and range of motion, and to assist him in returning to his pre-accident activities of daily living. The applicant submits that this is especially appropriate given the applicant's pre-existing left leg amputation and the necessity to tailor any treatment for his accident-related exacerbation of said injury to his particular circumstances. The applicant relies on the records of Dr. Hussain, the applicant's family physician, regarding pain in his right shoulder and left hip and Dr. Hussain's referral of the applicant to an orthopaedic surgeon. Lastly, the applicant submits that an OHIP-funded assessment is inadequate to formulate a treatment plan utilizing accident benefits and that the Tribunal has considered this relevant before[5].

[14] The respondent submits that it is not reasonable and necessary to fund a third orthopaedic assessment given that the applicant had two orthopaedic consultations within four months after the accident funded by OHIP, the applicant had concerns with his left stump prior to the accident and there are no orthopaedic related complaints or injuries as a direct result of the accident alleged in the applicant's submissions. The respondent also submits that the Tribunal has repeatedly found that where there is no evidence distinguishing additional assessments proposed by an applicant from those otherwise available through OHIP, they will not be considered reasonable and necessary as OHIP is an "insurance plan or law" for purposes of s. 47 (2) of the *Schedule.*

[15] I find that the applicant has not met his burden to establish that the cost of this orthopaedic assessment is reasonable and necessary for the following reasons.

[16] I accept the respondent's submission that it is not reasonable and necessary for the respondent to fund TDI's orthopaedic assessment with Dr. Alexander given that the applicant had two orthopaedic consultations with Drs. Abbas and Safir, on the referral of Dr. Hussain, which were funded by OHIP.

[17] The applicant has not brought forward persuasive evidence that the consultations with Drs. Abbas and Safir were "inadequate to formulate a treatment plan" as he suggests or to establish why Dr. Alexander's orthopaedic assessment would be superior to those of Drs. Abbas and Safir.

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[5] *G.T. v. Unifund Assurance Company,* 2017 CanLII 33656 (ON LAT), upheld on Reconsideration reported at 2017 CanLII 81567 (ON LAT). The applicant also relies on *L.D. v. Aviva Insurance Canada,* 2020 CanLII 12700 (ON LAT).

[18] In both OHIP-funded assessments, the accident was discussed with the applicant and noted in the reports. Neither report indicated any treatment was called for at the time other than physiotherapy. Neither report indicated any specific type of physiotherapy was required because of the applicant's pre-accident amputation.

[19] Further, with respect to the applicant's shoulder, Dr. Abbas diagnoses chronic myofascial pain syndrome as a result of the accident that "probably" needs a physiotherapy program. With respect to other medical issues, Dr. Abbas diagnoses chronic neuroma as a result of the amputation and, with regard to his left hip chronic subluxation, suggests that if it causes a problem for him in the future then he may need a total hip arthroplasty.

[20] Dr. Safir's examination was completed by Moneet Dogra, Advanced Practice Physiotherapist, Department of Rehabilitation, Mount Sinai Hospital. The applicant reported increased pain in his left hip and stump area since the accident. Neuroma is noted and that the applicant uses Lyrica for that and Advil and another pain killer for pain management. The conclusion is that the applicant appears to have had a congenital proximal focal femoral deficiency and would not benefit from orthopedic surgery.

[21] I find that OHIP is an "insurance plan or law" for purposes of s. 47 (2) of the *Schedule* and that, as a result, the respondent is not required to pay for the disputed orthopaedic assessment as two orthopaedic assessments have already been provided to the applicant by OHIP, which constitute a medical benefit for which payment is reasonably available to the insured person under any insurance plan or other plan or law. The applicant received his orthopaedic assessments in a timely fashion, two of them within four months of the accident. The first orthopaedic assessment took place some two weeks after the denial. Those facts make this case factually distinct in a fundamental way from the cases, including *G.T.*, relied on by the applicant and I decline to follow them. In *G.T.*, the Executive Chair found that there was a lack of evidence about the orthopaedic assessment and if it would be covered by OHIP. That is not the case here.

[22] Although the applicant submits in reply that the respondent cannot rely on the disputed orthopaedic assessment being unnecessary because the respondent's denial was made January 3, 2019 when the respondent did not know about the other two OHIP-funded assessments, I find this argument unpersuasive. Whether or not the respondent knew of the upcoming OHIP-funded orthopaedic consultations has no bearing on whether the proposed assessment is reasonable

and necessary. Had there not been two OHIP-funded orthopaedic assessments within four months after the accident, this may have had a bearing on the reasonableness and necessity of the disputed orthopaedic assessment, but those are not the facts here.

[23] Shortly after the accident, on November 6, 2018, Dr. Hussain notes the applicant's complaints of pain 1) in the shoulder, 2) in the amputee stump and 3) above knee on the left side since the accident. Dr. Hussain records his referral to an orthopaedic surgeon. The applicant knew before the disputed orthopaedic assessment was proposed on December 14, 2018 that he had been referred to an OHIP-funded orthopaedic surgeon. As it turned out, the applicant saw Dr. Abbas on January 16, 2019 and Dr. Safir on February 22, 2019.

[24] In reaching this conclusion, I give no weight to the respondent's evidence from the CPSO regarding the remediation plan for Dr. Alexander as it has not been established that this relates to the applicant's medical matters.

[25] For the reasons above, I find that the disputed orthopaedic assessment is not reasonable and necessary. This claim is dismissed.

Chronic Pain Assessment of $2,496.00

[26] The applicant submits that the chronic pain assessment is reasonable and necessary in order to evaluate the applicant, to investigate the degree to which his pre-existing chronic pain, if any, was exacerbated by the accident, to determine relevant treatment, reduce his ongoing pain, increase his strength and range of motion and assist him to returning to his pre-accident activities of daily living. The applicant relies on Dr. Abbas' diagnosis of chronic pain, Dr. Alexander's recommended referral to a multidisciplinary pain program and a previous decision[6] in support of this claim.

[27] The respondent submits that the applicant has not proven this cost is reasonable and necessary.

[28] I find that the applicant is not entitled to the payment of the chronic pain assessment because he has not established, on a balance of probabilities that it is reasonable and necessary.

[29] The chronic pain assessment was completed by Dr. Alexander, the applicant's orthopaedic surgeon, on November 28, 2019. In listing his credentials, Dr Alexander does not refer to any experience, education or training specific to

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[6] *L.D. v. Aviva Insurance Canada,* 2020 CanLII 12700 (ON LAT) at para 4, 5 and 9.

chronic pain. Other than describing the applicant's medical history and his examination, the clinical basis for Dr. Alexander's diagnosis is not sufficiently explained.

[30] This proposed treatment plan is 13 months post-accident. In the 13 months between the accident and proposed treatment plan, the weight of the evidence, including those of Dr. Hussain, considered in totality is that the applicant's accident-related symptoms are managed with medication. There is no evidence that the applicant was referred by Dr. Hussain or any of his other physicians to any specialist for chronic pain resulting from the accident even though pain and the accident was discussed with all of them. Dr. Abbas, with respect to the applicant's shoulder, diagnoses chronic myofascial pain syndrome as a result of the accident and recommends physiotherapy only. Dr. Safir's report notes that the applicant reported increased pain in his left hip and stump area since the accident and that the applicant uses Advil, Lyrica and another unidentified pain killer for pain management. No further treatment or assessment is suggested.

[31] The applicant sought treatment from Dr. Hussain for accident-related pain infrequently in the one-and-one-half years following the accident. When the treatment plan for the disputed chronic pain assessment was submitted in June 2019, there is no evidence that the applicant was seeking any treatment from his physicians for chronic pain, tending to indicate his pain was being managed with medication.

[32] The applicant reported to his physicians that he can no longer work as an Uber driver but is able to attend school. The applicant's ability to carry on his activities, even if limited in some respects, is not consistent with the severe, debilitating pain associated with chronic pain. Little evidence has been put forward by the applicant that he would receive any meaningful medical benefit from this proposed chronic pain assessment.

[33] The applicant has failed to establish that his post-accident pain results from the accident given that, pre-accident, the applicant complained to Dr. Hussain of back pain, and expressed concern with his left stump and his prostheses.

[34] The applicant's claim for payment of the chronic pain assessment is denied.

[35] The applicant submits that the respondent failed to present any evidence to advance its position that the denied accident benefits are not reasonable and necessary, save for the excessive fee for acupuncture. This argument is unpersuasive with respect to all medical benefits in dispute. The onus of proof is

on the applicant and he has not met it with respect to the claimed medical benefits.

Award

[36] Section 10 of Ontario Regulation 664 provides that a special award may be granted if the respondent unreasonably withheld or delayed payments. I find that there was no payment unreasonably withheld or delayed. No award is made.

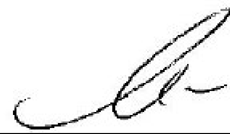
Interest

[37] As I have found that no benefits are payable, no interest is payable.

ORDER

[38] For the reasons outlined above, the applicant's claims for the physical treatment balance of $768.10, for the orthopaedic assessment of $2,813.13 and for the chronic pain assessment of $2,496.00 are dismissed. There is no special award. There is no interest.

Released: October 23, 2020



Avril A. Farlam
Vice Chair