Tribunals Ontario
Licence Appeal Tribunal

Tribunaux décisionnels Ontario
Tribunal d'appel en matière de permis

Citation: Adu v. Allstate Canada, 2021 ONLAT 19-012192/AABS-A

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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:

Justice Adu

Applicant

and

Allstate Canada

Respondent

AMENDED DECISION

ADJUDICATOR: **Lindsay Lake**

APPEARANCES:

For the Applicant: Miguel Maruszki, Counsel

For the Respondent: Maia Abbas, Counsel

HEARD: **By way of written submissions**

OVERVIEW

[1] Justice Adu (the "applicant") was involved in two motor vehicle accidents – the first on March 5, 2017 and the second on June 24, 2017. Following the June 24, 2017 accident, the applicant sought benefits pursuant to the *Statutory Accident Benefits Schedule – Effective September 1, 2010*[1] from Allstate Canada (the "respondent").

[2] The respondent denied the applicant's claim for several treatment plans and, as a result, the applicant submitted an application to the Licence Appeal Tribunal – Automobile Accident Benefits Service (the "Tribunal").

[3] A case conference was held on April 8, 2020 and the matter proceeded to a written hearing.

ISSUES IN DISPUTE

[4] The following issues are to be decided:

(a) Is the applicant entitled to the following treatment recommended by Toronto Medical Centre:

(i) $1,656.81 for chiropractic treatment and massage therapy in a treatment plan ("OCF-18") dated December 1, 2017, and denied on December 5, 2017?

(ii) $2,743.37 for psychological services in an OCF-18 dated July 24, 2019, and denied on August 27, 2019?

(b) Is the applicant entitled to the following assessments recommended by Toronto Medical Centre:

(i) $1,672.11 for a functional abilities' assessment in an OCF-18 dated February 14, 2019, and denied on February 22, 2019?

(ii) $1,131.44 for an attendant care assessment in an OCF-18 dated October 3, 2018, denied on October 9, 2018?

(iii) $1,970.00 for a neurological assessment in an OCF-18 dated October 3, 2018, and denied on October 9, 2018?

[1] O. Reg. 34/10 (the "*Schedule*").

(c) Is the applicant entitled to the following assessments recommended by 101 Assessment Centre:

(i) $7,807.70 for a neuropsychological assessment in an OCF-18 dated October 11, 2018, and denied on October 31, 2018?

(ii) $2,460.00 for a vocational assessment in an OCF-18 dated September 3, 2019, and denied on September 30, 2019?

(iii) $2,460.00 for a chronic pain assessment in an OCF-18 dated September 3, 2019, and denied on September 30, 2019?

(d) Is the applicant entitled to interest on any overdue payment of benefits?

RESULT

[5] I find that:

(a) While the June 24, 2017 accident is not the sole cause of the applicant's neck, back and knee issues, the June 24, 2017 was a necessary cause of the applicant's pain complaints which would not have been exacerbated after the March 5, 2017 accident but for the June 24, 2017 accident; and

(b) The applicant is not entitled to any of the disputed treatment plans as he failed to prove that they were reasonable and necessary on a balance of probabilities and, therefore, no interest is payable.

ANALYSIS

Causation

[6] In its hearing submissions, the respondent raised the issue of causation related to the applicant's physical injuries. The respondent submitted that the applicant's neck pain, back pain and knee issues were not caused as a result of the June 24, 2017 accident, but rather arose as a result of a gun shot wound that the applicant sustained in 2011 and/or as a result of the applicant's March 5, 2017 motor vehicle accident.

[7] The applicant did not respond to the causation issue raised by the respondent in his reply hearing submissions.

[8] In order to determine entitlement to accident benefits, the applicant is required to prove, on a balance of probabilities, that the subject accident caused his

impairments. The applicable test in making this determination is the "but for" test: whether the applicant would have had the impairments but for the subject accident.[2] The subject accident is not required to have been "the cause" – that is, the subject accident need not be the sole cause or have been sufficient in itself to have caused the impairments at issue. Rather, the subject accident need only to have been a "necessary cause."[3]

[9] I find that, on the evidence, the applicant has proven on a balance of probabilities that his neck pain, back pain and knee issues were caused by the March 5, 2017 accident and were exacerbated by the June 24, 2017 accident. Therefore, the causation test has been met as the June 24, 2017 accident is a necessary cause such that the applicant's pain complaints would not have been exacerbated but for the June 24, 2017 accident.

The 2011 Gunshot Wound Injury

[10] On December 11, 2011, the applicant sustained a gun shot wound to his left hip/buttock.[4] The bullet stopped close to his sciatic nerve which caused pain, numbness and tingling in his buttock and in the back of his left calf down to his toes.[5] The applicant was subsequently diagnosed with a drop foot and a sciatic nerve condition.[6] Due to potential complications from surgery to remove the bullet, the applicant declined any surgical intervention and, as a result, several metal fragments remain in his body.[7]

[11] The respondent relied upon a February 10, 2016 clinical note and record ("CNR") entry by Dr. Suzanne Strasberg, the applicant's family physician, in support of its position that the applicant's knee complaints were caused by his gun shot wound rather than the subject accident. In this entry, Dr. Strasberg attributed the applicant's complaint of left leg weakness due to his gunshot wound injury. This CNR entry, however, is well over a year prior to the subject accident and there is no other entry in Dr. Strasberg's CNRs until *after* the March 2017 accident. Therefore, I find that any complaints from the applicant's gun shot wound were asymptomatic for at least one year prior to the March 2017 accident.

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[2] *Sabadash v. State Farm et al.*, 2019 ONSC 1121 (CanLII).
[3] *Ibid.* at para. 39.
[4] July 31, 2018 Psychological Report by Sylvia Antal, psychometrist, and supervised by Dr. Kenneth R. Keeling, psychologist, Submissions of the Applicant, tab 3, page 3.
[5] *Ibid*.
[6] December 3, 2018 Neuropsychological Assessment – Diagnostic and Interpretation Report by Dr. John Gilman, psychologist, Submissions of the Applicant, tab 5, page 2.
[7] *Supra* note 4 at page 3.

[12] The evidence also shows that the applicant had recovered and resumed many of his activities following his 2011 gun shot wound injury. For example, at the time of the March 5, 2017 accident, the applicant was working as a drywall taper[8] and as a loader/shipper[9,10] with Maximum Shipping.[11,12] He had also previously worked as a cook after 2011,[13] and had resumed walking and participating in sports activities, including soccer,[14,15] within two years after his injury.[16]

[13] The only evidence before me that supports the respondent's position regarding causation and the applicant's 2011 gun shot wound injury is the December 27, 2018 Independent Orthopaedic IE Report by Dr. Ramunas Saplys, orthopedic surgeon.[17] In his report, Dr. Saplys opined that the applicant's left leg symptoms were related to his previous gunshot wound and were unrelated to the subject motor vehicle accident.[18] I do not place weight on Dr. Saplys' opinion, however, because Dr. Saplys provided no comment or discussion on the applicant's asymptomatic period of at least one year prior to the March 2017 accident or on the applicant's functionality following his recovery from his 2011 gun shot wound injury.

[14] For these reasons, I find that the applicant's 2011 gun shot wound injury was not the cause of the applicant's leg complaints following his motor vehicle accidents in 2017.

The March 2017 Motor Vehicle Accident

[15] The applicant attended Dr. Strasberg's office on March 7, 2017 and reported that he was involved in a motor vehicle accident on March 5, 2017. At that time, the applicant reported pain in his left leg, his back and neck. The applicant also reported that he experienced burning and numbness in his left leg like he experienced after his gun shot wound injury. Dr. Strasberg reported that the applicant had lower spine tenderness at L4-5 and a tender left calf. Dr.

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[8] *Ibid*. at page 2.
[9] August 28, 2018 Independent Medical Evaluation Report by Dr. Igor Wilderman, physician, Submissions of the Applicant, tab 4.
[10] December 3, 2018 Neuropsychological Assessment – Intake Interview and Screening Report by Dr. John Gilman, psychologist, Submissions of the Applicant, tab 5, page 3.
[11] *Supra* note 6 at page 2.
[12] December 27, 2018 Independent Psychology Insurer's Examination Report by Dr. Alan Chan, psychologist, Submissions of the Applicant, tab 6, page 9.
[13] *Supra* note 6 at page 2.
[14] *Supra* note 12 at page 10.
[15] Clinical Notes and Records ("CNRs") of Dr. Suzanne Strasberg, family physician, Submissions of the Applicant, tab 1, March 7, 2017 entry.
[16] *Supra* note 10 at page 3.
[17] Hearing Submissions of the Respondent, tab 26.
[18] *Ibid*. at pages 7 and 9.

Strasberg diagnosed the applicant with a low back strain with sensory involvement and referred him to physiotherapy and massage therapy. No pain medication was prescribed to the applicant at that time.

[16] The applicant followed-up with Dr. Strasberg on April 10, 2017 and May 29, 2017 prior to the subject accident. On April 10, 2017, the applicant reported ongoing left calf pain and cramping, knee pain and intermittent low back pain which was causing him difficulties with walking and sleeping. At that time, the applicant had not returned to his pre-March 5, 2017 employment, he was attending physiotherapy once per week and he was not taking any pain medication.

[17] On May 29, 2017, the applicant again reported intermittent pain in his left leg and leg cramps to Dr. Strasberg. The applicant confirmed that he was still attending physiotherapy and not working at the time of this visit. Dr. Strasberg diagnosed the applicant with a back and left leg injury and recommended that he continue with physiotherapy. Dr. Strasberg also prescribed the applicant naproxen 500 mg tablets which was to be taken twice per day as needed.

[18] On July 4, 2017, the applicant attended Dr. Strasberg's office but was seen by Dr. Diana Wu. Dr. Wu's CNR entry noted that the applicant's second accident occurred on the May 24/25 weekend rather than on June 24, 2017. I accept that this is a clerical error on Dr. Wu's part as the applicant had seen Dr. Strasberg on May 29, 2017, which would have been *after* May 24/25, and there was no mention of a second accident. In my opinion, it is more likely that Dr. Wu had meant the June 24/25 weekend as May 24 and 25 also fell on a weekday in 2017.

[19] In any event, on July 4, 2017 the applicant reported to Dr. Wu bilateral shoulder pain and bilateral trapezius pain with turning of his head. Dr. Wu's CNR entry noted that the applicant had no headache, no limb weakness or paresthesia, no head injury and no loss of consciousness. Dr. Wu also reported that the applicant was still undergoing physiotherapy treatment for his leg and back pain from his March motor vehicle accident and that his, "back and leg pain is improving slowly, not worsened by recent new MVA." Dr. Wu's physical examination revealed pain on palpation over the applicant's bilateral trapezius, no cervical spine tenderness on palpation and full range of motion of the cervical spine. Dr. Wu diagnosed the applicant with "minor MVA post bilat[eral] trapezius sprain" and recommended over the counter Aleve and Zantac as the applicant had no prescription medication coverage at that time. Dr. Wu also reported that the applicant had taken all of the Naproxen prescribed by Dr. Strasberg in May.

[20] The applicant returned to Dr. Strasberg on September 12, 2017. Although Dr. Strasberg noted that it was a follow-up appointment from the May 2017 accident, this incorrect information was likely brought forward from Dr. Wu's incorrect July 4, 2017 CNR entry. Regardless, the applicant reported ongoing back pain, neck pain and headaches at this visit. Dr. Strasberg diagnosed the applicant with soft tissue injuries and recommended that he continue with physiotherapy.

[21] After this visit, Dr. Strasberg's CNRs do not reference the June 2017 accident until July 31, 2018 when the applicant reported ongoing back pain since the March *and* June 2017 accidents. I agree with the respondent's submission that this is the first time that any back pain had been attributed to the June 2017 accident in Dr. Strasberg's CNRs. In fact, earlier visits to Dr. Strasberg attribute the applicant's ongoing issues to other causes. For example, when the applicant visited Dr. Strasberg on December 12, 2017, Dr. Strasberg attributed the applicant's worsening back and leg pain to the cold weather. On March 12, 2018, Dr. Strasberg's CNRs show that the applicant reported that he could not sleep due to his pain and worry after the March 5, 2017 accident with no mention of the more recent accident.

[22] The respondent, however, failed to make any submissions on two insurer's examination ("IE") reports that contradict its position regarding causation of the applicant's neck pain, back pain and knee issues. In the December 27, 2018 Independent Neurology IE report by Dr. Verity John, neurologist,[19] Dr. John accepted the applicant's self reports that he had a recurrence of his left leg, right knee and neck pain following his March 5, 2017 accident and that following the June 2017 accident, the applicant's left leg, neck and back pain increased.[20] Further, in her December 27, 2018 report, Dr. Saplys opined that the applicant sustained musculoligamentous strains of the pericervical and paralumbar structures as well as bilateral knee strains or contusions from the June 2017 accident.[21] Dr. Saplys also opined that the applicant may have sustained an exacerbation of his pre-existing soft tissue injuries from the March 5, 2017 accident in the June 2017 accident.[22]

[23] Additionally, all of the assessment reports submitted by the applicant in this matter maintain that the applicant's neck and back pain and knee issues began after the March 5, 2017 accident and were exacerbated by the June 24, 2017 accident.

[19] Hearing Submissions of the Respondent, tab 25.
[20] *Supra* note 17 at page 7.
[21] *Ibid*. at page 7.
[22] *Ibid*. at page 10.

[24] Therefore, despite the lack of reference to the June 2017 accident in Dr. Strasberg's CNRs in late 2017 and into 2018, I find that while the June 2017 accident is not the sole cause of the applicant's neck, back and knee issues, the June 2017 accident was a necessary cause such that the applicant's pain complaints following the March 5, 2017 accident would not have been exacerbated but for the June 24, 2017 accident.

Treatment Plans

[25] Sections 14 and 15 of the *Schedule* provide that an insurer shall pay medical benefits to, or on behalf of, an applicant so long as the applicant sustains an impairment as a result of an accident and the medical benefit is a reasonable and necessary expense incurred by the applicant as a result of the accident.

[26] I find that the applicant has not met his onus[23] of proving entitlement to any of the disputed treatment plans as he failed to prove that they are reasonable and necessary on a balance of probabilities.

Chiropractic Treatment and Massage Therapy

[27] The December 1, 2017 treatment plan for chiropractic treatment and massage therapy was completed by Dr. Luela Louis, chiropractor, and sought funding for 8 sessions of physical rehabilitation provided by a chiropractor,[24] 8 sessions of chiropractic treatment, 8 sessions of massage therapy and education on promoting health and preventing disease. The goals of this treatment plan were pain reduction, increased range of motion, increased strength, return to activities of normal living and to restore pre-accident level of function within this patient's health status. The OCF-18 reported that the applicant had made some improvements over the course of his previous treatment plan but that he continues to complain of pain in the head, neck, upper, mid and lower back, left hip, thigh ankle and bilateral ribs.

[28] On the evidence, I find that the applicant has not met his burden of proving that the December 1, 2017 treatment plan was reasonable or necessary. The only recommendation for physical treatment prior to the date of this treatment plan was made by Dr. Strasberg on September 12, 2017 but the recommendation was only for physiotherapy, not chiropractic treatment or massage therapy. Dr.

[23] *Scarlett v. Belair Insurance*, 2015 ONSC 3635 (CanLII) at paras. 20-24.
[24] The additional comments portion of the OCF-18, however, noted that the physical rehabilitation sessions were to be provided by physical therapy assistants under the direct supervision of chiropractors.

Strasberg also only recommended that the applicant continue with physiotherapy at the applicant's December 12, 2017 visit.

[29] In his reply, the applicant submitted that he ought to be approved for more physical treatment by relying on his diagnoses of chronic pain syndrome, post-traumatic headaches, chronic low back pain and chronic left knee pain as diagnosed by Dr. Michael Gofeld, in the November 4, 2019 Chronic Pain Assessment report.[25] While this report was not in existence at the time that the December 1, 2017 treatment plan was submitted for consideration by the respondent, Dr. Gofeld made no recommendations for facility based physical treatment. Instead, Dr. Gofeld only recommended a fitness membership with personal training sessions.[26] Therefore, I find that even if Dr. Gofeld's report was prepared contemporaneously with the December 1, 2017 OCF-18, which it was not, that it does not support the proposed chiropractic treatment and massage therapy.

[30] For these reasons, I find that the applicant has failed to prove on a balance of probabilities that the proposed treatment plan is reasonable and necessary and, therefore, he is not entitled to this treatment plan.

Psychological Services

[31] The July 24, 2019 treatment plan was completed by Dr. Kenneth Keeling, psychologist, and sought funding for 12 sessions of psychological counselling to be provided by Dr. Keeling, time for communicating with other providers, treatment planning and a progress report. The goals of this treatment plan were pain reduction, a return to pre-accident level of psychological functioning and a return to activities of normal living.

[32] I find that the applicant has failed to prove the reasonableness and necessity of this treatment plan on a balance of probabilities. A previous treatment plan dated April 8, 2019 for psychological treatment was approved by the respondent. In support of the April 8, 2019 OCF-18, a progress report by Dr. Keeling and Ms. Galina Chachshina[27] provided their reasons for seeking ongoing psychological treatment for the applicant and noted that the additional sessions were required to transition the applicant out of therapy.[28]

[25] Submissions of the Applicant, tab 8.
[26] *Ibid*. at page 27.
[27] Hearing Submissions of the Respondent, tab 33.
[28] *Ibid*.

[33] The July 24, 2019 progress report by Dr. Keeling and Ms. Chachshina[29] again provided their reasons for recommending additional psychological treatment as set out in the July 24, 2019 OCF-18. Dr. Keeling and Ms. Chachshina again noted that the additional sessions were to transition the applicant out of therapy. There was no discussion as to why this step was not taken or was not completed as part of the previously approved April 8, 2019 OCF-18. I also agree with the respondent that the July 24, 2019 progress report recommendations were a duplicate of the April 8, 2019 progress report recommendations.

[34] Therefore, I find that the applicant is not entitled to the July 24, 2019 OCF-18 for psychological services as he failed to prove that it was reasonable and necessary on a balance of probabilities.

Functional Abilities Assessment

[35] The February 14, 2019 OCF-18 was completed by Dr. Gloria Cheung, chiropractor, and sought funding for a functional abilities assessment to be completed by Dr. James Fung, chiropractor. The goals of this treatment plan were pain reduction, increase in strength, increased range of motion and return to activities of normal living. The additional comments portion noted that as a result of the applicant's ongoing complaints and symptoms, an evaluation is recommended to be conducted to determine if any disability exists beyond the acute stages of injury. The functional abilities assessment would assess the applicant's handgrip strength, pinch grip strength as well as range of motion for affected joints. All tests were to be performed to determine the degree of impairment as well as reliability of effort. The functional abilities assessment would be completed to objectively determine the applicant's physical abilities and if he could complete home care tasks or return to full occupational duties.

[36] The applicant made no submissions regarding the proposed functional abilities assessment in either his initial hearing submissions or in reply.

[37] I find that the applicant is not entitled to a functional abilities assessment as he has failed to prove that it was reasonable and necessary. At almost two years post-accident, the applicant had undergone several assessments and was being followed by his family doctor. It is unclear why an additional specialist would be required to assess the degree of his impairment and to test his range of motion. The reasons to measure the applicant's handgrip strength and pinch grip strength are also unclear, as the applicant made no complaints regarding his

[29] Hearing Submissions of the Respondent, tab 33.

arms and hands as a result of the June 24, 2017 accident. As a result, the applicant is not entitled to this treatment plan.

Attendant Care Assessment

[38] The October 3, 2018 OCF-18 was completed by Dr. Kate O'Hara, chiropractor, and sought finding for an attendant care assessment to be complete by Anastasiya Kolelanais, registered nurse. The goals of this treatment plan were pain reduction, increase in strength and a return to activities of normal living. The OCF-18 noted that the attendant care assessment is recommended to provide a detailed comparison of the applicant's pre-accident levels of function with respect to attendant care needs. The assessment would entail the reinforcement of hurt vs. harm principles, energy conservation techniques to facilitate recovery and to prepare an Assessment of Attendant Care Needs form ("Form 1"). The additional comments portion of the OCF-18 noted that Dr. Khal Efala, orthopaedic surgeon, spine consultant and interventional pain specialist, recommended an attendant care assessment in his September 27, 2018 Independent Orthopaedic Examination report.[30]

[39] The only submissions made by the applicant regarding his entitlement to the attendant care assessment was that as a result of the respondent's removal of the applicant from the Minor Injury Guideline (the "MIG")[31] on January 8, 2019, that the respondent's earlier denial of the assessment, which was based upon the applicant being confined to the MIG, should have been reversed and approved in full. The applicant made no submissions regarding the reasonableness and necessity of the proposed assessment.

[40] Notwithstanding the lack of guidance in the applicant's submissions, I find that the applicant has not proven on a balance of probabilities that the proposed attendant care assessment was reasonable and necessary.

[41] In his September 27, 2018 report, Dr. Efala stated that the applicant suffered from a musculoskeletal impairment and that he would have difficulty performing the essential tasks of attendant care activities that involved prolonged standing, walking, lifting, heavy carrying and climbing. Therefore, Dr. Efala recommended an attendant care assessment to be completed by an occupational therapist to clarify the applicant's needs and for education on the necessary pacing and task modification strategies.

[30] Submissions of the Applicant A, tab 2.
[31] Minor Injury Guideline, Superintendent's Guideline 01/14, issued pursuant to s. 268.3 (1.1) of the *Insurance Act*.

[42] I place little weight to no weight on Dr. Efala's report and his opinions contained therein in determining the applicant's entitlement to the proposed attendant care assessment due to the number of significant errors contained in his report. For example, Dr. Efala reported:

(a) That the applicant denied any previous motor vehicle accidents[32] despite the overwhelming evidence that he was involved in at least one other motor vehicle accident on March 5, 2017;

(b) That the applicant's past medical history was unremarkable[33] when the applicant sustained a 2011 gun shot wound injury;

(c) That the applicant was working at the time of the June 24, 2017 accident[34] when all other evidence indicates that the applicant left work following the March 5, 2017 accident and had not returned prior to the June 24, 2017 accident; and

(d) That the applicant was in "excellent medical health" and had no activity limitations at the time of the June 24, 2017 accident.[35]

[43] Dr. Efala's report is also unclear on what documents were reviewed as part of his assessment, which may account for the significant errors in the applicant's pre-June 24, 2017 accident health and functioning. The report also included the credentials of a second physician, Dr. Mohapatra,[36] and it is unclear what role Dr. Mohapatra had in conducting the assessment of the applicant.

[44] On the evidence, I find that the applicant has failed to prove the reasonableness and necessity of the proposed treatment plan for an attendant care assessment and I also find that it is unclear what, if any, attendant care assistance that is covered by a Form 1 the applicant required at the time the assessment was proposed based on the following:

(a) While the applicant complained of bilateral knee pain that felt like his left knee was giving out on him, especially when he was navigating stairs, with pain radiating to his left hip and ongoing upper and lower back pain to Dr. Strasberg on October 3, 2018, and that the applicant was observed walking with a left stepped gait by Dr. Saplys[37] with a

[32] *Supra* note 30 at page 7.
[33] *Ibid*. at page 8.
[34] *Ibid*. at page 10.
[35] *Ibid*. at page 12.
[36] *Ibid*. at page 6.
[37] *Supra* note 17 at page 6.

limp by Dr. Alan Chan, psychologist, in his December 27, 2018 Independent Psychology IE Report,[38] there were no reports of any falls or any recommendations for mobility supervision of the applicant; and

(b) The applicant reported in December 2018 that he was independent with his personal care[39] and that he was able to participate in light household chores, such as light sweeping and tidying as well as some dishes, but that they were completed at a slower pace. [40] The applicant also reported to Dr. Chan in his December 27, 2018 report that he had returned to all of his usual pre-accident housekeeping tasks but with reduced frequency.[41]

Neurological Assessment

[45] The October 3, 2018 OCF-18 was completed by Dr. O'Hara and sought funding for a neurological assessment to be completed by Dr. Lance Brian Majl. The goals of the treatment plan were pain reduction, increase in strength, increased range of motion, return to activities of normal living and a return to pre-accident work activities. The OCF-18 noted that the neurological assessment was recommended as a result of the applicant's present complaints and ongoing symptoms of headaches, dizziness, nausea and/or numbness. The purpose of the assessment was to evaluate the extent of the neurological injuries that the applicant sustained and to provide a prognosis and recommendations to facilitate recovery. The OCF-18 referred to Dr. Efala's recommendations in his September 27, 2018 Orthopaedic Assessment report to support the proposed assessment.

[46] The applicant made no submissions regarding the reasonableness and necessity of the neurological assessment in either his initial hearing submissions or in reply.

[47] In addition to the reasons discussed above in paragraphs [42] and [43], I also do not give weight to Dr. Efala's September 27, 2018 report because it contains additional discrepancies regarding the reasons for his recommendation that the applicant be assessed by a neurologist. For example, in his summary and analysis section, Dr. Efala stated that there was positive pertinent neurological

[38] *Supra* note 12 at page 9.
[39] *Ibid*. at page 10 and *supra* note 19 at page 6.
[40] *Supra* note 12 at page 10.
[41] *Ibid.* at page 6.

findings of the applicant's lower extremity.[42] However, under the section of the report entitled, "Neurological Examination of the Lower Extremity," the applicant reportedly had normal strength in his lower limbs and no other positive testing outcomes to signal a neurological condition.[43] Further, the only stated reason for Dr. Efala's recommendation for a neurology assessment was to address the applicant's headaches.[44] Dr. Efala, however, only reported that the applicant complained of headaches – there is no further discussion of the frequency or intensity or any further basis for the recommendation of a neurological assessment outside of the sole fact that the applicant complained of headaches.

[48] There is also conflicting evidence before me about whether the applicant hit his head in the June 24, 2017 accident. At the applicant's first post-accident visit with Dr. Strasberg on July 4, 2017, Dr. Strasberg noted "no head injury" and no loss of consciousness. The applicant also denied hitting his head or losing consciousness in the June 2017 accident to Ms. Sylvia Antal, psychometrist, and to Dr. Keeling in their July 31, 2018 Psychological report.[45]

[49] The first report that stated that the applicant hit his head in the accident was the December 3, 2018 Neuropsychological Assessment – Intake Interview & Screening Report by Dr. John Gilman, psychologist.[46] Dr. Gilman reported, "there was a hit to Mr. Adu's head with transient confusion and disorientation, followed by difficulties with concentration and memory."[47] Thereafter, the applicant reported:

(a) hitting his head on the headrest in the accident, but not losing consciousness, to Dr. John in his December 27, 2018 Neurology report;[48] and

(b) hitting his head to Dr. Gofeld.[49] Dr. Gofeld's November 4, 2019 report stated, "Mr. Adu reports hitting his whole body, specifically his left knee and his head, on the inside of the vehicle. He is unable to recall whether or not he lost consciousness. After the accident, Mr. Adu conveys feeling dizzy and choked."[50]

[42] *Supra* note 30 at page 12.
[43] *Ibid*. at page 11.
[44] *Ibid*. at page 16.
[45] *Supra* note 4 at page 3.
[46] *Supra* note 10.
[47] *Ibid*. at pages 2-3.
[48] *Supra* note 19 at page 7.
[49] *Supra* note 25 at page 16.
[50] *Ibid*.

[50] Despite these inconsistencies in the evidence, Dr. Gilman opined that the applicant sustained "notable deceleration forces in two successive impacts" which caused the applicant's brain to slide forward, scraping against the sharp bony edges of the basal skull, that he sustained a vascular contusion to the frontal and temporal poles with possible diffuse axonal injuries as a result of the two 2017 accidents.[51] As a result, Dr. Gilman opined that the applicant sustained a moderate brain injury and suffered from ongoing concussion symptoms "consistent with two successive concussions sufficient to interrupt awareness with confusion and disorientation."[52]

[51] I do not place weight on Dr. Gilman's opinion regarding the applicant sustaining a moderate brain injury and two concussions as he is the only assessor to reach such a conclusion. There are no family doctor's CNRs that diagnose the applicant with a concussion or post-concussion symptoms beyond headaches. Dr. Gilman also failed to acknowledge that he was the first assessor to report that the applicant hit his head in the accident, and he did not provide any discussion on this discrepancy between his report and the earlier medical evidence.

[52] I place greater weight on the applicant's earlier reporting of not sustaining a head injury or hitting his head in the accident given that his earlier reports were made closer in time to the accident date when his memory would have been more clear in his mind rather than his reports to Dr. Gilman, which were made almost one and a half years post-accident. Therefore, I find that the applicant has not proven on a balance of probabilities that he hit his head in the accident or that his headaches had any neurological cause such that a neurological assessment was reasonable and necessary.

Neuropsychological Assessment

[53] The October 11, 2018 OCF-18 was completed by Dr. Gilman and sought funding in the total amount of $7,807.70 for an assessment of the applicant's neurocognitive and emotional functions. The goals of the treatment plan were to examine the applicant's cognitive and emotional functioning and to provide recommendations for treatment.

[54] Despite the respondent's denial of this treatment plan on October 31, 2018, the applicant underwent the proposed assessment on October 9 and 10, 2018 which

[51] *Supra* note 6 at page 5.
[52] *Ibid*.

resulted in the following four reports all dated December 3, 2018 and prepared by Dr. Gilman:

(a) Neuropsychological Assessment Intake Interview & Screening Report;

(b) Neuropsychological Assessment Psychometric Examination Report I – Intelligence and Memory;

(c) Neuropsychological Assessment Psychometric Examination Report II – Neuropsychological Functioning; and

(d) Neuropsychological Assessment Diagnostic & Interpretation Report.

[55] I find that the applicant has failed to prove on a balance of probabilities that that October 11, 2018 OCF-18 was reasonable and necessary for the following reasons:

(a) As discussed in paragraphs [48] to [52] above, I place more weight on the evidence that the applicant had given closer in time to the accident that he did not strike his head in the accident and less weight on Dr. Gilman's report which report the applicant did hit his head in the June 24, 2017 accident;

(b) One of the goals of the treatment plan was to provide recommendations for treatment. Dr. Gilman made no treatment recommendations in his reports and, therefore, this stated goal was not achieved by the assessment;

(c) The other goal of examining the applicant's cognitive and emotional functioning produced the same diagnoses that Dr. Igor Wilderman, physician, made in his August 28, 2018 Independent Medical Evaluation Report[53] aside from the concussion related diagnoses which I do not place weight on as discussed above. In comparison to Dr. Wilderman's report, I find Dr. Gilman's report to largely be a duplication of services;

(d) Dr. Gilman opined that the applicant's social and occupational impairments currently prevented his return to work when income replacement benefits and non-earner benefits are not in dispute between the parties; and

[53] *Supra* note 9 at page 10 and *supra* note 6 at page 3.

(e) It is unclear who performed the assessments of the applicant that were the basis of the reports prepared by Dr. Gilman. In the additional comments section of the disputed OCF-18, there is discussion of amounts paid to psychometrists who are supervised by psychologists. Nowhere in these four reports does it state who administered the testing or completed the interview of the applicant. There are also no credentials provided for Dr. Gilman.

[56] For these reasons, the applicant is not entitled to the October 11, 2018 treatment plan for a neuropsychological assessment.

Vocational Assessment

[57] The September 3, 2019 OCF-18 was completed by Dr. Wayne Coghlan, chiropractor, and sought funding for a vocational assessment which was to be completed by Marg Smith, vocational rehabilitation counsellor. The goals of this treatment plan were to identify the applicant's current capabilities regarding his work-related duties and to achieve a return to pre-accident work activities. The additional comments portion noted that the assessment would provide expert insight into the identification of the applicant's sustained impairment as a result of the accident and is required to determine whether or not the applicant can return to work and, if so, in what capacity. The assessment will determine if an occupational disability exists, identify the applicant's areas of strengths and barriers to success and will include an assessment of the applicant's performance in the areas of cognitive, academic and vocational functioning. Finally, the assessment would identify suitable occupational options. The OCF-18 also listed the July 31, 2018 Psychological Report by Dr. Keeling and Ms. Antal as well as the December 3, 2018 Neuropsychological Assessment Report by Dr. Gilman in support of the proposed assessment.

[58] The vocation assessment was denied by the respondent on October 12, 2019 because the respondent had determined that the applicant was not substantially disabled from returning to work following s. 44 assessments and, as a result, his income replacement benefits ("IRBs") were terminated effective January 8, 2019.[54]

[59] Despite the respondent's denial, the applicant underwent the vocational assessment with Jennifer Griffiths, vocational rehabilitation evaluator. In her October 31, 2019 Vocational Assessment report,[55] Ms. Griffiths opined that the

[54] Hearing Submissions of the Respondent, tab 41.
[55] Submissions of the Applicant, tab 7.

applicant was not likely able to meet the demands of his pre-accident occupation and that he is not competitively employable due to his physical and cognitive defects resulting from the subject accident.[56]

[60] In his reply submissions, the applicant submitted that the proposed vocational assessment was reasonable and necessary as he was responding to the respondent's position that he was not substantially disabled from returning to work and that he did not suffer a complete inability to carry on a normal life.[57] The applicant, however, did not address why he waited to respond to the respondent's position regarding his employability until over eight months after the termination of his IRBs and his entitlement to non-earner benefits ("NEBs") which were also denied eight months earlier on January 8, 2019.

[61] Moreover, while the applicant is correct that he is not statute barred from pursuing IRBs or NEB, he also confirmed that he is not currently disputing his entitlement to IRBs or NEBs. Additionally, the vocational assessment took place outside the period for which the applicant may be entitlement to NEBs. Therefore, I find that the applicant has not proven on a balance of probabilities the reasonableness and necessity of the OCF-18 for the vocational assessment given that it does not pertain to any issues in dispute between the parties and I do not accept that it was completed in response to the respondent's termination of IRBs or denial of NEBs as the applicant failed to address the time gap between the termination/denial and the assessment taking place. For these reasons, the applicant is not entitled to this treatment plan.

Chronic Pain Assessment

[62] The September 3, 2019 OCF-18 was completed by Dr. Michael Gofeld, physician, and sought funding for a chronic pain assessment. The respondent denied this treatment plan by way of an explanation of benefits dated September 30, 2019.[58] The respondent advised that the proposed chronic pain assessment was not reasonable because a previous chronic pain assessment had been completed on August 28, 2018 by Dr. Wilderman. The respondent maintained this position in its hearing submissions and added that the applicant had not provided any evidence as to why a second chronic pain assessment was warranted only a year after Dr. Wilderman's assessment.

[63] I agree with the respondent that the chronic pain assessment is a duplication of services and I do not accept the applicant's submissions that the second chronic

[56] *Ibid*. at page 17.
[57] Reply Submissions of the Applicant, para. 20.
[58] Hearing Submissions of the Respondent, tab 42.

pain assessment was required because of the two-year anniversary of the accident or to address the applicant's ongoing need for therapy. Dr. Wilderman diagnosed the applicant with, among other conditions, a chronic pain disorder in his August 28, 2018 report and made several treatment recommendations.[59] I also find that the decision relied upon by the applicant of *B.M. v Allstate Insurance*[60] is not applicable to this matter as in *B.M.*, the applicant was not seeking entitlement to a second chronic pain assessment.

[64] Therefore, I find that the applicant has not proven on a balance of probabilities that the second proposed chronic pain assessment was reasonable and necessary and, as a result, he is not entitled to this treatment plan.

Interest

[65] As there are no benefits owing, interest is not payable.

CONCLUSION

[66] For the reasons outlined above, I find that:

(a) While the June 24, 2017 accident is not the sole cause of the applicant's neck, back and knee isses, the June 24, 2017 was rather a necessary cause of the applicant's pain complaints which would not have been exacerbated after the March 5, 2017 accident but for the June 24, 2017 accident;

(b) The applicant is not entitled to any of the disputed treatment plans as he failed to prove that they were reasonable and necessary on a balance of probabilities; and

(c) No interest is payable.

Released: July 7, 2021

Lindsay Lake
Adjudicator

[59] *Supra* note 9 at pages 10 and 13.
[60] 2019 CanLII 101616 (ON LAT) ("*B.M.*").