Citation: Obaidi v. Allstate Insurance, 2023 ONLAT 21-002991/AABS

Licence Appeal Tribunal File Number: 21-002991/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:

Shamsullah Obaidi

Applicant

and

Allstate Insurance

Respondent

DECISION

ADJUDICATOR: **Rachel Levitsky**

APPEARANCES:

For the Applicant: Bambi Santiago, Paralegal

For the Respondent: Ashley Shmukler, Counsel

HEARD: **By way of written submissions**

OVERVIEW

[1] Shamsullah Obaidi, the applicant, was involved in an automobile accident on September 21, 2018, and sought benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010 (including amendments effective June 1, 2016)* (the "*Schedule*"). The applicant was denied benefits by the respondent, Allstate Insurance, and applied to the Licence Appeal Tribunal - Automobile Accident Benefits Service (the "Tribunal") for resolution of the dispute.

ISSUES

[2] The issues in dispute are:

i. Are the applicant's injuries predominantly minor as defined in s. 3 of the *Schedule* and therefore subject to treatment within the $3,500.00 limit in the Minor Injury Guideline ("MIG")?

ii. Is the applicant entitled to $2,600.00 for physiotherapy services, recommended by York Medical Centre, in a treatment plan dated March 8, 2019?

iii. Is the applicant entitled to $2,600.64 for physiotherapy services, recommended by York Medical Centre, in a treatment plan dated November 8, 2019?

iv. Is the applicant entitled to $4,467.07 for psychological services, recommended by York Medical Centre, in a treatment plan dated July 29, 2019?

v. Is the applicant entitled to $2,350.00 for a social work assessment, recommended by York Medical Centre, in a treatment plan dated September 14, 2020?

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

RESULT

[3] The applicant has not demonstrated on a balance of probabilities that he is entitled to treatment beyond the $3,500.00 limit of the MIG.

[4] As the limits under the MIG are exhausted, the applicant is not entitled to any of the treatment plans in dispute.

[5] Given that there are no benefits owed, the applicant is not entitled to interest pursuant to s. 51 of the *Schedule.*

ANALYSIS

Applicability of the Minor Injury Guideline

[6] Section 18(1) of the *Schedule* provides that medical and rehabilitation benefits are limited to $3,500.00 if the insured sustains impairments that are predominantly a minor injury. Section 3(1) defines a "minor injury" as "one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury."

[7] An insured may be removed from the MIG if they can establish that their accident-related injuries fall outside of the MIG or, under s. 18(2), that "his or her health practitioner determines and provides compelling evidence that the insured person has a pre-existing medical condition that was documented by a health practitioner before the accident and that will prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the limit or is limited to the goods and services authorized under the Minor Injury Guideline". The Tribunal has also determined that chronic pain with functional impairment or a psychological condition may warrant removal from the MIG. In all cases, the burden of proof lies with the applicant.

[8] The applicant submits that he should be removed from the MIG for the following reasons: his pre-existing medical conditions would prevent maximal recovery within the limits of the MIG, he sustained a torn meniscus to his left knee, he suffers from chronic pain, and he suffers from a psychological condition that would remove him from the MIG. The respondent disagrees.

Pre-Existing Conditions

[9] I find that the applicant has not proven on a balance of probabilities that any pre-existing injuries or conditions would prevent him from achieving maximal medical recovery within the MIG.

[10] The records from Dr. Louvaris, family doctor, show that in 2010, the applicant was involved in an accident at work where he was hit in the head. As a result, he suffered from neck pain and headaches. CT scans to his neck and head were normal. There are no further records before me with respect to that incident, or whether the applicant continued to experience neck pain or headaches as a result.

[11] In 2015, the applicant was investigated for, and diagnosed with, aortic valve disease requiring ongoing care from a cardiologist.

[12] On May 4, 2015, the applicant advised Dr. Louvaris that he had right shoulder pain for years, which had worsened. This right shoulder pain was mentioned again on May 28, 2015, and the applicant was diagnosed with mild supraspinatus tendinopathy and subacromial bursitis. He mentioned right shoulder pain again to Dr. Louvaris on February 27, 2016.

[13] The next time the applicant visited Dr. Louvaris was on March 15, 2018. He was experiencing left upper back pain after work, and the pain was worse moving his shoulder. It is likely that Dr. Louvaris was referring to the applicant's left shoulder, as it was his left upper back that was hurting, and he had tenderness along the medial left scapular border. It was noted that the applicant's shoulder did not have tenderness, and it had full range of motion.

[14] The accident took place on September 21, 2018, and the applicant went to the hospital that day. He complained of neck swelling and pain, lower cervical spine tenderness and lumbar spine tenderness with radiation of pain down. He had decreased sensation in his left leg, pain radiating into his left leg, and difficulty moving his left leg due to pain. X-rays were normal. He was provided with Tylenol but refused a Toradol injection. He began receiving physiotherapy at York Medical Centre on September 24, 2018, where it was noted that he had pain in his neck and lower back, headaches, dizziness, and blurry vision. An OCF-3 completed that same day by Dr. San Bui, chiropractor at York Medical Centre, lists the applicant's injuries as sprain and strain of his cervical spine, concussion, headache, and sprain and strain of his lumbar spine.

[15] The applicant did not speak to Dr. Louvaris about the accident until March 7, 2019. He told Dr. Louvaris that he was receiving physiotherapy and that x-rays were normal, but no further discussion about the accident, diagnosis, or treatment was noted.

[16] On September 25, 2019, the applicant returned to Dr. Louvaris and advised that he was having sharp pains in his left knee for 6 months, "since MVA". I note that the accident was one year prior, not 6 months. He was also having pain to his left ankle for 6 months. An ultrasound on his left knee and ankle were normal. There was no mention of neck pain, back pain, or shoulder pain at this visit, or any further visits with Dr. Louvaris. The only injuries he complained of to Dr. Louvaris were pain to his left knee and left ankle. A left knee MRI in April 2020 indicated that there were signs of inflammation and a tiny radial tear of the lateral meniscus. He was referred to Dr. Han, physiatrist, for his left knee only.

[17] The applicant obtained a new family physician, Dr. Paywandi, in July 2020. Throughout the evidentiary record before me, the applicant does not complain of accident-related symptoms to Dr. Paywandi, despite approximately 15 visits in one year. He does however mention other incidents – he fractured his coccyx after falling in July 2020, fell while riding a bike in August 2020 and had right hip/thigh pain, and injured his left hip in a fall in July 2021.

[18] The applicant submits that he requires additional treatment that exceeds the limits of the MIG as a result of his underlying pre-existing injuries. He states that he was already suffering from neck, back, right shoulder, arm, and leg pain prior to the accident, in addition to vascular heart disease. In his submissions, he explains that most of his musculoskeletal injuries appear to have been related to a workplace accident in "2012 or 2015". In actuality, the records indicate that the workplace accident occurred in 2010. There is no indication in the records of Dr. Louvaris that the workplace incident was the cause of any ongoing difficulties. There is no evidence that the applicant was having issues with his neck, arm, or leg from 2010 to the date of the accident. The evidence suggests that the applicant had some right shoulder issues that were never mentioned past 2016.

[19] The applicant had left upper back pain and left shoulder pain after work in March 2018, but no diagnosis was made and he never spoke with Dr. Louvaris about that issue again afterwards. There is no evidence to indicate that this pain was due to an ongoing condition, let alone a condition that would make it difficult to recover from a subsequent injury.

[20] I accept that the applicant's vascular heart disease is likely ongoing. However, I do not see how it is at all related to injuries sustained in the accident and have not been provided with evidence as to whether it would preclude recovery from the accident.

[21] The applicant further argues that neck, coccyx trauma, low back, and leg issues were noted in the OHIP summary in 2012 and 2015. Upon review of the OHIP summary, I note that there is record of "sprains, strains and other trauma – neck, low back, coccyx" on June 28, 2012 and April 17, 2015. On April 29, 2015 and May 28, 2015, there is a record of "signs/symptoms not yet diag – musculoskeletal system – leg". These descriptions are indicated under the column for the description of a diagnostic code.

[22] An OHIP summary without further elaboration is not sufficient evidence of a specific injury or diagnosis. The diagnostic codes appear to have boilerplate descriptions and do not necessarily align with actual injuries or diagnoses. The May 28, 2015 entry is the only one with a corresponding medical record before

me. As an example of the limited value of the diagnostic code descriptions in the OHIP summary, on that visit to Dr. Louvaris, nothing is noted about the applicant's leg.

[23] The applicant has not specified which pre-existing conditions he believes were exacerbated by the accident. He simply points to "some, if not all" of them. In any event, simply pointing to a few prior records of pain is not sufficient. The applicant must prove that his pre-existing conditions will prevent him from achieving maximal recovery under the MIG.

[24] The only practitioner who stated that the applicant's pre-accident injuries may preclude him from recovery under the MIG was Dr. Castro, general practitioner at York Medical Centre. In his report of April 29, 2021, he refers to the applicant's previous head/neck injury, and states that the applicant "has a documented pre-existing condition to the head/cervical spine, and has not achieved pre-injury status despite continued facility-based treatments and conservative measures". It is clear however that Dr. Castro did not have an accurate picture of the applicant's medical condition. He stated that the applicant sustained a sacral fracture in the accident, which is inaccurate. He stated that the applicant has not been able to return to work in any capacity since the accident, which is also inaccurate. He does not discuss any pre-accident diagnoses, underlying mechanisms, or reasons why a head/neck injury in 2010 without documented sequalae would preclude recovery almost 10 years later. I do not assign much weight to his report.

[25] The applicant notes that in the s. 44 report of June 5, 2019 from Dr. Oleg Safir, his diagnoses included cervical spine sprain/strain (WAD I/II) on the background of previous injury, and thoracolumbar spine strain/sprain on the background of previous injury. I agree with the respondent that this comment from Dr. Safir is not, on its own, compelling evidence that the applicant cannot be treated within the MIG based on pre-accident conditions. In fact, Dr. Safir concluded that even though there was a history of a previous workplace injury to the applicant's neck and upper back, there was no compelling evidence that this would prevent him from achieving maximum recovery if subject to the MIG.

[26] The burden of proof rests with the applicant. I find that he has not proven on a balance of probabilities that his pre-accident conditions prevent him from achieving maximum medical recovery under the MIG.

Meniscal Tear

[27] The applicant argues that he sustained a meniscal tear to his left knee in the accident which falls outside the definition of a "sprain" in the MIG. I find that the

applicant has not met his burden of proof in showing that the meniscal tear was caused by the accident.

[28] The applicant did not complain of pain to his left knee until he mentioned it to s. 44 assessors in May and June of 2019. He did not report knee issues to Dr. Louvaris until September 2019, and did not report these issues to York Medical Centre until November 2019. He told Dr. Louvaris that he had been experiencing the knee issues for 6 months, and when Dr. Louvaris referred the applicant to Dr. Han, he indicated that the issue began in March 2019. I accept that it was likely the applicant was experiencing knee pain as early as March 2019, approximately 6 months after the accident.

[29] I do not accept the applicant's argument that the leg pain he reported at the hospital was related to a meniscal tear in his left knee. The hospital note states that the applicant was experiencing cervical pain and lower left back pain that was radiating into his left leg. X-rays were completed of his cervical and lumbar spine, but no investigations were done with respect to his knee, and there is no mention of knee complaints specifically. There is no evidence that the leg pain the applicant was experiencing on that date was localized to his knee, or came from a tear in his knee. The applicant also argues that in a treatment record from York Medical Centre from March 7, 2019, he was experiencing left "piriformis tightness", which is a muscle located in the buttock region and can apparently also cause pain, numbness, and tingling along the back of the leg into the foot. Nowhere in the records does it say that he actually was experiencing that kind of radiating pain on that date, nor does it mention the knee specifically. In any event, the applicant appears to be conceding that this is could be pain radiating from his buttock, and not stemming from a meniscal tear.

[30] The applicant argues that the meniscus tear seems to be in keeping with the Lachman testing conducted by Dr. Safir, who identified "mild knee laxity". However, Dr. Safir indicated that this laxity did not appear to be related to the subject accident. While I agree with the applicant that Dr. Safir did not provide a reason why he came to that conclusion, I do not agree with the submission that this testing demonstrated a possible torn knee. In fact, Dr. Safir's meniscal tests were negative, and Lachman testing later performed by Dr. Castro was negative. Dr. Castro did not mention the meniscus tear either. I find that the applicant made the leap in his submissions from "mild knee laxity" to "meniscus tear" without any evidence of that assertion.

[31] I also do not accept the applicant's argument that the reason why his left knee was not specifically mentioned was simply because of a language barrier. He suggests that when he reported pain in his left leg immediately after the accident,

he meant that to include the knee. While I appreciate that English is not the applicant's first language, there is no evidence before me that the applicant had difficulty communicating with doctors or treatment providers to the point where he was unable to show them the areas of his body that were in pain. Submissions are not evidence. The applicant was able to specifically mention specific areas of pain to Dr. Louvaris, including his knee pain in 2019, and was able to describe the pain as being localized "inside the knee" to Dr. Han. Finally, in the records from York Medical Centre, there are pain diagrams which were completed periodically by the applicant. The applicant would circle areas on a picture of a body where he was experiencing pain, which did not require the use of language. He did not circle the left knee until November 7, 2019.

[32] Even if the accident caused the applicant to experience some knee pain, there is no evidence that the pain was due to a meniscal tear, or that the meniscal tear itself was caused by the accident. The applicant was referred to Dr. Han specifically to discuss the MRI results and issues with his knee. On April 23, 2020, Dr. Han indicated that the applicant's left knee pain "may be due to a non-specific soft-tissue strain". He did not attribute the pain to the meniscal tear, nor did he attribute the tear to the accident. There is no other evidence before me that points to the accident as having caused the meniscal tear, and no medical practitioner has stated as much. A diagnosis of soft-tissue strain is not sufficient to remove the applicant from the MIG.

Chronic Pain

[33] I find that the applicant has not proven that he suffers from chronic pain with functional impairments such that he should be removed from the MIG.

[34] The applicant submits that, since the accident, he has consistently reported worsening of his neck, back, left shoulder, left leg, left knee, and left ankle pain, as well as headaches. His pain interferes with his work and sleep. He submits that his consistent reporting of pain, and the limitations to his activities, satisfy the requirements for removing him from the MIG.

[35] The respondent submits that the applicant does not meet any of the six criteria in the American Medical Association Guidelines ("*AMA Guides*") with respect to chronic pain. I agree with the applicant that the criteria in the *AMA Guides* are not binding on the Tribunal and are an assistive tool in evaluating chronic pain, and further that a diagnosis of chronic pain or chronic pain syndrome is not strictly required. However, the applicant must still demonstrate that if he has pain that has become chronic, there is an associated functional impairment to remove him from the MIG.

[36] I do not agree with the applicant's submission that he has consistently reported pain complaints. As noted above, the applicant only spoke with Dr. Louvaris a handful of times after the accident. He has never complained of any pain stemming from this accident to his new family physician, Dr. Paywandi, since becoming his patient in July 2020. He reported knee pain to Dr. Han, who recommended a follow up appointment for a full physical examination and potentially a steroid injection. There is no evidence that the applicant ever saw him again or received the injection. It does not appear that the applicant takes any prescription medication for pain. The only other evidence of pain from the applicant's treating practitioners is noted in the records of York Medical Centre. The records are mostly illegible, but where it is apparent that the applicant was experiencing pain, I am unable to determine to what degree and whether he was suffering from functional difficulties as result. It is also difficult to determine whether at a certain point the applicant was receiving physiotherapy as a result of the accident, or because of his subsequent injuries (e.g. his coccyx fracture).

[37] There are multiple differing accounts within the records and reports as to the applicant's work status. On June 25, 2019, he told Dr. Safir that he returned to work on modified duties 4 months after the accident for a short period of time, attempted another return in April 2019, and has not worked since. He subsequently told Dr. Safir on March 16, 2022 that he returned to work in February 2019 and now works 20 hours per week. He told Dr. Han on April 23, 2020, Dr. Castro on February 24, 2021, and Sebastian Joseph on February 16, 2021, that he had not returned to work since the accident. After sustaining a coccyx fracture in July 2020, he advised Dr. Paywandi that he was working modified duties a few weeks after the fracture. A biopsychosocial screen from October 13, 2020, indicates that the applicant had stopped working due to physical pain. I am unable to determine based on the evidentiary record what the applicant's difficulties are with respect to work, whether those difficulties are ongoing, or whether those difficulties are as a result of the accident and not subsequent injuries.

[38] The respondent conducted surveillance on the applicant in August and September 2021. I find the surveillance evidence to be of limited value, as it does not provide an indication of the applicant's pain, and does not depict full days. However, I do give some weight to the evidence contained in the surveillance report where it contradicts the applicant's self-reports. The surveillance report shows the applicant working, going shopping, socializing, and departing for the Toronto Islands on a water taxi with a friend.

[39] The applicant's perceived disability as reported to Dr. Castro was 100% with respect to recreation, social activity, and his occupation. He reported spending

most of his day lying down watching television and occasionally going to treatment. The level of disability that the applicant reported to Dr. Castro does not line up with the activities he was doing in the surveillance report only 6 months after the assessment.

[40] The applicant saw his family physicians regularly, but rarely as a result of the accident. He has advised assessors that he has withdrawn socially, but not to what degree, and the surveillance depicts him on social outings (shopping and having lunch with someone, and going on a trip to the Toronto Islands). I have been provided very little evidence with respect to the applicant's ability to complete his housekeeping tasks, and cannot determine which tasks he was able to complete before that he is unable to do now. I am also unable to determine what effect, if any, the accident had on his ability to work, given the conflicting self-reports and lack of any other evidence to show a decline in work function. I also do not know to what degree, if any, the coccyx fracture or any of the other subsequent injuries had on the applicant's functional abilities. The fact that I am unable to make a determination as to the degree of the applicant's functional difficulties stemming from this accident serves to demonstrate that the applicant has not met his burden of proof.

[41] I find that the applicant has not demonstrated that he suffers from chronic pain as a result of the accident that has caused functional impairments, such that he should be removed from the MIG.

Psychological Conditions

[42] I find that the applicant has not met his burden of proof in establishing that he suffers from a psychological impairment such that the MIG would not apply.

[43] The applicant argues that the absence of a formal psychological diagnosis does not mean that he is not suffering from significant and ongoing emotional difficulties as a result of the accident. He submits that since the accident, he has "consistently reported his psycho-social issues".

[44] The respondent's argument is that there is no credible evidence of a mental health condition as a result of the accident. The respondent relies on the s. 44 report of Dr. Mandel, and the report Dr. Enright, stating that they seemed to agree that there was insufficient credible evidence to diagnose a psychological condition.

[45] Dr. Enright explained that the applicant reported significant emotional difficulties. However, he noted that there was evidence of over reporting on psychometric testing. The applicant consistently reported symptomatology at an extremely high

level, at or above the 99th percentile on most measures. Dr. Enright found that the degree of endorsed severity was inconsistent with the nature of the stressors and level of function in his daily life. He indicated that this level of reporting might be an attempt at a cry for help, however it can also be indicative of intentional over-reporting. He was not able to make any diagnoses as a result.

[46] Dr. Mandel similarly found that some of the testing he administered was invalid. He noted that there was a lack of consistent objective information that would support a diagnosis or suggest that the applicant suffers from clinically significant symptoms.

[47] The respondent submits that Sebastian Joseph's social work report should be given little weight as it was based solely on self-reports without any validity testing, and that it is inconsistent with the medical records. I agree. It appears Mr. Joseph only reviewed the report of Dr. Castro, and some ultrasound and x-ray reports. No validity testing was conducted, Mr. Joseph is not qualified to provide diagnoses, and he appeared to rely primarily upon the applicant's self-reports in coming to his conclusions.

[48] I find it significant that there were no psychological complaints to Dr. Louvaris or Dr. Paywandi throughout the entirety of the medical record, and yet the applicant apparently endorsed extreme levels of psychological distress to the assessors. The applicant has never been referred by his family physicians to a psychiatrist, nor has he been prescribed medication for psychological conditions. He apparently attended anger management counselling, but this was unrelated to the accident. He was able to speak with Dr. Louvaris about that issue, and I find it likely that if he was experiencing emotional symptoms as a result of the accident, he would have spoken with his doctors about that as well.

[49] It is unclear what prompted the referral for psychological treatment or assessments. An OCF-18 for psychological counseling was prepared on July 29, 2019 by the applicant's chiropractor, Dr. Bui, noting post-traumatic stress disorder, depressive episode, and specific phobias. Dr. Bui is not qualified to opine on the applicant's psychological condition, and an OCF-18 is not evidence of a condition existing. The applicant refers to a "biopsychosocial prescreen" from October 13, 2020 from York Medical Centre as evidence of his psychological difficulties. There is no name attributed to that report, it is once again based on the applicant's self-report, and I do not know what kind of practitioner it was completed by. I give it little weight.

[50] Without sufficient corroborating evidence, I am unable to determine whether the reporting issues described by Dr. Enright were because of a cry for help, or intentional over-reporting.

Treatment Plans in Dispute

[51] As the applicant has exhausted the monetary limits under the MIG, it is not necessary for me to consider whether the applicant is entitled to the treatment plans in dispute.

Interest

[52] Interest applies on the payment of any overdue benefits pursuant to s. 51 of the *Schedule.* As no benefits are owing, no interest is payable.

ORDER

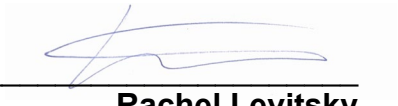
[53] The applicant is not entitled to treatment beyond the $3,500.00 limit of the MIG.

[54] The applicant is not entitled to the treatment plans in dispute.

[55] Given that there are no benefits owed, the applicant is not entitled to interest.

[56] The application is dismissed.

Released: May 8, 2023



Rachel Levitsky
Adjudicator