LICENCE APPEAL TRIBUNAL

TRIBUNAL D'APPEL EN MATIÈRE DE PERMIS

Safety, Licensing Appeals and Standards Tribunals Ontario

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

Ontario

Citation: David Sannella vs. RSA Insurance, 2020 ONLAT 19-000169/AABS

Released Date: 07/03/2020
File Number: 19-000169/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:

David Sannella

Applicant

and

RSA Insurance

Respondent

DECISION

ADJUDICATOR: **Rebecca Hines**

APPEARANCES:

For the Applicant: Arash Goneh-Farahani, Paralegal

For the Respondent: Sabina Arulampalam, Counsel

HEARD: **By way of written submissions**

OVERVIEW

[1] David Sannella (the “applicant”) was involved in an automobile accident on **February 3, 2018** and sought benefits from RSA Insurance (the “respondent”) pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010* (the "*Schedule*"). The applicant was denied certain benefits by the respondent and submitted an application to the Licence Application Tribunal - Automobile Accident Benefits Service (“Tribunal”).

[2] The parties participated in a case conference, however, were unable to resolve the issues in dispute. The matter proceeded to this written hearing.

ISSUES IN DISPUTE:

[3] I have been asked to decide the following issues:[1]

i. Is the applicant entitled to a medical benefit in the amount of $3,166.16 for physiotherapy treatment recommended by 101 Physio in a treatment plan (OCF-18) submitted on November 22, 2018, and denied on December 4, 2018?

ii. Is the applicant entitled to a medical benefit in the amount of $640.70 for other assistive devices recommended by 101 Physio in a treatment plan (OCF-18) submitted on September 24, 2018, and denied on September 26, 2018?

iii. Is the applicant entitled to payment for transportation expenses in the amount of $282.50 submitted on August 27, 2018 and denied on September 10, 2018?

iv. Is the applicant entitled to payment for transportation expenses in the amount of $1,128.20 submitted on May 15, 2018 and denied on May 28, 2018?

v. Is the applicant entitled to payment for the cost of examination in the amount of $2,460.00 for an attendant care assessment recommended by 101 Assessments in a treatment plan (OCF-18) submitted on July 10, 2018, and denied on July 20, 2018?

[1]The applicant confirmed that issue ii. outlined in the Tribunal’s case conference report and order is no longer in dispute as the respondent approved the benefit prior to the hearing.

vi. Is the applicant entitled to payment for the cost of examination in the amount of $2,460.00 for an MRI head assessment recommended by 101 Assessments in a treatment plan (OCF-18) submitted on August 8, 2018, and denied on August 21, 2018?

vii. Is the applicant entitled to payment for the cost of examination in the amount of $2,460.00 for a drive evaluation assessment recommended by 101 Assessments in a treatment plan (OCF-18) submitted on September 17, 2018, and denied on September 26, 2018?

viii. Is the applicant entitled to payment for the cost of examination in the amount of $2,460.00 for a chronic pain assessment recommended by 101 Assessments in a treatment plan (OCF-18) submitted on September 24, 2018, and denied on September 26, 2018?

ix. Is the applicant entitled to payment for the cost of examination in the amount of $2,460.00 for a cognitive assessment recommended by 101 Assessments in a treatment plan (OCF-18) submitted on October 4, 2018, and denied on October 16, 2018?

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

RESULT

[4] After reviewing the parties' submissions and all the evidence I find the applicant is not entitled to any of the disputed treatment plans or interest.

PROCEDURAL ISSUE

[5] The applicant opposed the respondent's submission of a newspaper article dated December 1, 2016 which indicates that the applicant was arrested for theft. The applicant maintained that it is not relevant to the issues in dispute or his entitlement to accident benefits. The respondent relied on the document to support its position that the applicant had psychological issues pre-accident. I agree with the applicant that this article is not relevant to his entitlement to accident benefits. Therefore, I have assigned it no weight.

BACKGROUND

[6] On February 3, 2018, the applicant was driving his vehicle when he lost control and struck a retaining wall. Police attended the scene and the applicant was brought to Lakeridge Health Hospital where he was diagnosed with a

concussion. He was charged with driving under the influence ("DUI") as he was intoxicated at the time of the collision.

[7] On December 3, 2018, the respondent removed the applicant from the Minor Injury Guideline ("MIG") as a result of an accident related psychological impairment.

ANALYSIS

[8] Sections 14 and 15 of the *Schedule* provide that an insurer is only liable to pay for medical expenses that are reasonable and necessary as a result of an accident. The applicant bears the onus of proving on a balance of probabilities that any claimed medical expenses are reasonable and necessary.

[9] The applicant argues that he is entitled to all the disputed treatment plans because he suffers from chronic pain as a result of the accident and has yet to recover from his accident related impairments.

[10] The respondent submits that the applicant is not a credible witness as he was not forthcoming about the accident details in his application for accident benefits and in his self-reports to the various assessors. Further, the applicant has not met his onus in proving entitlement to the treatment plans as he has not provided any submissions or objective evidence regarding the treatment plans themselves to support that they are reasonable and necessary. Further, the applicant's assessors relied on the applicant's self-reports in reaching their opinions on his accident related impairments. Therefore, the applicant's assessor's reports should be given little weight. For the reasons that follow, I agree with the respondent and do not find any of the treatment plans reasonable or necessary.

[11] The bulk of the applicant's submissions focussed on his argument that he should be removed from the MIG from a physical perspective because he suffers from chronic pain. He provided this blanket argument in support of his entitlement to all the disputed treatment plans. However, I find his argument irrelevant because he was removed from the MIG as a result of a psychological impairment. Therefore, the test for entitlement to the disputed medical benefits and cost of examinations is whether they are reasonable and necessary as a result of his accident related impairments.

[12] The applicant did not address the treatment plans in his submissions and direct me to the evidence he relies upon to support his position that each is reasonable and necessary. The respondent raised this concern in its submissions and, although the applicant made reply submissions, he chose not to address them.

[13] Overall, I do not find the applicant's evidence to be credible as he was not honest in reporting the accident details in his application for accident benefits. For example, he reported to his insurer that he was a passenger (not the driver) of the vehicle involved in the accident. This was inconsistent with the applicant's description of the accident in his submissions as well as in the reports of all assessors. In his reply submissions, the applicant indicated that this was a clerical error. Due to the many inconsistencies throughout the records, I do not accept this explanation. There were also inconsistent reports regarding whether the accident was responsible for the concussion sustained by the applicant. He reported to hospital staff and a few assessors that "the police smashed his head against a brick wall" following the collision. In my view, these inconsistencies raise red flags about the validity of the applicant's self-reports regarding his accident related symptoms and impairments. Consequently, I have assigned the reports of his assessors less weight as they are based on the applicant's self-reports and not objective evidence. I also find that the applicant's reports regarding his symptoms and impairments to the various assessors are inconsistent and contradictory.

[14] Despite the fact that the applicant did not address each treatment plan in his submissions, for clarity, the following is an analysis of the evidence I find to be relevant to each issue and the reasons for my findings.

Treatment Plans for Physiotherapy and Assistive Devices

[15] I find the applicant is not entitled to either treatment plan for physiotherapy or assistive devices for the following reasons.

[16] The first treatment plan submitted on August 14, 2018 authored by Bill Nikols, chiropractor, in the amount of $640.70 recommended a lumbar brace, bio freeze and costs for completion of the treatment plan and delivery. Under activity limitations it states that the applicant's accident related impairments have impacted his employment and activities of daily living. The goals of the treatment plan are for pain reduction and increase range of motion (ROM) and strength.

[17] The second treatment plan submitted November 15, 2018 also recommended by Mr. Nikols, in the amount of $3,166.16, recommended ten sessions of physiotherapy, four sessions of acupuncture, five sessions of osteopathy treatment, eight sessions of manual therapy, a tens unit and included various amounts for other miscellaneous fees such as education, assessment, progress report and transportation. Under activity limitations it states that the applicant continues to have difficulties with regular tasks, constant low back pain, he cannot lift or carry heavy things and has difficulty with pushing and pulling and

prolonged standing, sitting and walking exacerbate his symptoms. The treatment plan identifies the same goals as the previous one and indicates that there has been improvement, but the applicant still has back pain.

[18] I agree with the respondent that Mr. Nikols had limited knowledge of the applicant's functional status as the applicant reported to all assessors that he had returned to his employment, and he was independent with self-care. I find the applicant has not submitted any evidence to support that he had any functional limitations other than his self-reports to all assessors that he was limited in heavier household and home maintenance tasks such as shoveling snow and mowing the lawn. However, I find that this conflicts with what the applicant reported to insurer examiner ("IE") Dr. Moolla, general practitioner, as in the doctor's report dated November 26, 2018 the applicant stated that he goes to the gym two to three times a week and can bench press 165 pounds. In my opinion, someone who can bench press 165 pounds conflicts with someone that cannot shovel a driveway or mow the lawn. Significantly, Dr. Moolla's IE was conducted the same month the treatment plan was submitted. Further, the applicant did not submit any CNRs from 101 Physiotherapy noting that past physical treatment was helpful in alleviating his pain or improving his ROM and function. In fact, the applicant reported to Dr. Lau, IE psychologist, that he did not find physiotherapy helpful.

[19] The applicant relied on Dr. Getahun's report dated September 14, 2018, wherein the applicant reported that he suffers from intermittent low back pain which is aggravated by prolonged standing and limits his tolerance for sitting and walking. Further, he has occasional pain in his neck which is aggravated by sleeping in an awkward position. Dr. Getahun's physical examination revealed that the applicant's ROM in the cervical and lumbosacral spine was restricted and he diagnosed him with myofascial strain of the cervical and lumbosacral spine. Moreover, he opines that the applicant's injuries are "suggestive of the development of chronic pain as his symptoms have not resolved within the expected time," and that the applicant's prognosis is poor. He recommends ongoing physiotherapy focussed on ROM and strengthening the applicant's cervical and lumbar spine.

[20] I did not find Dr. Getahun's report persuasive as his opinion was not based on objective medical evidence. Dr. Getahun reviewed the hospital record from the date of loss, a few CNRs of Dr. Cecutti, family doctor and the s.25 assessments of Dr. Majl, neurologist, and Dr. Lotfalizadeh, psychologist. I find the majority of these CNRs are based on the applicant's self reports of his symptoms. I also find Dr. Getahun's report lacks specifics regarding how often the applicant

experiences back and neck pain and how that impacts his ability to function. Dr. Getahun notes that the applicant's prognosis is poor but provides no rationale with respect to why. In my opinion, the fact that the applicant experiences occasional back and neck pain does not support Dr. Getahun's conclusion that he will likely develop chronic pain and that his prognosis is poor. The applicant had returned to work, had resumed going to the gym and was independent with his self-care. In my view, this does not correlate with Dr. Getahun's opinion or prognosis. Furthermore, Dr. Getahun does not indicate whether past treatment had been helpful in alleviating the applicant's pain or had improved his ability to function. Consequently, I do not accept his recommendation that the applicant continue with physiotherapy.

[21] In addition, I did not find CNRs of Dr. Cecutti convincing evidence that the applicant continues to suffer from any significant physical impairment. The applicant has only attended his family doctor's office three times since the date of the accident. His first visit was 7 months post-accident in September 2018, and he attended two more times in October 2018 and January 2019. Dr. Cecutti's CNR dated January 11, 2019 indicates that the doctor disagrees with the respondent's opinion that the applicant's physical complaints had resolved, and the doctor recommended ongoing physiotherapy treatment. In my view, one CNR of the applicant's family doctor supporting entitlement to continued treatment is not enough when viewed with the inconsistencies in the other evidence.

[22] Further, I did not see any reference in any of the expert reports recommending a back brace or bio freeze gel and this was not something that was supported by Dr. Cecutti. In my view, the treatment plan on its own is not sufficient evidence.

[23] By contrast, the respondent relied on the IE of Dr. Urovitz, orthopaedic surgeon, dated November 26, 2018 in support of its denial. The applicant reported to Dr. Urovitz that overall he was much better except for some minimal back pain. Dr. Urovitz's physical examination was normal and the applicant had no restrictions to his ROM. Dr. Urovitz opined that the applicant sustained a soft tissue injury and further treatment is not reasonable and necessary. In light of the above inconsistencies, I accept Dr. Urovitz's opinion.

[24] The applicant has not met his onus on a balance of probabilities that he is entitled to the treatment plans for physiotherapy or assistive devices.

Transportation Expenses

[25] I find the applicant is not entitled to payment of either treatment plan for transportation expenses for the following reasons.

[26] The first treatment plan dated May 8, 2018, in the amount of $1,128.20 authored by Wayne Coughlan, chiropractor, indicates that the applicant suffered from vehicular anxiety and the purpose of the treatment plan was for the service provider's travel time for in-home treatment. In its explanation of benefits dated May 28, 2018, the respondent denied the treatment plan on the basis that there was no coverage for a provider to travel to the claimant's home for treatment.

[27] The second treatment plan dated August 1, 2018, in the amount of $282.50 submitted by Mr. Coughlan, states that the purpose was for the patient to travel to an orthopaedic assessment due to vehicular anxiety. The round-trip totals 210 kms. The respondent denied this treatment plan on the basis that it was not reasonable and necessary.

[28] The applicant did not refer to these treatment plans for transportation expenses in his submissions and address why each is reasonable and necessary. Nor did he direct me to any evidence or refer to any authority under the *Schedule* to support that they are payable. The respondent raised this concern in its submissions and, although the applicant filed reply submissions, he chose not to address them.

[29] The respondent argued that the transportation expenses claimed by the applicant are not "authorized transportation expenses" as defined by section 3(1) of the *Schedule* and the Financial Services Commission of Ontario's Superintendent Guideline No.04/16 ("Guideline"). The respondent submits the Guideline supports that transportation expenses are meant for an insured to travel to and from medical appointments and do not apply to service providers as that is included in their professional fees.

[30] In addition, s.3 (1)(b) of the *Schedule* limits payment for mileage after the first 50 kilometres of a trip unless an insured person sustained a catastrophic impairment. A google map search conducted by the respondent from the applicant's home to the orthopaedic assessment centre supports that the applicant's claim for mileage does not meet the threshold provided for in s. (3)(1)(b) of the *Schedule*. Further, the applicant has not sustained a catastrophic impairment, so he not entitled to claim mileage above 50 kilometres.

[31] In the absence of submissions and evidence that address these issues, the applicant has not met his onus on a balance of probabilities that these two treatment plans for transportation expenses are reasonable and necessary.

Attendant Care Assessment

[32] I find the applicant is not entitled to an attendant care assessment for the following reasons.

[33] The treatment plan for the in-home assessment dated June 6, 2018, in the amount of $2,460.00 authored by Bushra Bayan, occupational therapist, indicates under activity limitations that the applicant is unable to perform normal range of motion for daily activities as well as self-care, without aggravation of symptoms. Activities such as bending, twisting, lifting, overhead reaching, pushing and pulling aggravate his symptoms. The goal of the treatment plan is for pain reduction, increase strength and return the applicant to his pre-accident employment and activities of daily living.

[34] The evidence confirms that the applicant returned to work as a warehouse worker three days following the accident. He eventually obtained a job in a more sedentary position, but no evidence was before me that he had any limitations in resuming his employment. Further, the applicant reported to all assessors that he was independent with his personal care and had resumed his activities of daily living. He reported that he had limitations with heavier housekeeping and home maintenance tasks such as mowing the lawn and shovelling the driveway. As already highlighted above, I find the applicant's self-reports regarding these limitations inconsistent with what he reported to Dr. Molla and the other IE assessors. Therefore, I do not find the in-home assessment to be reasonable or necessary.

[35] The applicant has not met his onus on a balance of probabilities in demonstrating that the attendant care assessment is reasonable and necessary.

MRI Expense

[36] I find the applicant is not entitled to the cost of examination for an MRI head assessment for the following reasons.

[37] The treatment plan recommending the MRI dated July 31, 2018, in the amount of $2,460.00 authored by Wayne Coughlan, chiropractor, states under activity limitations that functional restrictions continue to remain at this time. The applicant is complaining about headaches, difficulty with tasks and sleeping. The goal of the treatment plan is to identify any accident related head injury.

[38] The applicant failed to address in his initial or reply submissions why this treatment plan is reasonable or necessary. However, a few of his assessors

recommended that he go for an MRI because he sustained a concussion on the date of the accident and had reported issues with cognition and memory to assessors.

[39] The respondent argued that the applicant is not entitled to payment of this expense because this expense is available through OHIP. Subsection 47(2) of the *Schedule* provides that the insurer is not liable to pay for a medical benefit if the expense is reasonably available to the insured person under any insurance plan or law. Even though he filed reply submissions the applicant did not address this issue. The onus is on the applicant to prove that any disputed benefits are reasonable and necessary. There are no references in the applicant's family doctors CNRs relating to the applicant reporting problems with cognition or memory post-accident, nor does Dr. Cecutti refer the applicant for an MRI. The applicant provided no explanation for why he did not seek a referral for an MRI from his family doctor first.

[40] The applicant has not met his onus in proving on a balance of probabilities that the MRI assessment is reasonable and necessary.

Driving Evaluation Assessment

[41] The applicant is not entitled to the treatment plan for the driving assessment for the following reasons.

[42] The treatment plan for the driving evaluation assessment in the amount $2,460.00 authored by Silvia Tenanbaum, submitted on September 17, 2018 indicates under activity limitations that the patient has not been able to return to his pre-accident activities of daily living due to driving and passenger anxiety. Under the additional comments section of the treatment plan Dr. Tenanbaum highlights the findings of Dr. Lotfalizadeh's psychological report dated June 30, 2018 as justification for the assessment. I do not find the driving assessment reasonable and necessary for the following reasons.

[43] I find the applicant reported his issues pertaining to driving and passenger anxiety inconsistently to the various assessors. The only report that addresses the applicant's symptoms of driving anxiety is the psychological report of Dr. Lotfalizadeh dated June 30, 2018. I found the applicant's reports to the doctor contradictory and inconsistent with what he reported to the other assessors. For example, the applicant indicated to Dr. Lotfalizadeh that he had severe anxiety as a driver for the first three months post-accident. In my view, this conflicts with information contained in other reports such as Dr. Moolla's IE which notes that the applicant's licence was suspended for three months following the accident

because he was charged with a DUI. Other assessments confirm the applicant did not return to driving until May 2018. Therefore, in my view, how could he have driver's anxiety for three months when he had not resumed driving until May 2018? The applicant also reported to Dr. Lotfalizadeh that as of the date of the assessment he felt less intense when in control of the car and has higher anxiety as a passenger. Consequently, Dr. Lotfalizadeh recommended that he undergo a driving assessment.

[44] Dr. Lotfalizadeh's opinion conflicted with the applicant's second psychiatric assessor, Dr. Mamalek. The doctor's report dated June 21, 2019 states that the applicant had "returned to work and driving a car without great anxiety, for the most part." In addition, the IE reports of Dr. Moola, Dr. Urovitz, and Dr. Goodwin, psychologist, dated November 26, 2018 note that the applicant had resumed driving and do not mention driving or passenger anxiety. Dr. Goodwin's IE indicates that as of the date of the assessment the applicant "drives regularly including on the highway and he is fine as a passenger." Due to these contradictions and inconsistencies, I give the applicant's self-reports to Dr. Lotfalizadeh regarding driving and passenger anxiety little weight.

[45] The applicant has not met his onus in proving on a balance of probabilities that he is entitled to the driving assessment.

Chronic Pain Assessment

[46] I find the applicant is not entitled to the cost of examination for a chronic pain assessment for the following reasons.

[47] The treatment plan for the chronic pain assessment in the amount of $2,460.00, dated August 27, 2018, proposed by Dr. Gofeld, physician, states under activity limitations that the applicant is exhibiting signs of chronic pain syndrome characterized by pain which is exacerbated by attempts to increase daily activities and has existed longer than 6 months. The persistent pain has surpassed the acute phase and has become chronic. The goals of the treatment plan are to restore functional tolerance and endurance and return the applicant to normal activities.

[48] Dr. Gofeld indicates that the applicant's pain is exacerbated by attempts to increase daily activities. However, the evidence demonstrates that shortly following accident the applicant returned to his employment and was independent with his self care and activities of daily living. The applicant did not submit any evidence regarding his accident related impairments impacting his functional status. As indicated above I do not accept the applicant's self reports

as he was inconsistent. Also, as already established, I do not find that the evidence supports that the applicant suffers from chronic pain or chronic pain syndrome. Finally, for the aforementioned reasons I do not accept Dr. Getahun's opinion that the applicant is at risk of developing chronic pain.

[49] The respondent relied on Dr. Moolla's IE which concluded that the applicant sustained a lumbar strain injury. In that assessment, the applicant reported that he had returned to his activities of daily living and did not have any functional limitations. Further, Dr. Moolla's physical examination concluded that the applicant demonstrated excellent functional range of motion of the lumbar spine; with normal power, sensation, and reflexes of the lower limbs. Dr. Moolla noted that there was no deterioration in the applicant's function that would require an assessment by a chronic pain specialist. I prefer Dr. Moolla's opinion over Dr. Getahun's as the applicant's self-reports were inconsistent and were not backed up by sufficient objective medical evidence.

[50] The applicant has not proven on a balance of probabilities that the treatment plan for the chronic pain assessment is reasonable and necessary.

Cognitive Assessment

[51] I find the applicant is not entitled to the cost of examination for a cognitive assessment for the following reasons.

[52] The treatment plan for the cognitive assessment in the amount of $2,460.00, dated September 14, 2018, proposed by Bushra Bayan, occupational therapist, states the cognitive assessment is to determine the applicant's level of cognitive function and to investigate cognitive deficits that were indicated by the applicant during his psychological and neurological assessment. Under goals it states, "Cognitive dysfunction, memory issues and sleeping difficulties. The client reported problems with short-term, long-term memory, problems with attention, concentration and substantially reduced performance in activities of daily living."

[53] The treatment plan does not refer to what activities of daily living have been substantially reduced. As already established, the applicant returned to his normal activities post accident. Therefore, the treatment plan is not going to meet its stated goals. The applicant reported to Dr. Lotfalizadeh and Dr. Majl that he has been experiencing problems with his memory post-accident. He misplaces objects, forgets to pay bills and has difficulty remembering names. In addition, he gets distracted during a conversation and struggles making decisions and planning. Despite the fact that the applicant reported these issues, Dr. Lotfalizadeh states that while the applicant's memory appeared faulty it was not

indicative of any major neurocognitive difficulty. The doctor then goes on to recommend that the applicant undergo a cognitive assessment. In my view, Dr. Lotfalizadeh's report is contradictory and does not lend strong support that the cognitive assessment is reasonable and necessary.

[54] The applicant did not meet his onus in proving on a balance of probabilities that the cognitive assessment is reasonable and necessary.

[55] The applicant is not entitled to interest on the denied treatment plans as I do not find them to be reasonable and necessary.

ORDER

[56] For all of the above reasons I order as follows:

i. The applicant is not entitled to any of the disputed treatment plans or interest.

ii. The application is dismissed.

Released: July 3, 2020

Rebecca Hines
Adjudicator