Citation: Atkinson v. Economical Mutual Insurance Company, 2023 ONLAT 22-002008/AABS

Licence Appeal Tribunal File Number: 22-002008/AABS

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

Between:

Patricia Atkinson

Applicant

and

Economical Mutual Insurance Company

Respondent

DECISION

ADJUDICATOR: **Clive Forbes**

APPEARANCES:

For the Applicant:	Patricia Atkinson, Applicant Ashu Ismail, Counsel
For the Respondent:	Francesco Turchiaro, Adjuster Martin Forget, Counsel Stephen Whibbs, Counsel
Court Reporters:	Jason Nebelung and Alyssa Scott

HEARD: by Videoconference: June 26 to 30, 2023 and July 4 to 5, 2023

OVERVIEW

[1] Patricia Atkinson, the applicant, was involved in an automobile accident on December 3, 2019, and sought benefits from the respondent, Economical Mutual Insurance Company, pursuant to the *Statutory Accident Benefits Schedule – Effective September 1, 2010 (including amendments effective June 1, 2016)* ("*Schedule*"). The applicant was denied benefits by the respondent and applied to the Licence Appeal Tribunal - Automobile Accident Benefits Service (the "Tribunal") for resolution of the dispute. The applicant submits that she suffers from various pain conditions and is psychologically impaired as a result of the accident.

[2] The applicant's position is that she is entitled to the benefits claimed. The respondent's position is that the benefits claimed are not reasonable and necessary. The parties also submit that the applicant has optional medical, rehabilitation and attendant care benefit of up to $1,000,000.00 for non-catastrophic impairment according to the Schedule.

ISSUES IN DISPUTE

[3] The issues to be decided in the hearing are:

1. Is the applicant entitled to ACBs as follows:

    (a) $10,228.37 per month from February 3, 2021, to date and ongoing?

    (b) $216.96 for ACBs, proposed by Neural Rehabilitation Group ("NRG") in a treatment plan/OCF-18 ("plan") and denied January 19, 2022?

    (c) $289.28 for ACBs, proposed by NRG in a plan and denied February 2, 2022?

2. Is the applicant entitled to HKHM as follows:

    (a) $100 per week from December 3, 2019, to December 3, 2021?

    (b) $333.35 for HKHM, proposed by NRG in a plan and denied January 19, 2022?

    (c) $300.02 for HKHM, proposed by NRG in a plan and denied March 14, 2022?

(d) $7,575.04 for HKHM, proposed by Gail Atkinson in a plan submitted January 7, 2022?

3. Is the applicant entitled to occupational therapy ("OT") services as follows:

   (a) $2,045.28 for OT services, proposed by RF in a plan and denied October 14, 2020?

   (b) $3,602.65 for OT services, proposed by RF in a plan and denied February 10, 2021?

   (c) $4,084.12 for occupational therapy services, proposed by RF in a plan and denied August 30, 2021?

   (d) $401.60 ($3,744.73 less $3,343.13 approved) for occupational therapy services, proposed by RF in a plan and denied November 11, 2022?

4. Is the applicant entitled to case management services as follows:

   (a) $5,075.00 for case management services, proposed by Rehab First ("RF") in a plan and denied December 23, 2020?

   (b) $3,691.26 for case management services, proposed by RF in a plan and denied June 2, 2021?

5. Is the applicant entitled to physiotherapy services as follows:

   (a) $1,700.00 for physiotherapy services, proposed by Laura Tambosso in a plan and denied February 2, 2022?

   (b) $1,715.89 for physiotherapy services, proposed by Laura Tambosso in a plan and denied February 4, 2022?

   (c) $2,031.18 for physiotherapy services, proposed by Tossios Physio in a plan and denied August 16, 2022?

6. Is the applicant entitled to $1,325.00 for chiropractic services, proposed by Dino Mavrou in a plan and denied June 8, 2022?

7. Is the applicant entitled to $4,096.44 for a visual assessment, proposed by Functional Oculo in a plan and denied August 10, 2021?

8. Is the applicant entitled to $1,883.30 for voice therapy services, proposed by MacPherson Communication Clinic in a plan and denied January 19, 2022?

9. Is the applicant entitled to the following medical cannabis, botox injections and prescription medical expenses that were submitted on an OCF-6:

    (a) $736.95 for medical cannabis ($734.46) and Auro Topiramate ($2.49) submitted on an OCF-6 dated June 19, 2020.

    (b) $313.11 for medical cannabis submitted on an OCF-6 dated July 13, 2020.

    (c) $109.71 for medical cannabis submitted on an OCF-6 dated September 3, 2020.

    (d) $185.42 for medical cannabis submitted on an OCF-6 dated September 24, 2020.

    (e) $256.01 for medical cannabis submitted on an OCF-6 dated October 19, 2020.

    (f) $281.51 for medical cannabis submitted on an OCF-6 dated October 21, 2020.

    (g) $500.00 for medical cannabis ($261.13), botox ($225.01) and prescription medication ($13.86) submitted on an OCF-6 dated December 7, 2020.

    (h) $286.08 ($313.64 less $27.56 approved) for medical cannabis submitted on an OCF-6 dated January 20, 2021.

    (i) $586.80 ($620.29 less $33.49 approved) for medical cannabis ($361.79) and botox injection ($225.01) submitted on an OCF-6 dated March 30, 2021.

    (j) $10.49 ($32.66 less $22.17 approved) for botox submitted on an OCF-6 dated April 13, 2021.

    (k) $254.84 for botox prescription and injection fee for botulinum submitted on an OCF-6 dated June 3, 2021.

(l) $378.47 ($413.86 less $35.39 approved) for medical cannabis ($361.79) and Techa and Fucidin ointment ($16.68) submitted on an OCF-6 dated July 8, 2021.

(m) $20.35 ($70.47 less $50.12 approved) for Techa, Fucidin cream and botox submitted on an OCF-6 dated August 20, 2021.

(n) $231.83 ($392.89 less $161.06 approved) for botox injection ($225.01) and Tecta ($6.82) submitted on an OCF-6 dated October 6, 2021.

(o) $481.62 ($509.01 less $27.39 approved) for medical cannabis ($256.61) and botox injections ($225.01) submitted on an OCF-6 dated December 1, 2021.

10. Is the respondent liable to pay an award under s. 10 of O. Reg. 664 because it unreasonably withheld or delayed payments to the applicant?

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

RESULT

[4] I find that:

i. The applicant is not entitled to the ACBs claimed.

ii. The applicant is not entitled to HKHM services claimed.

iii. The applicant is not entitled to the OT, case management, physiotherapy, chiropractic, visual assessment and voice therapy services claimed.

iv. The applicant is not entitled to the medical cannabis, botox injections and prescription medication expenses claimed.

v. No award is payable.

vi. No interest is payable.

PROCEDURAL ISSUES

I admitted the report of Dr. R. Van Reekum into evidence

[5] At the commencement of the hearing, the respondent's motion seeking the exclusion of the neuropsychiatric report of Dr. R. Van Reekum dated May 23,

2023, was heard. The respondent submits that Dr. Reekum's report should be excluded because it was submitted weeks after the April 19, 2023, deadline as stated in the case conference report and order dated February 1, 2023. The respondent argued that if the applicant's report, served almost two months late by email on June 6, 2023, is allowed into evidence it would be significantly prejudiced. The respondent asserted it would be ill equipped to address the report or obtain responding reports of its own. The respondent relies on Rules 1.1, 3.1 and 9.4 of the *Licence Appeal Tribunal, Animal Care Review Board, and Fire Safety Commission Common Rules of Practice and Procedure, Version I (October 2, 2017) as amended (Rules)* and sections 2, 5.3(d), 16.1 and 16.2 of *Statutory Powers Procedure Act*, R.S.O. 1990, c. S.22 (*SPPA*).

[6] The applicant submitted that the report of Dr. Van Reekum was obtained as a result of a recommendation by Dr. Gregory Belchetz, otolaryngologist, in his Otolaryngology-ENT Head and Neck Surgery report dated January 11, 2023, that she could benefit from a neuropsychiatric assessment as part of the evaluation of her diagnosis of persistent, postural perceptual dizziness. The applicant also submitted that she did not anticipate that Dr. Van Reekum's report would be completed before the hearing but since it was, she decided to submit it even though the April 19, 2023, timeline for the production of documents had passed. She argued that the respondent would not be significantly prejudiced if the report were admitted and there is enough time during the eight-day hearing for the respondent to review the two-page summary of the report and provide any response accordingly.

[7] I ordered that the report of Dr. Van Reekum be admitted into evidence. Rule 3.1 requires the Tribunal to apply the *Rules* so as to:

i. Facilitate a fair, open and accessible process and to allow effective participation by all parties, whether they are self-represented or have a representative;

ii. Ensure efficient, proportional and timely resolution of the merits of the proceedings before the Tribunal; and

iii. Ensure consistency with governing legislation and regulations.

[8] I do not agree that the respondent is significantly prejudiced because the applicant has failed to produce Dr. Van Reekum's report before the submission deadline. The respondent did not provide details as to why it would be unable to respond to the report between June 6, 2023, and when the hearing began twenty days later, or that it had made any attempts during that time to determine

whether a responding report could be obtained. I note that the respondent did not request an adjournment of the hearing to deal with the report in the event the Tribunal accepted it into evidence, and I find that this is an indication that any prejudice to the responded would be minimal.

[9] Therefore, the respondent's request that Dr. Van Reekum's report be excluded is denied.

I admitted the reports of Dr. Khaled into evidence.

[10] During the hearing the applicant brought an oral motion requesting that all of Dr. Mohamed Khaled's general physician s. 44 IE reports be excluded if he does not attend to testify. The applicant submits that she summoned Dr. Khaled to give evidence, but he was not co-operating with her attempts to arrange a time for him to testify. To support her position, she relies on *Girao v. Cunningham,* 2020 ONCA 260, at paragraph 45, that indicates that the "trial judge must, at the request of a party, oblige the medical practitioner to testify in order to permit cross-examination".

[11] The respondent argues that the applicant was in receipt of all of Dr. Khaled's s. 44 reports well in advance of the hearing and the applicant never notified it that she intended to request that the reports be excluded. The respondent further submits that it would be procedurally unfair if Dr. Khaled's reports were excluded as evidence since the respondent intends to rely on these and other reports as the basis of its denial for the issues in dispute.

[12] I do not agree with the applicant that Dr. Khaled's reports should be excluded if he fails to testify. The applicant has had notice of the respondent's intention to submit Dr. Khaled's reports for a significant period of time and first requested their exclusion at the hearing. It would be unfair to the respondent to require that it proceed with the hearing without those reports, and I am not satisfied that the applicant will suffer prejudice by their admission.

[13] Therefore, the applicant's request to exclude Dr. Khaled's reports is dismissed.

ANALYSIS

The applicant is not entitled to the ACBs claimed.

[14] I find that the applicant has not established on a balance of probabilities that she is entitled to the ACBs claimed.

[15] Section 19 of the *Schedule* states that an insurer shall pay for all reasonable and necessary expenses incurred by or on behalf of an insured person as a result of an accident for ACBs provided by an aide or attendant. Section 42(1) of the *Schedule* provides that an application for ACBs must be in the form of, and contain the information required to be provided in, the version of the document entitled Assessment of Attendant Care Needs ("Form-1"). The following table illustrates the claims made in the Form-1 submitted by the applicant:

ACB Form 1	Applicant	Respondent
Level 1	950 minutes per week	420 minutes per week
Level 2	9,025 minutes per week	1,050 minutes per week
Level 3	105 minutes per week	0 minutes per week
Total	10,080 minutes per week	1,470 minutes per week

[16] With respect to the Form-1 dated February 18, 2021, I find that the applicant's request for 950 minutes per week for Level 1 attendant care services, 9,025 minutes per week for level 2 attendant care services and 105 minutes per week for Level 3 attendant care services are not reasonable and necessary.

[17] The applicant relies on the s. 25 OT assessment report of Ms. Angela Hubbard, OT, dated February 03, 2021, to support her claim. In her report, Ms. Hubbard recommended:

Level 1

i. 70 minutes per week under Dressing/Undressing because the applicant reported that she requires more time to complete these tasks and she demonstrates the use of modifications;

ii. 145 minutes per week for grooming;

iii. 630 minutes per week for feeding because the applicant demonstrated limitations reaching high cupboard shelves and experienced difficulty reaching into the low cupboards and because the applicant's ongoing fatigue and low mood affects her motivation to prepare meals; and

iv. 105 minutes per week for mobility assistance because the applicant reported that if she turns her head quickly, she can become unbalanced as a result of dizziness.

Level 2

i. 4,170 minutes per week for hygiene assistance;

ii. 24 hours a day, 7 days per week assistance in supervisory care because the applicant lacks the ability to be self-sufficient in an emergency; and

iii. 30 minutes per week assistance in coordinating attendant care.

Level 3

i. 55 minutes per week assistance with medications; and

ii. 50 minutes per week assistance with bathing.

[18] The respondent relies on the s. 44 OT assessment report of Ms. Joan Saunders, OT, dated September 16, 2021, who argues that the applicant's ACBs request is not reasonable. Ms. Saunders' Form-1 dated June 22, 2021, recommended 420 minutes per week under Level 1 attendant care services, 1,050 minutes per week under Level 2 attendant care services and 0 minutes per week for Level 3 attendant care services. Ms. Saunders indicated that the applicant demonstrated the ability to access all levels in the kitchen, the upper cupboard and the lower cupboards and the refrigerator using mainly her left hand. She also noted that due to the Covid-19 pandemic the applicant was working part-time in her pre-accident job with no reported supervisor-identified problems. In addition, Ms. Saunders indicated that the applicant reported experiencing manageable emotional issues prior to the accident and she was now endorsing significantly worsened anxiety and depression as well as dizziness, fatigue, vision issues and headaches.

[19] Ms. Saunders concluded that given the diagnosis of major depressive disorder with anxious distress by s. 44 assessor Dr. Paul Robinson, psychologist, and the diagnosis of predominantly right sided mechanical and low back pain as well as grade 2 whiplash of the neck with associated cervicogenic and migraine type headaches by s. 44 assessor Dr. Khaled, assistance with feeding is recommended and allotted 420 minutes per week for same. In addition, Ms. Saunders recommended 1,050 minutes per week with hygiene to ensure the applicant's safety and security from an emotional perspective.

[20] I find that Ms. Saunders ACBs recommendations are consistent with the bulk of the contemporaneous medical and documentary evidence at the time both OT assessments were conducted. The applicant's mother testified that pre- and post-accident she lived and stayed with her daughter and her daughter's children Monday to Friday and went to her own home on weekends. Whilst with her daughter she prepared breakfast, lunch and dinner for the kids and family, did house chores and laundry. The applicant's partner also testified that she did not cook and he, along with the applicant's mother, did the cooking. Post-accident the applicant continued to work in her pre-accident job fulltime driving from Penetanguishene to Barrie until the onset of the Covid-19 pandemic when she worked from home part-time without any difficulties doing her job. This evidence is consistent with the level of function set out in Ms. Saunders' assessment and is inconsistent with the level of care Ms. Hubbard says was required as the result of the accident.

[21] The applicant was also observed by Ms. Saunders to get up and down, transfer from sitting to standing without any difficulties and without holding onto anything to support her for fear of falling or because of dizziness. This is inconsistent with the level of services recommended by Ms. Hubbard.

[22] In addition, a review of the medical records does not support the applicant's position that she needs 24 hours per day of support because she lacks the ability to be self-sufficient in an emergency. None of the applicant's treating healthcare professionals at the time suggested that she was not safe in an emergency. Moreover, her family physician considered it safe for her to work from home.

[23] I find that ACBs in the amount of $1,501.99 per month as recommended by Ms. Saunders is reasonable and necessary.

[24] The records also reveal that, even though the respondent has approved ACBs in the amount of $1,501.99 per month, the applicant has not claimed or incurred this amount. The fact that she has not used all of the amounts that have been approved is evidence that she does not require more than that amount and supports my finding that the services set out in the Form-1 prepared by Ms. Hubbard are not reasonable and necessary. Furthermore, in accordance with s. 19 of the *Schedule,* ACBs claimed must be incurred and I was not directed to any evidence to support that ACBs in the amount of $10,228.37 per month were incurred.

[25] The applicant also submits that she is entitled to ACBs in the amount of $216.96 and $289.28 for November 2021 and December 2021, respectively. These amounts are set out in invoices for services provided by NRG which were

presented in evidence. However, the applicant did not provide any detailed breakdown of ACB services provided in the hours billed for November 2021 and December 2021. Therefore, it is not possible to determine the level of care the invoices relate to and the amount to which the applicant is entitled to be paid by the respondent.

[26] As such and having found that ACBs in the amount of $1,501.99 per month is reasonable, I agree with the respondent that it is proper to use the “ratio method” as in *S.M. v Unica Insurance Inc*., 2020 CanLII 61460 (ON LAT Reconsideration) and *Malitskiy v. Unica Insurance Inc.*, 2021 ONSC 4603 (CanLII) based on the recommendations in the s. 44 Form 1 dated June 22, 2021 to pay the applicant $85.61 and $114.15, respectively, for the November 2021 and December 2021 ACB services. I find that the respondent is justified in using the ratio method since the applicant failed to provide any detailed breakdown of the ACB services rendered after being requested to do so by the respondent. Since the respondent has already paid those amounts to the applicant, there are no ACBs owing to the applicant.

The applicant is not entitled to the amounts claimed for HKHM Services

[27] I find that the applicant has not established that she is entitled to the HKHM services claimed. The applicant purchased optional HKHM benefits, and I find that her claims are mainly for services which either were primarily performed by others prior to the accident, or which are for services rendered more than two years after the accident, for which the applicant is not entitled to claim a benefit.

[28] The applicant bears the onus to prove on a balance of probabilities that she has a substantial inability to perform HKHM services that she normally performed before the accident. Since the applicant has not sustained a catastrophic impairment and in accordance with s. 28(1)2.ii. of the *Schedule*, her entitlement to HKHM services ends December 3, 2021, being two years post-accident.

[29] The applicant submits that she is entitled to the following HKHM services:

i. $100.00 per month from December 3, 2019, to December 3, 2021.

ii. $7,575.04 for housekeeping services done by her mother as per the OCF-6 dated January 07, 2022.

iii. $333.35 for December 2021 HKHM as per the invoice from NRG dated January 13, 2022.

iv. $300.02 for January 2022 HKHM as per the invoice from NRG dated February 11, 2022.

[30] The respondent submits that the HKHM services claimed are not payable because a) they were not incurred by the applicant; b) some are being claimed more than two years post-accident contrary to s. 28(1)2.ii. of the *Schedule;* and c) mileage claimed for the applicant's mother to travel to and from her home is not payable under the *Schedule*.

[31] While I accept the applicant's participation in housekeeping activities changed after the accident, I find that the applicant was not a primary contributor to the maintenance and cleaning of the house before the accident took place. The applicant testified that after the accident her participation in housekeeping activities changed and she has challenges with washing the floor, vacuuming, shoveling snow, cutting grass, cleaning the bathrooms, meal preparation and washing dishes. She indicated that before the accident she could make her bed, do some snow shoveling and mow the lawn. However, it is clear from the evidence at the hearing, including the testimony of the applicant's mother and partner, that the applicant's mother and her partner did most, if not all, of the housekeeping and home maintenance duties before and after the accident. The evidence is that this was primarily because of the applicant's early and long daily work commute from Penetanguishene to Barrie which left her little or no time to do house chores.

[32] I find that Ms. Hubbard's housekeeping findings in her report dated February 3, 2021, are not consistent with the bulk of the evidence. Ms. Hubbard indicated that the applicant reported that she was independent with her HKHM tasks including dusting, vacuuming, sweeping, floor washing, cleaning kitchen, grocery shopping, laundry, lawn care and snow removal. The applicant also reported that she is having increased difficulty performing these tasks post-accident. Based on the applicant's self reporting, Ms. Hubbard recommended six hours per week of indoor housekeeping assistance. However, the applicant did not tell Ms. Hubbard and Ms. Hubbard did not write in the report that her mother and her partner did most of the HKHM before the accident. Ms. Hubbard's assessment does not assist me in determining whether there are housekeeping and home maintenance activities that the applicant normally performed before the accident, that she is no longer able to do because, the applicant's pre- and post-accident reporting is not consistent with the balance of the evidence.

[33] I find that the applicant has not established that she has a substantial inability to perform HKHM services that she normally performed before the accident.

[34] I find that the applicant is not entitled to the amount of $7,575.04 for housekeeping services done by her mother for the following reasons. In addition to the fact that the applicant has not established that she has a substantial inability to perform HKHM services that she normally performed before the accident, a review of the OCF-6 dated January 07, 2022 revealed that a large portion of the $7,575.04 the applicant is claiming is for mileage for the applicant's mother to travel to and from her home, which is not payable under the *Schedule*. Also, the applicant's mother testified that she never billed her daughter for the HKHM work that she did, and no invoices were prepared for it, which is required in order to claim for services under the *Schedule*. In addition, the applicant's mother was not a professional housekeeper, and neither was I directed to any corresponding loss of income for the applicant's mother, which would be required for the applicant to establish an entitlement to benefits pursuant to s. 3(7)(e) of the *Schedule*. Finally, the claim for housekeeping included services which were performed after the expiry of the two year timeline set out in s. 28(1)2.ii. of the *Schedule.*

[35] I find that the applicant has not established that she is entitled to payment for December 2021 housekeeping services rendered in the amount of $333.35 or for January 2022 housekeeping services rendered in the amount of $300.02. A review of the corresponding invoices reveals that the housekeeping services being claimed are beyond the two-year time limit as specified by the *Schedule*, which is December 3, 2021. The December 2021 invoice reveals one notation of housekeeping for December 3, 2021, for $30.00 but no breakdown of the type of housekeeping services rendered on that day.

[36] Given all of the above, I find that: i) the applicant is not entitled to HKHM benefits in the amount of $100.00 per week from December 03, 2019 to December 3, 2021; ii) the applicant's claim for $7,575.04 for housekeeping services and or transportation for her mother is not payable; iii) the respondent has paid all housekeeping invoices that were submitted by the applicant within the two-year limit as per the *Schedule*, and no other housekeeping invoices are payable.

Treatment and Assessment Plans (OCF-18s)

[37] To receive payment for a treatment and assessment plan under s. 15 and 16 of the *Schedule*, the applicant bears the burden of demonstrating on a balance of probabilities that the benefit is reasonable and necessary as a result of the accident. To do so, the applicant should identify the goals of treatment, how the goals would be met to a reasonable degree and that the overall costs of achieving them are reasonable.

The applicant is not entitled to OT services.

[38] I find that the applicant has not demonstrated that the OT services claimed are reasonable or necessary as the result of the accident and she is not entitled to payment of these expenses under the *Schedule*.

[39] The applicant submits that she is entitled to the following OT services recommended by Rehab First Inc.:

i. $2,045.38 in a plan dated October 09, 2020, for 8 weeks of OT services;

ii. $3,602.65 in a plan dated January 27, 2021, for 12 weeks of OT services;

iii. $4,084.12 in a plan dated August 24, 2021, for 8 weeks of OT services; and

iv. $401.60 ($3,744.73 less $3,343.13 approved by the respondent) in a plan dated October 28, 2022, for 16 weeks of OT services.

[40] The applicant argues that the OT plan dated October 9, 2020, for the purposes of assessing her current level of functioning, safety and independence with her pre-accident activities of normal living within the home and community environment with a view to return to activities of normal living, is reasonable and necessary.

[41] In its denial letter dated October 14, 2020, the respondent denied the OT assessment plan dated October 9, 2020. The respondent indicated that it did not consider the plan reasonable and necessary because the OCF-23 submitted listed the applicant's injuries as whiplash associated disorder with complaint of neck pain with musculoskeletal signs; that she continued to work since the accident and that her May 8, 2020, statement indicates that she had no additional functional impairments since the December 3, 2019, accident.

[42] I find that the OT plan dated October 14, 2020, is not reasonable and necessary. A review of the contemporaneous clinical notes and records (CNRs) of Dr. Veall, Dr. Jahangirvand and Dr. Kathryn Wilkins, physiatrist, does not reveal any recommendation that the applicant requires an assessment of her current level of functioning or safety and independence with her pre-accident activities of normal living. In fact, shortly after the accident the applicant continued to work fulltime as a payroll administrator in her pre-accident job. The evidence also suggests that there was little to no change in her level of functioning in her pre-accident activities of normal living. As such, I am not convinced that this OT treatment plan is reasonable and necessary.

[43] The applicant submits that the OT plan dated January 27, 2021, is reasonable and necessary because its goal is to promote her safety and re-engagement in pre-accident activities including self-care with a view to return to her activities of normal living.

[44] In its denial letter dated February 10, 2021, the respondent relied on the findings of Dr. Khaled, general physician, in his s. 44 report dated December 9, 2020. Dr. Khaled indicated that from his physical examination he did not identify any valid indicators to support residual or ongoing or permanent musculoskeletal, neurological or orthopedic accident-related injury or impairment. He also stated that there is no objective evidence of ongoing permanent accident-related impairment and concluded that the treatment plan was not reasonable and necessary.

[45] I find that Dr. Khaled's opinion is more consistent with the bulk of the other evidence. As mentioned earlier, none of the application's treating healthcare professionals at the time recommended that she would benefit from OT services to promote her safety and re-engagement in pre-accident activities. In addition, an OCF-18 is not sufficient on its own to prove that the treatment is reasonable and necessary. There needs to be contemporaneous evidence in support of the OCF-18, and I have not been directed to evidence to support that the applicant requires this treatment. Therefore, I am not persuaded that this OT treatment plan is reasonable and necessary.

[46] The OT treatment plan prepared by Ms. Hubbard and dated August 24, 2021, for the provision of a new queen mattress and pillows to promote healthy sleep hygiene and mitigate daytime fatigue and pain, was denied by the respondent in a letter dated August 30, 2021. In its denial letter the respondent noted among other things that there is no documentation on file to indicate that the applicant requires a new mattress or other related devices for the treatment of her accident-related injuries and how this would cause functional improvements or significantly improve the applicant's pain symptoms.

[47] I find that the OT plan dated August 24, 2021, is not reasonable and necessary. There is no mention or suggestion in the contemporaneous medical and documentary records of Dr. Veall, Dr. Jahangirvand, Dr. Hercig and Ms. Jiha Humayun, the applicant's treating psychologist, that there is a need and that the applicant's psychological and pain symptoms would benefit from her obtaining a new mattress and pillows. In fact, in her psychological progress report dated May 06, 2021, Ms. Humayun indicated, after completing 17 psychotherapy sessions, that the applicant had made progress and psychotherapy was providing her with

relief and helping her manage, cope and reduce her psychological impairments. Ms. Humayun also noted that the applicant would continue to benefit from additional psychotherapy sessions. As such, I am not convinced that this OT treatment plan is reasonable and necessary.

[48] The OT treatment plan dated October 28, 2022 was partially approved by the respondent and the amount that was not approved was the transportation expense of the treating occupational therapist. The respondent in its denial letter dated November 11, 2022, correctly stated that pursuant to the *Schedule* only authorized transportation expenses are payable by the respondent and transportation expenses of a service provider is not considered authorized transportation by the *Schedule*. Therefore, there is no outstanding amount owing on this OT treatment plan.

The applicant is not entitled to case management services.

[49] I find that the applicant has failed to establish entitlement to the case management services claimed.

[50] The applicant submits that she is entitled to the following case management services recommended by Rehab First Inc.:

i. $5,075.00 in a plan dated October 09, 2020, for 12 weeks of case management services; and

ii. 3,691.26 in a plan dated May 13, 2021, for 15 weeks of case management services.

[51] She argues that the case management plans dated October 9, 2020, and May 13, 2021, for the purposes of identifying rehabilitation needs and to coordinate and implement the recommended rehabilitation services with a view to return to activities of normal living are reasonable and necessary.

[52] The respondent relied on the findings of Dr. Khaled in his report dated December 9, 2020, for its denial of the two case management treatment plans. Dr. Khaled stated that based on his examination of the applicant, from a cognitive perspective, significant cognitive deficits that would be identified functionally without detailed neuropsychological testing were not observed. He also indicated that the applicant should be reassured that it is safe to resume all aspects of life that were engaged in prior to the subject accident without restrictions. Given his findings he concluded that the treatment plan was not reasonable and necessary.

[53] I find that the findings of Dr. Khaled are consistent with the contemporaneous medical evidence of the applicant's family physician, treating neurologist, psychiatrist and psychologist. A review of the contemporaneous evidence does not reveal any recommendation from her treating healthcare professionals that she needed case management assistance to coordinate and implement the recommended rehabilitation services that were being provided. In fact, i) all of her neurological examinations were normal, ii) she made psychological progress and psychotherapy was providing her with relief and helping her manage, cope and reduce her psychological impairments, and iii) with the appropriate medical treatment, the applicant's psychiatric and psychological condition improved, and she was encouraged to continue working part time during the COVID-19 pandemic. Therefore, I am not persuaded that the case management plans are reasonable and necessary.

The applicant is not entitled to physiotherapy and chiropractic services.

[54] I find that the applicant has failed to establish entitlement to the physiotherapy and chiropractic services claimed.

[55] The applicant submits that she is entitled to the following physiotherapy recommended by Laura Tambosso and K. A. Tossios Physiotherapy and chiropractic services recommended by Mavrou Chiropractic:

i. $1,700.00 in a plan dated November 1, 2021, for 20 weeks of massage treatment;

ii. $1,715.89 in a plan dated January 18, 2022, for 12 weeks of physiotherapy services;

iii. $1,325.00 in a plan dated May 18, 2022, for 6 weeks of chiropractic services; and

iv. $2,031.16 in a plan dated August 16, 2022, for 12 weeks of physiotherapy services.

[56] She submits that the goals of the above treatment plans are for the purposes of pain reduction, increased ROM, increase strength, to improve overall conditioning and activity tolerance with a view to return to activities of normal living. She further submits that these plans are reasonable and necessary.

[57] The respondent in its denial letters addressing the above physiotherapy, massage and chiropractic treatment plans in dispute, relied on the findings in Dr. Khaled's s. 44 report dated January 31, 2022, for the basis of its denial. Dr.

Khaled stated that based on his assessment of the applicant on November 20, 2020, she has had appropriate and adequate facility based soft tissue rehabilitation therapy. Dr. Khaled also indicated that prolonged facility-based treatment for individuals with these types of injuries are rarely recommended. As such, he concluded that the treatment plans were not reasonable and necessary.

[58] I find that the applicant has failed to present evidence that satisfies me that the goals would be met by the proposed treatments or that the overall cost of achieving them are reasonable. A review of Dr. Veall's CNRs from August 13, 2021, to August 16, 2022, reveals that most of the applicant's complaints to Dr. Veall were about her psychological condition. During that same period of time, there were also a few notations of pain complaints that were mostly associated with headaches and migraine. In addition, these CNRs did not indicate any recommendation by Dr. Veall that the applicant would significantly benefit from further physiotherapy and or chiropractic services.

[59] Given all of the above, I am not convinced that the physiotherapy, massage and chiropractic treatment plans in dispute are reasonable and necessary.

The applicant is not entitled to visual assessment and voice therapy services.

[60] I find that the applicant has not demonstrated that the visual assessment and voice therapy services are reasonable or necessary as a result of the accident and she is not entitled to payment of these expenses under the *Schedule*.

[61] The applicant submits that she is entitled to the following visual assessment recommended by Foveal Corporation and voice therapy services recommended by MacPherson Communication Clinic:

i. $4,096.44 in a plan dated March 19, 2021, for 15 sessions of vision therapy; and

ii. $1,883.30 in a plan dated May 09, 2022, for 8 sessions of voice therapy.

[62] For the vision therapy plan in dispute, the applicant submits that the goal is to improve her vision symptoms with a view to address blurred vision, double vision, headaches and to provide her with reading glasses, polarized prism single vision distance glasses, and clear prism single vision glasses for night driving. She submits that this plan is reasonable and necessary.

[63] The respondent denied the vision therapy plan based on the findings of Dr. Rajveer Randhawa, optometrist, in his s. 44 report dated July 19, 2021. Following his optometric examination of the applicant, Dr. Randhawa diagnosed

her with presbyopia with mild myopia, not accident related. He indicated that there is no accident-related diagnosis from an optometric perspective. He stated that presbyopia usually becomes noticeable in the early to mid-40s and continues to worsen around age 65 and this would explain the applicant's complaints about near vision problems. Dr. Randhawa indicated that there was no true double vision noted during his examination of the applicant and that her visual acuity was exceptional for distance and her near visual acuity was correctable and not accident related. He stated that her vision standards are well above driving standards uncorrected and that there is no medical evidence that vision therapy would help the applicant. Therefore, he concluded that the visual therapy plan was not reasonable and necessary.

[64] I find that the findings of Dr. Randhawa are consistent with the bulk of the contemporaneous medical and documentary evidence. For more than one year and three months after the subject accident, Dr. Veall's CNRs did not indicate any accident-related visual impairments from the applicant nor make any referral to an optometrist or ophthalmologist. In fact, Dr. Veall referred the applicant to see Dr. Daniel Scanlan, ophthalmologist, who saw her on February 7, 2022. Dr. Scanlan found no sensory or neuro-ophthalmological abnormality and indicated that he did not see any value in oculomotor or vision training. Furthermore, in her treating neurologist Dr. Jahangirvand's CNRs, there is no notation of abnormality from all the neurological examinations conducted, inclusive of certain basic vision testing. As such, I am not convinced that the visual treatment plan is reasonable and necessary.

[65] For the voice therapy plan in dispute, the applicant submits that the goal of the plan is for restoring her voice; reducing feeling of globus; providing tools and strategies to assist her in managing voice symptoms in the future; and to screen for cognitive communication difficulties with a view to restore a resonant, effortless, voice quality so that she can communicate with ease in her everyday life. She submits that her voice deteriorated since the accident, and she believes the accident contributed to the deterioration. However, the applicant was seen by otolaryngologists Dr. Ngo and Dr. Belchetz, and neither attributed the applicant's voice impairment to accident-related injuries.

[66] The respondent issued a denial letter dated May 19, 2022. The respondent indicated that it did not consider the plan reasonable and necessary because Dr. Veall, who completed the OCF-3 dated March 13, 2020, made no reference to cognitive communication impairment or issues with the applicant's voice and that the injuries were listed as cervical spine strain and post-concussion syndrome. In addition, the respondent stated that the CNRs of Dr. Veall that were received,

displayed no indications of the impairments listed in the voice therapy plan in dispute.

[67] The applicant did not present any medical evidence to support that her speech condition was due to a psychological injury that was a result of the accident, and I accept the findings of Dr. Ngo and Dr. Belchetz that the applicant's speech condition is not as a result of the subject accident. As such I am not convinced that the voice therapy treatment plan is reasonable and necessary as a result of the accident.

The applicant is not entitled to the medical cannabis, botox injections and prescription medication expenses.

[68] I find that the applicant has not established that she is entitled to the medical cannabis, botox injections and prescription medication expenses claimed.

[69] The applicant submits that she is entitled to all the medical cannabis, botox injections and prescription medication expenses as stated at issues 9(a) to 9(o) above. She further submits that when prescribed by a regulated health professional, medical cannabis falls under s. 38(2)(c) of the *Schedule* and this does not require medical cannabis to be submitted to an insurer on an OCF-18, which might then trigger a s. 44 assessment. As such, the applicant did not submit an OCF-18 for any of the medical cannabis expenses in dispute and she refused to participate in any medical cannabis related s. 44 insurer's examination (IE).

[70] The respondent submits that as per s. 38(2) of the *Schedule*, an insurer is not liable to pay an expense in respect of a medical or rehabilitation benefit or an assessment or examination that was incurred before the insured person submits a treatment and assessment plan (OCF-18). The respondent further submits that no testing was provided by Dr. Amy Thiele, anesthesiologist and prescribing doctor, to support her opinion that the applicant needed medical cannabis. In addition, the respondent argues that it is unclear if the medical cannabis prescription is reasonable and necessary to treat the applicant's injuries from the subject accident. As such, pursuant to s. 33 of the *Schedule* it requested information from the applicant to assist in determining her entitlement. The respondent also submits that it is important to look at the whole cost of the treatment, and as such, on numerous occasions requested the applicant submit an OCF-18 for review and/or participate in a s. 44 IE to which she refused.

[71] Pursuant to s. 38(2)(c)(i) of the *Schedule*, an insurer is not liable to pay an expense unless the expense is "reasonable and necessary" as a result of the

impairment sustained by the insured person for drugs prescribed by a regulated health professional. As such, if an insurer is not sure if an expense for drugs prescribed is reasonable and necessary, the insurer may request additional information pursuant to s. 33 of the *Schedule*. In addition, the insurer may deny the claim pursuant to s. 33(6) of the Schedule.

[72] I find that the information provided by the applicant was not adequate and does not support eligibility for the medical cannabis expenses. A review of the contemporaneous medical and documentary records reveal that the medical cannabis expense dated June 19, 2020 was the first benefit sought by the applicant following the subject accident after she was referred to Dr. Thiele of the Canabo clinic in March 2020. In addition, Dr. Thiele, in a letter dated October 22, 2020, stated that it is true that she was missing some clinical information from the applicant's family doctor in the beginning of her clinical encounter with the applicant that started in March 2020. Dr. Thiele also indicated in the letter that she has enough clinical experience and knowledge of the applicant as of October 2020 to know that the applicant is suffering from post-concussion syndrome, chronic pain, and severe anxiety as a result of the subject accident.

[73] Given the contemporaneous medical and documentary evidence and Dr. Thiele's acknowledgement that she had limited clinical information about the applicant's condition when she started to treat her, I find that the respondent was justified in denying the medical cannabis expenses claimed. As such, I am not persuaded that the applicant is entitled to the medical cannabis expenses claimed.

The applicant is not entitled to the botox expenses.

[74] I find that the applicant has not demonstrated that the botox expenses are reasonable and necessary and she is not entitled to payment under the *Schedule*.

[75] With respect to the botox related expenses claimed, the applicant says that the cost of the botox is less than $250 and pursuant to s. 38(2)(d) of the *Schedule*, an OCF-18 is not required.

[76] The respondent argues that as per s. 38(2) of the *Schedule* it was not liable to pay for the incurred botox injection expenses before an OCF-18 was submitted. In addition, s. 38(2)(d) of the *Schedule* also requires the insurer to agree that the expense is essential which it did not.

[77] I find that pursuant to s. 33 of the *Schedule*, the applicant has not met her onus to provide adequate information as requested by the respondent, to support her

eligibility for the botox expenses claimed. A review of Dr. Jahangirvand's CNRs does not support that the botox expenses are reasonable and necessary. In fact, Dr. Jahangirvand also testified that he would not even discuss the possibility of botox treatment with a patient unless there was private coverage. Furthermore, Dr. Jahangirvand in his CNRs dated October 13, 2020, indicated that the applicant was interested in treatment with botox therapy, and that she would be filling out paperwork for private coverage. I find that since the respondent did not agree that the botox expenses are essential pursuant to s. 38(2)(d) of the *Schedule* and the applicant did not comply with s.33 of the *Schedule*, she is not entitled to the botox expenses claimed.

The applicant is not entitled to the prescription medication expenses.

[78] I find that the applicant has not established that the prescription medication that is being claimed was prescribed as a result of the accident and therefore the applicant is not entitled to payment of those expenses.

[79] The applicant submits that she is entitled to the prescription medication expenses that are in dispute. She further submits that prescribed drugs submitted pursuant to s. 38(2)(c)(i) do not require a treatment plan.

[80] In its denial of the prescription medications in dispute, pursuant to s. 33 of the *Schedule*, the respondent requested that the applicant provide confirmation from Dr. Veall, her family physician, that the auro topiramate, Tecta and Fucidin cream/ointment prescriptions were prescribed as a result of the subject accident and that she requires ongoing use of these medications because of the injuries sustained. The respondent also indicated that without this information from Dr. Veall, the disputed prescribed medication expenses are not payable.

[81] The applicant has the onus to prove entitlement to benefits claimed. Section 38(2)(c)(i) still requires the applicant to demonstrate that the expense is reasonable and necessary in addition to being prescribed by a health professional. I was not directed to any notation from Dr. Veall confirming that the auro topiramate, Tecta and Fucidin cream/ointment prescriptions were prescribed as a result of the subject accident and that she requires ongoing use of these medications because of the injuries sustained. Also, a review of the contemporaneous medical and documentary evidence does not reveal that any of the applicant's other treating physicians prescribed these medications because of the subject accident. As such, I am not convinced that the applicant is entitled to the prescription medication expenses claimed because….

No award is payable.

[82] The applicant sought an award under s. 10 of Regulation 664, submitting that the respondent has deliberately ignored the medical evidence supporting the ACBs and HKHM claims, OT, case management, physiotherapy, chiropractic, visual assessment and voice therapy treatment plans and the medical cannabis, botox injections and prescription medication expenses issues in dispute. Under s. 10, the Tribunal may award up to 50% of the total benefits payable if it determines that the insurer unreasonably withheld or delayed the payment of benefits.

[83] I find an award is not appropriate. As the applicant is not entitled to any of the issues in dispute and no benefits are overdue, it follows that the Tribunal cannot order an award.

No Interest is payable.

[84] Interest is payable on the overdue payment of benefits in accordance with s. 51 of the *Schedule* on any overdue payments of benefits. As there were no overdue payments found, no interest is payable under s. 51.

ORDER

[85] I find that:

i. The applicant is not entitled to the ACBs in dispute.

ii. The applicant is not entitled to the HKHM services in dispute.

iii. The applicant is not entitled to the OT, case management, physiotherapy, chiropractic, visual assessment and voice therapy services claimed.

iv. The applicant is not entitled to the medical cannabis, botox injections and prescription medication expenses claimed.

v. No award is payable.

vi. No interest is payable.

[86] The application is dismissed.

Released: October 3, 2023

Clive Forbes
Adjudicator