Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A16-004703

BETWEEN:

YESHITLA DADI

Applicant

and

AVIVA CANADA INC

Insurer

REASONS FOR DECISION

Before:	Arbitrator Charles D. Matheson
Heard:	In person in Ottawa on May 17 & 18, 2017, and by written submissions completed on May 31, 2017
Appearances:	Mr. Alan J. Clausi, lawyer for Mr. Dadi Mr. Alex Robineau, lawyer for Aviva Canada Inc

Issues:

The Applicant, Mr. Yeshitla Dadi, was injured in a motor vehicle accident on June 10, 2015 and sought accident benefits from Aviva Canada Inc. ("Aviva"), payable under the *Schedule*.[1] The parties were unable to resolve their disputes through mediation, and the Applicant, through his representative, applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c. I.8, as amended.

[1] *The Statutory Accident Benefits Schedule - Effective September 1, 2010,* Ontario Regulation 34/10, as amended.

The issues in this Hearing are:

1. Is Mr. Dadi entitled to receive a medical benefit of $1,822.04 for the treatment plan as submitted on October 23, 2015 by Ms. Van Gendt?
2. Is Aviva liable to pay a special award because it unreasonably withheld or delayed payments to Mr.Dadi?
3. Is Mr. Dadi entitled to interest for the overdue payment of benefits?
4. Is Aviva liable to pay Mr. Dadi's expenses in respect of the arbitration?
5. Is Mr. Dadi liable to pay Aviva's expenses in respect of the arbitration?

Result:

1. Mr. Dadi is entitled to receive the medical benefit of $1,822.04 for the treatment plan dated October 23, 2015.
2. Aviva is not liable to pay a special award.
3. Mr. Dadi is entitled to interest for the overdue payment of benefits.
4. Should the parties become unable to resolve the expenses issue, they shall subsequently schedule an Expense Hearing before me in accordance with the provisions of the *Dispute Resolution Practice Code.*

Background

The Applicant is a 55 year old Ethiopian-born Canadian citizen, working as a taxi driver, who lived with his wife and 6 children in Ottawa at the time of the accident.

The Applicant had suffered a slip and fall in March 2012, where he injured his left shoulder rotator cuff and fractured ribs on his left side. On April 30, 2013 the Applicant underwent arthroscopic surgery to repair his rotator cuff. On November 24, 2013 the Applicant underwent an MRI of his right shoulder, which identified a full thickness tear of the complete extension of the supraspinatus tendon and other significant injuries to this shoulder as well.

The Applicant was involved in a second motor vehicle accident on July 31, 2016.

I note the Application for Arbitration and the Pre–Hearing Letter cited that the Minor Injury Guidelines ("MIG") was in dispute. However, the Applicant was removed from the MIG as of April 2017, therefore the MIG is not in dispute in this Hearing.

Decisions on Preliminary Issues

The parties raised three preliminary issues at the start of the Hearing, which I shall deal with first.

Preliminary Issue #1

The Applicant wanted both adjusters involved with this file to be available for examination as the Applicant suggested that the adjusters would be able to shed light on the special award aspect of the Applicant's claim. The Applicant argues that the file was mishandled and the Applicant was unreasonably held within the MIG. The Applicant argues that both adjusters were properly advised and summoned. The Insurer objected as both testimonies were not necessary.

I ordered that both adjusters should be made available to give evidence at this Hearing. In my view, the adjuster's views and actions were relevant to the special award.

Preliminary Issue #2

The Applicant sought to add an attendant care benefit to this arbitration.
The Applicant argued that the treatment plan in dispute was the gateway for an attendant care Form 1, which should have been generated, if this plan was accepted by the Insurer.

The Insurer argues that Director's Delegate Evans decision in *Duong*[2] suggests that the Applicant, after April 1, 2016 cannot add issues not previously mediated, and therefore must arbitrate within at the LAT. I agree. I have no jurisdiction to add an issue as I note that the Report of Mediator,

[2] *Aviva Canada Inc. and Duong,* FSCO P16-00048, January 12, 2017

and the Form C (Application for Arbitration) do not contain or mention a disputed attendant care benefit issue.

Preliminary Issue #3

The Applicant wrote on several occasions that he wished to obtain under s. 46 of the *Schedule* a copy of the business contract between the Insurer and their preferred contractors known as LifeMark and Canadian Back Institute ("CBI").

The Applicant wanted to investigate how the third-party(s) get(s) paid and the pattern of bonuses (if any) and other forms of remuneration, which may shed light on why the Applicant was left within the MIG for so long.
The Applicant suggests that the Insurer and CBI acted together in an inappropriate manner, which impacted on how the file was adjusted and whether or not the Applicant was left within the MIG.

The Insurer objected to releasing the documents in question as they are privileged.

I deferred a decision on this matter at the beginning of the arbitration as I wanted to hear evidence of some wrong doing, from other sources, that would compel the production of such a contract. I did not hear any compelling information during the Hearing, and thus ruled against the motion, as it was clear that there was no factual basis provided for the relevancy of this documentation.

EVIDENCE AND ANALYSIS:

1. *Is Mr. Dadi entitled to receive a medical benefit of $1,822.04 for the treatment plan as submitted on October 23, 2015 by Ms. Van Gendt?*

The parties agree that the burden to establish entitlement for this benefit falls upon the Applicant.

I note the Applicant participated in a pre-planned family vacation from July 28, 2015 until October 1, 2015.

The Insurer argues that at the time when the treatment plan was submitted, the Applicant had not proven that he had sustained injuries that were not predominantly minor in nature. As such, coverage in this treatment plan was not available to the Applicant pursuant to the *Schedule*.

The undisputed evidence contained within the adjuster's log notes, hospital records, and the Applicant's family doctors clinical notes and records that were relied upon and argued by the parties' are listed below. I note that both of the Insurer's adjusters verified the Insurer's possession of this information in their testimony, and admitted to reviewing the file on numerous occasions.

- On June 10, 2015, the hospital emergency report noted findings of the Applicant as follows: alert, no distress, Glasgow Coma Scale: 15; pain 5/5 mid upper back, pain 5/5 right leg, left hip/knee pain 4/5, positive for tenderness T10/12 spinal process; full neck range of motion, zero pain, zero C spine tenderness; left knee positive tender; left greater trochanter positive for tenderness; decreased left hip and knee range of motion pain;
- On June 10, 2015, emergency records note that the Applicant hit the steering wheel with his head, zero loss of consciousness, dizziness, speed about 60 km/h, pain in head and lower back, and contusion of left hip. Naproxen and Tylenol were prescribed;
- On June 19, 2015, the adjusters log notes state the following: back and neck is sore and dizzy; pain on a scale of 1 to 10 is a 5, moderate pain; taking extra strength Tylenol; injury level is 'minor injury'; police attended collision; Applicant attended general hospital; part of body struck the interior of the vehicle; hit head on the steering wheel;
- On June 19, 2015, the adjuster's log notes state that the Applicant lost consciousness and that the Applicant had pre-existing injury conditions that required him to be off work;
- On June 23, 2015, the Applicant returned to the hospital for the second time complaining of headaches, neck pain and occasional episodes of dizziness. The final diagnosis was a viral upper respiratory infection and a post concussive syndrome;

- On July 3, 2015, the road adjuster, Ms. Wendy Ruthven, met the Applicant in his home and helped him fill out the OCF-1 and statement. The OCF-1 or Application for Benefits noted that the Applicant reported he suffered a concussion, neck and back pain;
- On July 9, 2015, Ms. Ruthven referred the Applicant to CBI and noted , in part that pain in the back, leg, neck, arm, and headaches were constant; pain was disturbing his sleep; in the collision his head hit on the windshield and his airbags deployed; he was diagnosed with concussion and low back pain;
- On July 15, 2015, the Applicant attended his family doctor's office (Dr. Lo) again, complaining that he was dizzy since the collision, panic, heart beating fast, dizzy today. The Applicant was found to have normal heart sound, and was noted to have acute anxiety;
- On July 16, 2015, CBI records note that the Applicant went to hospital due to concussion symptoms yesterday;
- On October 23, 2015, the adjusters log notes state CBI called Aviva to advise that the claimant had returned from being on vacation and started his MIG treatments;
- On October 23, 2015, the adjusters log notes state that the OCF-18 (now in dispute) was received, and that the treatment plan noted concussion, chronic intractable pain, dizziness and giddiness, headache, non-organic sleep disorders, malaise and fatigue;
- On November 13, 2015, the adjusters log notes state set up IE referral regarding OCF 18 dated October 23, 2015, In-home Occupational Therapy Treatment Plan for $1,822.04;
- On December 18, 2015, the Respondent, with an Explanation of Benefits, provided the December 4, 2015, Insurer's medical examination report of Dr. Aiello with respect to the OCF-18 treatment plan by Nicole van Gendt. It was also noted that the pre-accident medical documents were not provided to Dr. Aiello and that they would be forwarded to Dr. Aiello for an addendum report;
- On December 30, 2015, Dr. Aiello completed his addendum report, after being provided with the additional medical documentation, including the pre-accident Ambulance Call Report, the pre-accident Ottawa Hospital left shoulder imaging and rotator cuff surgical records, and the pre-accident physiotherapy file of OC Physiotherapy. Dr. Aiello did not

change his previous medical opinion and opined that the Applicant suffered predominantly minor injuries.

Despite the evidence of the above timeline the Insurer argues that I should rely upon Ms. Allard's and Dr. Aiello's testimony.

In my view, Ms. Allard is a physiotherapist not a doctor. I am unconvinced that she is able to diagnose a concussion or be relied upon to identify and treat post-concussive symptoms. I do not believe that Ms. Allard acted in a malicious manner toward the Applicant, or acted unprofessionally, as alleged by the Applicant.

In regards to Dr. Aiello, I was unable to accept him as an expert. I agreed with the Applicant's arguments that he lacked any specific area of speciality, and did not have the enough experience as a health care practitioner to be deemed an expert. The doctor did not have standing in any secondary professional organizations, and was not published on any noted area of practice. Therefore, I limited his evidence to his report alone.

I am unable to place any weight on Dr. Aiello's reports as he continued to rely heavily on the facts that the Applicant was working and had gone on a vacation in order to support his findings. Further, the doctor testified he did not believe that he should give any relevance or weight to any pre-existing medical conditions, nor did he appreciate or give emphasis to any other medical documentation when conducting his assessments or writing his reports. The doctor did not request further medical records despite the fact that the patient before him was complaining about:

- Hitting his head on the steering wheel during the accident;
- Losing consciousness at the time of the accident;
- Headaches;
- Neck and shoulder pain that interrupts his sleep;
- Anxiety attacks;
- Tingling in his arms when the pain is severe.

The doctor simply wrote his reports based on his interview. I am unable to give any credence or weight to this doctor's report.

Decision

For the above reasons, I find that the Insurer had the information which would have removed the Applicant from within the MIG far sooner than they did.

The Insurer argues that regardless of the question on the applicability of the MIG, the Applicant still bears the additional burden of proving that the treatment plan was reasonable and necessary. The Insurer argues that in this case, the Applicant has failed to prove on a balance of probabilities that the treatment plan is reasonable and necessary - that there is no cogent evidence justifying that the Applicant requires attendant care or occupational therapy, or an assessment of the need for same. I disagree.

The evidence shows that the Applicant hit his head, had significant bruising as a result, and complained constantly of issues of pain in the neck and shoulders and back. The adjusters log notes clearly show that the Applicant hit his head and was diagnosed with a concussion. Clearly, in my view, the Insurer chose to ignore the information in its possession and control along with two recommendations from two different competing treatment facilities who requested an assessment or deeper screening of the Applicant.

I give no weight to the hand written statement prepared by Ms. Allard, who acknowledged that the Applicant had difficulties understanding her questions and directions. In my view, the letter was self-serving for the Insurer and its credibility was reasonably challenged by the Applicant's testimony that he did not read the documents, he just signed what he was told to sign. In my view, a breach of trust by a person in authority may have occurred.

As such the Applicant was entitled to treatment outside the MIG and by extension is entitled to the treatment plan of October 23, 2015 at it was reasonable and necessary.

2. *Is Aviva liable to pay a special award because it unreasonably withheld or delayed payments to Mr. Dadi?*

Pursuant to section 282(10) of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, where an insurer has unreasonably withheld or delayed payments, an Arbitrator can, in addition to awarding the benefits and interest to which an insured person is entitled under the *Schedule*, award a lump sum of up to 50 per cent of the amount to which the person was entitled at the time of the award together with interest on all amounts then owing to the insured (including unpaid interest) at the rate of 1 per cent per month, compounded monthly, from the time the benefits first became payable under the *Schedule*.

The Insurer argues that the special award is not applicable in this case as an insurer is not held to the standard of perfection in responding to this claim. It is submitted that an insurer's claims decisions are to be judged on the basis of the information available at the time, and not from hindsight, and that an insurer is not to be found unreasonable just because an arbitrator concludes its claims decision was wrong. Further, the Insurer argues that the conduct of its adjusters should not be characterized as excessive, imprudent, stubborn, inflexible, unyielding or immoderate behaviour, when considering that the Applicant was eventually removed from the MIG as a result of a good faith belief in Dr. Payne's report.

Decision

I agree. Incorrect decisions made by the adjuster and her supervisors, while misinterpreting the information contained within the above listed events, may borderline incompetence, but is not the type of wrong doing that rises to the level required for a special award. Therefore, the Applicant is not entitled to a special award in this matter.

3. *Is Mr. Dadi entitled to interest for the overdue payment of benefits?*

Given the success of the Applicant in regards to the medical benefit, I find the Applicant is entitled to the interest on the overdue amount as prescribed by the *Schedule.*

EXPENSES:

Neither party made submissions on expenses. Should the parties become unable to resolve this issue, they shall subsequently schedule an Expense Hearing before me in accordance with the provisions of the *Dispute Resolution Practice Code*.

C. D. Matheson

Charles D. Matheson
Arbitrator

September 20, 2017
Date

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ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as it read immediately before being amended by Schedule 3 to the *Fighting Fraud and Reducing Automobile Insurance Rates Act*, 2014, and Ontario *Regulation 664*, as amended, it is ordered that:

1) Mr. Dadi is entitled to receive the medical benefit of $1,822.04 for the treatment plan dated October 23, 2015.
2) Aviva is not liable to pay a special award.
3) Mr. Dadi is entitled to interest for the overdue payment of benefits.
4) Should the parties become unable to resolve the expenses issue, they shall subsequently schedule an Expense Hearing before me in accordance with the provisions of the *Dispute Resolution Practice Code*.

C. D. Matheson

Charles D. Matheson
Arbitrator

September 20, 2017
Date