

**BETWEEN:**

**L.F.**

**Applicant**

**and**

**STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY**

**Insurer**

## **REASONS FOR DECISION**

**Before:** Lawrence Blackman

**Heard:** December 14, 15, 16 and 17, 2000, August 20, 21, 22, 23 and 27, 2001, at the Offices of the Financial Services Commission of Ontario in Toronto. Written submissions were received dated December 20, 2001 and January 10, May 10 and 16, 2002.

**Appearances:** David F. MacDonald for L.F.  
Robert S. Franklin for State Farm Mutual Automobile Insurance Company

**Issues:**

It is agreed that the Applicant, L.F.,<sup>1</sup> was injured in a motor vehicle accident on January 1, 1997. I accept the evidence, specifically as enunciated by Dr. A. Oshidari in his January 18, 2000 Designated Assessment Centre (“DAC”) physiatry report, that as a result of this accident, L.F. sustained a fracture of his C4-5 facet joint, which was treated by open reduction and internal fixation. I accept L.F.’s evidence, for reasons set out below, that since this accident he has suffered pain, specifically in his neck, shoulder and back as well as headaches, and has developed emotional difficulties, specifically depression.

---

<sup>1</sup>Due to the very personal nature of the evidence presented, I have exercised my discretion to anonymize this decision.

L.F. applied for and received statutory accident benefits from State Farm Mutual Automobile Insurance Company (“State Farm”), payable under the *Schedule*.<sup>2</sup> State Farm terminated weekly income replacement benefits in January 2000. The parties were unable to resolve their disputes through mediation and L.F. applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended (the “*Insurance Act*”).

The remaining issues, as agreed by the parties during the course of this hearing, are:

1. Is L.F. entitled to payment of weekly income replacement benefits of \$185 ongoing from January 24, 2000?
2. Is L.F. entitled to payment of further attendant care benefits, claimed pursuant to section 16 of the *Schedule*, and if so, what are the implications of the transitional provisions of subsection 70(3) of the *Schedule*?
3. Is L.F. entitled, pursuant to subsection 14(1) of the *Schedule*, to payment of the following medical benefits:
  - (a) chiropractic and physiotherapy treatment in the amount of \$9,737.65;
  - (b) a beach ball in the amount of \$35; and,
  - (c) \$791 for assistive devices recommended by Ms. E. Poon?
4. Is L.F. entitled to payment of the following rehabilitation benefits, pursuant to section 15 of the *Schedule*:
  - (a) a TENS machine in the amount of \$500; and,
  - (b) psychological treatment provided by Dr. R. Davila & Associates, in the amount of \$425?

---

<sup>2</sup>The *Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996*, Ontario Regulation 403/96, as amended by Ontario Regulations 462/96, 505/96, 551/96, 303/98, 114/00 and 482/01.

5. Is L.F. entitled to payment of following expenses, claimed pursuant to section 24 of the *Schedule*:
  - (a) \$100 for Dr. P.O.G. Butler's report dated December 8, 1998;
  - (b) \$1,489 for Dr. G.K. Lau's December 28, 1998 and November 22, 2000 reports;
  - (c) \$1,250 for Dr. A.R. Chaudri's January 26 and December 5, 2000 reports;
  - (d) \$628 for Dr. A. Kachooie's November 26, 1998 and December 12, 2000 reports;
  - (e) \$725 for Dr. R. Davila's October 13, 1998 and April 7, 2000 reports; and,
  - (f) \$2,632.52 for the reports of Rehabilitation Network Canada Inc., dated December 15 and 28, 1998, and February 26, 1999?
6. Is L.F. entitled to direct billing of the cost of his prescription medication, pursuant to subsection 44(2) of the *Schedule*?
7. Is L.F. entitled to a special award pursuant to subsection 282(10) of the *Insurance Act* because of the unreasonable withholding or delay of payments?
8. Is L.F. entitled to payment of interest on overdue expenses, pursuant to subsection 46(2) of the *Schedule*?
9. Is either party entitled to payment of their expenses of this arbitration proceeding?

**Result:**

1. L.F. is entitled to payment of weekly income replacement benefits of \$185 ongoing from January 24, 2000.
2. L.F. is entitled to payment of monthly attendant care benefits of \$744.18 from January 12 to March 30, 1997, \$147.92 from April 1 to August 30, 1997, and \$134.68 from August 31, 1997 to January 11, 2000, less payments made to date.

3. L.F. is entitled, pursuant to subsection 14(1) of the *Schedule*, to payment of:
  - (a) \$9,737.65 for treatment received at Rosedale Chiropractic & Physiotherapy Centre; and,
  - (b) \$85 for a high back support cushion recommended by Ms. E. Poon.
  
4. L.F. is entitled, pursuant to subsection 15 of the *Schedule*, to payment of:
  - (a) a TENS machine in the amount of \$488.85; and,
  - (b) \$425 for psychological treatment provided by Dr. R. Davila & Associates.
  
5. L.F. is entitled to payment of following expenses, pursuant to section 24:
  - (a) \$25 for Dr. Butler's December 8, 1998 report;
  - (b) Dr. Lau's accounts for his December 28, 1998 and November 22, 2000 reports, subject to proof of the amount and any dispute as to the reasonableness of the latter account;
  - (c) \$650 for Dr. Chaudri's December 5, 2000 report;
  - (d) \$453 for Dr. Kachooie's reports of November 26, 1998 and December 12, 2000;
  - (e) \$50 for Dr. Davila's October 13, 1998 report; and,
  - (f) \$2,632.52 for the reports of Rehabilitation Network Canada Inc., less any portion attributable to Dr. Lau's report noted above.
  
6. L.F. is not entitled to direct billing of the cost of his prescription medication.
  
7. L.F. is entitled to a special award of \$2,500.
  
8. L.F. is entitled to payment of interest on overdue expenses, pursuant to subsection 46(2) of the *Schedule*.
  
9. The parties may now speak to the question of entitlement to payment of the legal expenses of this arbitration proceeding.

## Index

	<b>Topic</b>	<b>Page Number</b>
1.	<b>Income Replacement Benefits</b>	<b>6</b>
	(a) post-104 week test	6
	(b) education, training and experience	6
	(c) complete inability	8
	<b>S</b> the Applicant's case	10
	<b>S</b> the Insurer's case	16
	(d) conclusion	21
2.	<b>Attendant Care</b>	<b>24</b>
	(a) the claim	24
	(b) implications of transitional provisional of s. 70(3)	25
	(c) "incurred"	27
	(d) "reasonable and necessary" (3 claim periods)	32
3.	<b>Medical Benefits</b>	<b>37</b>
	(a) Rosedale Chiropractic	37
	(b) beach ball	46
	(c) assistive devices	46
4.	<b>Rehabilitation Expenses</b>	<b>47</b>
	(a) a TENS unit	47
	(b) psychological treatment	48
5.	<b>Cost of Examinations, reports of:</b>	<b>48</b>
	(a) Dr. Butler	49
	(b) Dr. Lau	49
	(c) Dr. Chaudri	50
	(d) Dr. Kachooie	50
	(e) Dr. Davila	51
	(f) Rehabilitation Network Canada Inc.	52
6.	<b>Direct Billing of prescriptions</b>	<b>52</b>
7.	<b>Special Award</b>	<b>53</b>
	Conclusion	64
8.	<b>Expenses</b>	<b>64</b>

## EVIDENCE AND ANALYSIS

### 1. Income Replacement Benefits

#### **(a) *post-104 week test***

Section 5 of the *Schedule* provides that an insurer is not required to pay an income replacement benefit (“IRB”) for any period longer than 104 weeks of disability unless, as a result of the motor vehicle accident, the insured person is suffering a complete inability to engage in any employment for which that person is reasonably suited by education, training or experience.

L.F. was paid weekly IRBs for more than 104 weeks of disability from his January 1, 1997 accident. He claims ongoing weekly IRBs from January 24, 2000.

#### **(b) *education, training and experience***

I make the following findings, based on the oral evidence (specifically of the Applicant ) and the documents filed as exhibits:

- S L.F. was born on March 29, 1967;
- S his formal education ended part-way through Grade 11 in Montreal (other than later training with the Regal Constellation Hotel noted below);
- S L.F. has worked exclusively in the restaurant field, either as a cook or as a cook/manager in a variety of restaurants, hotels, pubs and fast-food establishments;
- S L.F. moved to Toronto in 1991;
- S in 1994, L.F. took a six-month course in restaurant management with the Regal Constellation Hotel, including training in the front desk, dining room, housekeeping, room service and maintenance. L.F. graduated from the course in 1995. L.F. has never been employed in the area of hotel management;

- S in 1995, L.F. earned \$13,719.75 in employment income from three different places of employment, including duties at Taco Bell as a “shift manager,” which entailed working as chef as well as dealing with the schedule and setting up the cash. That same year, L.F. received \$10,089 in social assistance;
- S in 1996, L.F. earned \$6,035 in employment income (also at three establishments, two of them new) as well as receiving \$9,267.44 in social assistance;
- S at the time of the accident, L.F. was working four days a week (approximately 30 hours) at Champs Restaurant & Lounge (“Champs”) as a cook, earning \$8 an hour. I accept the evidence of his employer in this regard, which L.F. described as “pretty accurate.” L.F. had started this employment on November 26, 1996.
- S about that same time, L.F. had started a catering company named Vesta Catering. L.F. has no records for this financial enterprise. I accept that L.F. had a dream of catering full-time. I am not persuaded that this was a very realistic dream. I am not persuaded that this was anything other than a very casual, infrequent enterprise, based on L.F.’s own evidence of very limited engagements (a boat cruise and a beauty pageant) and the evidently very minimal income earned in this regard, as related specifically to Dr. Geisler. In addition, I have significant doubts as to the expertise of L.F. as a cook beyond fast food, based on his own evidence and that contained in reports, such as again, that of Dr. Geisler;
- S L.F. has not worked since this accident. He has not looked for a job, nor has he looked into the job market for modified or part-time employment;
- S L.F. has made considerable efforts to rehabilitate himself, including receiving extensive physiotherapy, chiropractic and other treatment as well as psychological counselling. L.F. has further submitted to numerous expert assessments arranged by his insurer, his counsel, and by the Designated Assessment Centre (“DAC”) System;
- S L.F. was involved in a second motor vehicle accident in November 1999, while a passenger in the back seat of a taxi. I accept the Applicant’s evidence that this was a minor accident, that he did not apply for benefits as a result of that accident or commence any legal action in that regard. I find that L.F.’s continuing injuries as enumerated above were sustained as a result of the January 1, 1997 accident.

**(c) complete inability**

Under the *1990 Schedule*,<sup>3</sup> arbitrators dealt with an applicant's onus regarding the long-term weekly benefit entitlement test, by accepting that applicants were "not required to prove a negative: that there is no job that they can do."<sup>4</sup> Rather, arbitrators held that applicants might discharge their onus of proof by exploring career options<sup>5</sup> or by identifying some sort of suitable employment (and describing the physical demands of the work and demonstrating with credible evidence that their injuries continuously prevent them from engaging in such employment).<sup>6</sup>

A significant difference between the *1990 Schedule* and this *Schedule* is the present DAC system. DACs are authorized to conduct independent assessments designed to balance the interests of both insurance companies and claimants. The April 2000 Disability DAC Assessment Guideline states that with regard to income replacement benefits, the "purpose of the DAC assessment is to offer an independent opinion that will assist these two disputing parties to resolve their dispute."

An insurer does not have the ability to require an applicant to attend a DAC in order to assess IRB entitlement. That choice rests with an applicant. I find that an applicant may meet his or her onus of identifying suitable employment by opting for a DAC assessment. This meets the intent of this system being accessible, expert, less expensive, and quicker. I find that L.F., by opting for a DAC assessment, has met his onus of identifying or trying to find potentially suitable employment. L.F. has also met his onus by cooperating with a variety of assessors, including Mr. M. Jean, a vocational evaluation

---

<sup>3</sup> Prior to January 1, 1994, Ontario Regulation 672 was called the *No-Fault Benefits Schedule*. After that date it became the *Statutory Accident Benefits Schedule — Accidents Before January 1, 1994*. In this decision, the term "1990 Schedule" will be used to refer to Regulation 672.

<sup>4</sup> *Singh and State Farm Mutual Automobile Insurance Company* (OIC A-005714, May 8, 1995).

<sup>5</sup> *Gagnon and Jevco Insurance Company* (OIC A-015357, May 1, 1996).

<sup>6</sup> *Wigle and Royal Insurance Company of Canada* (OIC A-012312, January 12, 1996).

specialist (as well as Dr. G.K. Lau, a psychologist) with Rehabilitation Network Canada Inc. (“Rehabilitation Network”) and with Ms. J. Rosario, a certified evaluator, in their 1998 and 1999 work evaluations, respectively.

The next question is whether L.F. suffers a complete inability to engage in employment which is identified as being reasonably suited for his level of education, training or experience.

A word-by-word analysis of the “complete inability to engage in any employment” test, based on *The Concise Oxford Dictionary of Current English* (1990, Clarendon Press, Oxford), might lead to the following interpretation:

complete:	. . . of the maximum extent or degree ( <i>a complete stranger, a complete surprise</i> ) . . .
inability:	. . . a lack of power or means . . .
engage:	. . . take part . . .
any:	. . . whichever is chosen . . .

The danger in a word-by-word analysis is that the sum may become greater than the whole; that extra requirements are added which were not initially intended when the legislation was drafted. In this case, such a literal interpretation can lead to a requirement of the maximum degree of lack of power or means to take part in whatever employment for which one is suited by education, training or experience.

As an example, a concert clarinetist may lose a forefinger. The fact that he or she still has the power or means of playing some notes cannot be determinative, as that limited power or means may be insufficient to assist him or her to obtain employment of an appropriate remuneration and status.

A review of the case-law on this evolving issue reveals the following:

In *Lombardi and State Farm Mutual Automobile Insurance Company* (FSCO A99-000957, April 11, 2001), Arbitrator Sampliner held that:

I find that “complete inability” does not require the degree of impairment that is as high as a “catastrophic impairment” so as to preclude legitimate claims for ongoing disability, nor so low as a “substantial inability,” as that would encourage specious claims after the first 104 weeks.

In *Terry and Wawanesa Mutual Insurance Company* (FSCO A00-000017, July 12, 2001), Arbitrator Palmer held that:

Somehow the ability to engage in a reasonably suitable job, considered as a whole, including reasonable hours and productivity must be addressed. In my view, Mr. Terry has convincingly demonstrated in his attempt at a work trial that he is completely unable to engage in a sedentary job for which I find he was reasonably suited. He would be unable to consistently attend and sustain a reasonable number of hours of employment as a taxi dispatcher or any similar job.

In *Horne and CIBC Insurance* (FSCO A00-000291, December 20, 2001), Arbitrator Sone concurred with the views of Arbitrators Sampliner and Palmer on this evolving area of the law. I do as well.

### ***The Applicant's case***

The Applicant testified that there is no job that he can presently do. He stated that his symptoms have worsened over time. He testified that his headaches now require injections and that he has burning sensations going down his back and his feet. L.F. testified that he uses medication, a heating pad, liniment and a TENS machine to attain only limited pain relief.

The Applicant relies on the opinions of several doctors as confirming the requisite level of disability.

*Dr. W.O. Geisler*

Dr. W.O. Geisler, Professor Emeritus (Medicine) of the University of Toronto, initially interviewed L.F. for almost five hours on January 4, 2000. His 24-page January 11, 2000 report indicated that L.F. complained of ongoing headaches, sleeplessness, peripheral burning, lower limb pains, neck and scapular region pain and hand aching, as well as being irritable, anxiety-laden and depressed, with a diminished sense of energy and uncertainty about his future.

A further report dated December 1, 2000 followed a three-hour examination on November 29, 2000. Dr. Geisler was of the view that “it is thoroughly unrealistic to believe that this patient could compete in any reasonable employment environment and I would therefore categorize him as having a complete inability to engage in any employment for which he is reasonably suited by education, training or experience.” Dr. Geisler, however, was very vague as to the basis of this opinion, referring to “the knowledge, that I have, my interview with the patient and my observations.”

Dr. Geisler felt that L.F.’s symptoms were a mixture of organic and psychological causes and in part, iatrogenic (noted in the December report as “the relative failure of his therapy and his interpretation of reactions by his physicians”). Dr. Geisler did not believe L.F. was malingering.

*Dr. A.R. Chaudri*

Dr. Chaudri is a family doctor, who has seen L.F. since 1998. He opined in his December 5, 2000 report that L.F. “continues to suffer a complete inability to engage in any employment which he is reasonably suited by education training or experience. The reason I am confidently able to say this is that I have assessed the patient on a [sic] numerous basis as his family and treating practitioner and I believe the patient is not malingering and is motivated to get on with his life . . . I believe the patient does have some pain focus behaviours, however, pain is a subjective entity and is quite variable from person to person.”

Dr. Chaudri appears from his report to be a sympathetic doctor, which is commendable. However, he appears to accept, without reservation and often with little or no explanation, just about any suggestion apparently put to him by counsel for L.F., which undermines the weight that can be given to his opinion (see also below, regarding attendant care and the TENS unit).

*Dr. S.E. Scherer*

Dr. Scherer, a psychologist, prepared two reports in the year 2000, evidently at the referral of the Applicant's counsel. Dr. Scherer's diagnoses were Adjustment Disorder with Mixed Emotional Features and a Pain Disorder associated with medical and psychological factors. Dr. Scherer opined that L.F. "perhaps could work a sporadic schedule over the course of the work week, daily, regular, part time or full time employment remains highly unlikely." Dr. Scherer felt that if L.F. could obtain any employment, he would be relegated to accept limited hours in an unskilled position offering significantly reduced pay and responsibility with far less opportunity for promotion and earnings advancement. Considering that at the time of the accident L.F. was working at only slightly above minimum wage as a cook, I find that Dr. Scherer has significantly overstated L.F.'s pre-accident vocational profile.

Dr. Scherer's view was that "[a]ssuming the pain experience of [L.F.] is as he reports, it is highly doubtful that an individual having this level of discomfort and restriction would be capable of performing any job on a steady full time basis, including sedentary physical demand work . . . Individuals with these restrictions rarely are capable of coping with even steady part time employment (e.g. four hours daily, five days weekly). While [L.F.] might be able to manage some days work at this level there would be concern that he would not be able to maintain himself on a regular work schedule."

Dr. Scherer based his opinion in significant part on L.F.'s inability to persist with the DAC assessment in late 1999 or to persist with the three-day assessment involving "entirely sedentary" activities at Dr. Scherer's Read Clinic in May 2000. Dr. Scherer states that L.F. "was observed on each

assessment date to exhibit marked pain behaviour; such behaviour persisted even when L.F. was (unknowingly) being observed by a clinician. The longest he was able to remain was five hours (with frequent rest and stretching breaks) during one testing session, which in turn required multiple sessions for completion.”

*Dr. H.B. Scher*

Dr. Scher is a psychologist to whom L.F. was also apparently referred by his counsel. Dr. Scher saw the Applicant over a three-day period in February 2000, during which L.F. underwent a clinical interview and a battery of neuropsychological and psychological tests. Dr. Scher also concluded (in his March 10, 2000 report) that L.F. met the criteria of a DSM-IV<sup>7</sup> “Pain Disorder (chronic) associated with a medical condition and psychological factors, as well as an Adjustment Disorder (chronic and severe) with prominent features of anxiety and depression. These conditions (which include chronic sleep disturbance) result in poor energy and a severe inability to exercise normal cognitive powers. In my opinion, he is substantially disabled from returning to competitive employment or leading a normal life.”

Dr. Scher stated that there was objective evidence of good motivation by L.F., based on testing which was highly sensitive to submaximal effort. He was of the view that the Applicant, despite good motivation, had difficulty “sustaining the concentration required throughout the evaluation, likely on account of chronic sleep disturbance, high levels of pain and associated emotional distress.”

Dr. Scher found L.F. to be much below average intelligence. He felt that L.F. did have marked cognitive impairment, but this was likely related to chronic pain and sleep disturbance as opposed to traumatic brain injury. I accept this opinion that any cognitive impairment being suffered by L.F. is not a result of traumatic brain injury.

---

<sup>7</sup>*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (1994, American Psychiatric Association).

*Dr. R. Kaplan*

Dr. Kaplan is a psychologist. His report dated December 5, 2000 is essentially a critique of the DAC disability report. Dr. Kaplan indicated, correctly I believe, that considerations of employability include whether one demonstrates the “speed, accuracy, consistency and productivity sufficient to be employable in any of the suitable occupations.” Dr. Kaplan concluded that “the behaviours observed of taking many breaks, complaining of pain, and leaving early would suggest that he cannot sustain employment over the full day, day after day, week after week, month after month . . . Our view is that those who have worked with him over sustained periods of time [presumably such as the family doctor, Dr. Chaudri, and the treating psychologist, Dr. R. Davila] would know if the behaviours observed by the DAC team were characteristic of his response to his pain condition and reflect that he has not recovered and found a way to work with his persistent impairments.”

*Dr. I.B. Schacter*

Dr. Schacter is a neurosurgeon. He saw L.F. on August 29, 2000. He subsequently opined that L.F. was not “able to engage in any of the employment possibilities based on his present status and education and training.” Dr. Schacter was not very fulsome regarding the basis of his opinion, which appears to be based on L.F.’s limited academic education and his physical problems combined with his depression and anxiety.

*Dr. R. Davila*

As noted above, Dr. Davila is a treating psychologist. Dr. Davila diagnosed, in his April 7, 2000 report, a Chronic Pain Disorder, as delineated in the DSM-IV, associated with significant impairment in social and vocational function, which he did not consider to be feigned. Dr. Davila noted that L.F. had a lot of guilt regarding the impact of his accident and the toll that it was taking on his fiancée. He describes L.F.

as feeling desperate, worthless, being treated as dirt as if he did not exist anymore, and eventually, fed up, having reached the point where he did not care any more.

Dr. Davila concluded that L.F. “will not be able to return to his pre-accident employment or any other employment for which he is reasonably suited until his pain condition resolves.” He stated that although L.F.’s pain condition was not his area of expertise, the prognosis from a psychological perspective was guarded given the chronic nature of the pain condition. His opinion was based on L.F.’s self-report, test results and clinical observations.

*Dr. A. Kachooie*

Dr. Kachooie is a physiatrist, doctor of physical medicine and rehabilitation consultant. In his December 12, 2000 report, he stated that L.F.’s “symptomatology is typical of patients with serious spinal fractures requiring surgical intervention in addition to mild traumatic brain injury syndrome, namely functional limitation in performing prolonged activities, associated pain and stiffness to the neck area, symptoms of radicular pain which have been quite disabling for L.F. at one point post surgically. His symptomatology and function has definitely improved at this point in time with involvement in continued active treatment . . . is certainly at high risk of recurring symptoms if he undertakes performing heavy physical labour work, working at the shoulder level, above his head.”

Dr. Kachooie critiqued the DAC disability assessment, which he felt “overall . . . fails to offer conclusive evidence with regards to L.F.’s level of disability.” He further stated that “[t]heir focus is on physical demands, they dismiss the impact of cognitive impairment, spatial dimension impairment, memory difficulties, poor learning abilities, limited problem solving, dexterity which are not taken into consideration regarding his future job recommendations.”

*Dr. G.K. Lau*

Dr. Lau is a psychologist. In his December 28, 1998 report, he scored L.F. in the range of “severe” based on the Beck Depression and Anxiety Inventories. L.F. endorsed the following comments: “I feel the future is hopeless and that things cannot improve; I feel I have failed the average person . . . I feel guilty all the time; I feel I am being punished; I am disgusted with myself; I blame myself for everything bad that happened . . . I have lost most of my interest in other people.” Dr. Lau’s diagnosis was also a Chronic Adjustment Disorder with Depression and Anxiety Features (Moderate Severity) and Chronic Pain Disorder with a General Medical Condition and Psychological Factors. He also gave a guarded prognosis given the chronicity of L.F.’s difficulties.

In his November 22, 2000 report, Dr. Lau stated that L.F. appeared to be experiencing a lot of pain when sitting for a long time and that he “came across as genuine, and his remarks were forthcoming. He was also polite and pleasant throughout the interview.” He found L.F. to be “substantially disabled from returning to any work” given his severe level of depression, anxiety, pain problems and cognitive difficulties.

***The Insurer’s case***

*Credibility*

The Insurer submitted that L.F.’s case was essentially based on subjective complaints, which required one accepting him as credible. The Insurer submitted that L.F. was not credible. It pointed to what it termed his poor work history, his failure to try to reintegrate into the labour market, inconsistencies between his testimony and surveillance and his presentation at the hearing as exaggerating his symptoms. My findings in this regard are set out below.

*The disability DAC*

The Insurer further relied on the disability DAC, the Assessment Summary of which (dated January 18, 2000) concluded that the Applicant “did not, in fact, demonstrate to our satisfaction that he was **completely unable** to engage in any employment for which he was reasonably suited by virtue of education, training or experience as a result of this accident” [emphasis in the original]. In essence, the DAC based this conclusion on L.F.’s “inconsistent and submaximal performance.”

I have three fundamental concerns with this conclusion.

Firstly, there are different reasons why one may have an “inconsistent and submaximal performance.” One might be a person consciously feigning or exaggerating a sick role for monetary or other advantage. Or, one might truly be in pain. One may be afraid that the activity requested may cause pain. One may be significantly depressed. One may be distrustful of the independence, motives and/or neutrality of the assessor or the process.

I note, as an example of an alternative explanation, the Insurer’s expert, Ms. Lai, in her November 23, 1998 report, wherein she stated that “[o]verall testing revealed that the claimant has a high-perceived disability, which may have limited the participation during the testing.”

Psychiatrists, psychologists and other medical practitioners, in part, provide evidence as to the character, motivation and genuineness of the applicant; in a nutshell, whether an applicant is legitimate.

Dr. J. Douglas Salmon is a psychologist. He conducted a “neurovocational assessment report” as part of the disability DAC. As with several of the Applicant’s experts, Dr. Salmon’s diagnosis was that L.F. “appears to present with an **Adjustment Disorder with Mixed Emotional Features** secondary to his experienced level of pain . . . A **Pain Disorder with associated Medical and Psychological Factors** is also a likely appropriate diagnosis” [emphasis in the original].

The DSM IV, at p. 458, states that:

The essential feature of Pain Disorder is pain that is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention (Criterion A). The pain causes significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B). Psychological factors are judged to play a significant role in the onset, severity, exacerbation, or maintenance of the pain (Criterion C). *The pain is not intentionally produced or feigned as in Factitious Disorder or Malingering* (Criterion D) . . . [emphasis added]

Dr. Salmon, in his January 2000 report, described L.F. as “pleasant and cooperative.” He further states that “[d]uring testing, he was said to have been pleasant and cooperative and to have put forward a good effort,” although he “had some difficulty understanding instructions, tended to work slowly, and was easily frustrated at times. Overall test results suggested an invalid performance relative to his clinical presentation and reported occupational history.” Dr. Salmon, however, concludes that his “final hypothesis would be that of (un)conscious symptom exaggeration.”

I am not sure how one can be faulted for “(un)conscious symptom exaggeration,” especially in light of Dr. Salmon’s comment that L.F.’s emotional stress was likely aggravating and maintaining his pain.

A second difficulty with the disability DAC report is the implied assumption either that L.F. has the consistent ability to work competitively and remuneratively or that this is not a relevant consideration. At page three of their Assessment Summary, the DAC concludes that testing did provide “an indication of minimal baseline function in which L.F. demonstrated physical and functional capabilities within the **limited to light physical demands level of work**” [emphasis in the original].”

However, in her January 18, 2000 Assessment of Function, Ms. S. Wong states that on the first day of his three-day assessment, L.F. left at 2:08 p.m. with complaints of pain, dizziness and a “needles” sensation in the back of his head. On the second day, he stayed until 4:03 p.m., the third day until 1:30 p.m. (in Ms. Wong’s words, “despite having had an opportunity to lie down for almost 2 hours”). She further states that “[L.F.] required frequent rest breaks prior to, during and following assessment tasks.”

The Assessment Summary notes that the DAC was advised by L.F.’s counsel that following the last day of assessment he “became quite functionally incapacitated at home.” There is an entry for that date (November 25, 1999) in the notes of Dr. Chaudri, L.F.’s family doctor. The writing in the entry is difficult to discern, but as best I can read it, L.F. was crying, indicating that he had been assessed by Toronto Medical Associates who had, I believe the words say, “hurt him” and that he was “forced by staff to carry” what I believe says “five-pound weights,”

Given this evidence, it is hardly surprising that the disability DAC itself stated that this “raises the question, of course, particularly when coupled with the psychological diagnosis of Pain Disorder, as to whether or not [L.F.] is indeed capable of engaging in any employment for which he is reasonably suited.”

Which leads to a third concern, that of “onus” in a medical examination. This is implicitly addressed in the disability DAC Assessment Summary statement that L.F. failed to “demonstrate to our satisfaction that he was **completely unable** to engage in any employment for which he was reasonably suited by virtue of education, training or experience as a result of this accident” [emphasis in the original].

This is explicit in Dr. Ameis' paper review for the Insurer dated August 7, 2001. It was Dr. Ameis' opinion that few people will meet the post-104 test because of usual improvements, job accommodation, and vocational rehabilitation. He stated that "[i]nsofar as the onus is on the patient to prove complete inability to work, the assumption that the DAC must begin from is that the patient is not disabled until proven otherwise by clinical evidence: unless valid proof of disability is obtained the only conclusion open to the DAC is that the initial premise is valid, and the patient is not disabled." He stated that "[t]o be completely unable to work, the injured person must demonstrate that there are no prospects for successful work return utilizing either old or new skills and education, or prior experience." He further opines that of the small number of persons who meet "this rigorous threshold," most who would meet the test would also meet the test of catastrophic impairment but that there are those who meet the test of catastrophic impairment who would not meet this test.

Regarding this Applicant, Dr. Ameis stated that L.F. "did not persuasively demonstrate the complete inability to engage in suitably selected employment." He was of the view that "[m]aximum effort must be consistently exerted in order for test results to be both valid and reliable" and that "[w]hen a patient chooses to provide less than consistently full effort in a test, the results pertaining to the quantification of either impairment or residual capacity are invalidated and deemed unreliable."

Applicants do not "prove" a medical condition to a medical examiner, be it AIDs, cancer, strain or sprain. Medical examinations are not judicial proceedings. Medical practitioners are not adjudicators. Medical practitioners may be qualified as experts. Experts can give opinion evidence. If a medical expert is unable to provide an opinion within one's area of expertise, based on the history provided, the examination and testing conducted and the present level of scientific knowledge, one should say so and why, rather than render judgment based on a presumed medical onus of proof.

Dr. Ameis speaks of a patient "choosing" to "provide less than consistently full effort in a test.

I take it that Dr. Ameis is speaking of L.F. It is noteworthy that Dr. Ameis has never examined or even met L.F. He appears to rely on the disability DAC assessment. Dr. Salmon, however, who saw L.F. first hand and, as a psychologist, one might think would have greater expertise in this area, was of the view, as were other experts, that L.F. had a medically recognized Pain Disorder, which is distinct from intentionally producing or feigning pain, and by extension, disability.

**(d) Conclusion**

I agree with Arbitrator Makepeace in *Quattrocchi and State Farm Mutual Automobile Insurance Company* (OIC A-006854, September 29, 1997) that “an insured may be found entitled to benefits because of disabling pain, despite there being no objectively confirmable impairment.” Hence, the comments of Dr. M. Ford, who conducted an insurer’s orthopaedic examination in 1998 that there were “no objective determinants,” is not determinative. I further agree with Arbitrator Makepeace that “[w]here there is no objective evidence of impairment, or the objective evidence does not explain the degree of pain reported by the insured person, the insured’s credibility becomes important.”

As a witness, L.F. was cautious in his evidence. There were instances of exaggeration. As noted by counsel for the Insurer, L.F. sat rigidly throughout the hearing, in contrast to how he appears in the surveillance evidence.

However, a hearing is an artificial environment. I have no ability to look into the soul of another person nor feel their symptoms. Here is a man who has been investigated, probed, poked and invaded (including, for reasons which escape me, a rectal digital examination by one of his own experts). One can understand his distrust and being generally and genuinely angry.

In assessing L.F.’s subjective pain complaints, I must consider all of the circumstances, including the consistency of the insured person’s complaints and apparent functional level.

I note that L.F. did not have an especially impressive pre-accident employment history. However, he was employed full-time at the time of the accident and had a considerable attachment to the labour force, albeit at the lower end of the economic scale.

I also find it important that L.F. has not made any direct effort to return to the labour force. I find, however, that he has made considerable efforts to endeavour to rehabilitate himself. In her March 1999 report, Ms. J. Gilbert, with Brain Injury Rehabilitation Inc., stated that the Applicant appeared “highly motivated.” Drs. Becker and Oshidari, in their DAC assessments, both described L.F. as cooperative. Dr. Scher notes regarding psychological testing in February 2000, that L.F. by the afternoon, “was quite distraught . . . due to frustration associated with the testing, to the point where he was in tears.” In his June 28, 1999 report, Dr. Davila stated that L.F. was “a remarkable compliant client; he participated actively and eagerly in the treatment sessions, he attended our sessions regularly and punctually, he followed the advice provided, and worked on his own between treatment sessions processing the main issues worked in our sessions. His commitment to his rehabilitation was evident and there were no indications of symptom over-reporting or fabrication of symptoms.”

Dr. B. Sher, D.C., of Rosedale Chiropractic & Physiotherapy Centre (“Rosedale”), in his oral testimony described L.F. as very compliant and enthusiastic regarding treatment, often coming in every day of the week. He stated that L.F. was very motivated to get better, that while some patients had to be pushed, L.F., at the end of treatment, was in on his own accord, that he was very motivated to do whatever suggestions the clinic had and rarely missed a treatment.

I find L.F. to be a man of limited intellect (as documented, by amongst others, Dr. Sher and Dr. Scherer) and limited employment options. I accept the opinions of Drs. Geisler, Scherer, Scher, Kaplan, Lau and Salmon that L.F. has a pain disorder as a result of a combination of physical and emotional factors. I accept that L.F. has endeavoured to rehabilitate himself, but that he is now overwhelmed by this accident by factors beyond his control.

I find the surveillance submitted essentially consistent with a largely non-taxing lifestyle (I note that the DAC summary assessment states the surveillance did not contribute to their overall opinion). The surveillance, especially that conducted during the disability period in question, shows L.F. walking, sitting down, and generally moving slowly. I note, in June 1999, the Applicant sitting down and tying his shoe laces, not by bending over, but rather by raising his legs up. July 2001 surveillance shows the Applicant attending for several hours at High Park, accompanied by two other individuals. What is very noticeable is the relative lack of activity performed by this former competitive runner, who attended the 1988 Olympic trials and previously enjoyed a variety of sports. The video surveillance does not show L.F. running, playing soccer, throwing a frisbee or engaging in any other even moderately demanding physical activity.

I accept the statements noted by Dr. Lau, in his November 22, 2000 report, that L.F. now has extremely low self-esteem and has lost the motivation to do things. I found L.F. credible on the relevant testimony regarding his IRB claim. I accept his evidence of being depressed, stressed, anxious, frustrated and wishing to be alone. I accept that his intimate relationship with his fiancée has been affected, that some days he does not want to even be touched by her.

I further accept the evidence of Dr. Casses of the St. Joseph's Hospital DAC of March 1998, that L.F. had "sustained a very risky injury to his cervical spine" and was lucky that he only received a partial dislocation of his cervical spine without major damage to nerve roots or spinal cord. I further accept the 1997 orthopaedic opinion of Dr. T. Wilson, whom L.F. saw at the Insurer's request, that the Applicant "will never have normal range of motion in his neck" and will always have certain level of symptomatology. I accept the 1998 finding of Rehabilitation Network that L.F. was not able to attend a full day of assessment (which was consistent with the 2000 disability DAC assessment) and that his "pain behaviours demonstrated were consistent with the nature of [his] injuries."

I accept that reasonable employment for which L.F. is suited is semi-skilled employment of approximately 30 hours a week (i.e. four-day full time shifts or five six-hour shifts), at or near

minimum wage. I find that the dishwasher, recreational facility attendant, parking lot attendant and host positions identified by the post 104-week DAC meet these requirements.

I am persuaded, on a balance of probabilities, based on the weight of all of the medical evidence and my findings set out above, that L.F. has been unable and continues to be completely unable to maintain continuing, competitive, productive employment (which encompasses close to full-time hours) for which he is reasonably suited, due to his pain and other complaints resulting from this accident. Accordingly, I find that L.F. continues to meet the post 104-week disability test and is entitled to payment of weekly income replacement benefits at the agreed rate of \$185 ongoing from January 24, 2000.

## 2. Attendant Care

### (a) *the claim*

L.F. claims attendant care benefits pursuant to section 16 of the *Schedule*. The latter provides, in part, that an insurer shall pay an insured person (who sustains an impairment as a result of an accident) all reasonable and necessary expenses incurred (by or on behalf of the insured) for services provided by an aide or attendant as a result of the accident.

L.F. submits the following expenses for services provided by his parents and his fiancée:

S	January 12 to March 30, 1997 @ \$5,506.01 per month	=	\$13,769.00
S	April 1 to August 30, 1997 @ \$808.68 per month	=	4,033.40
S	August 30, 1997 to Dec. 18, 2000 @ \$134.68 per month	=	3,366.25
			<hr/>
			\$21,168.65
		Less payments made	4,764.46
			<hr/>
		Net	\$16,404.19

Plus continuing monthly expenses of \$134.68 ongoing from December 19, 2000.

It is clear that L.F. sustained an impairment (defined in section 2 of the *Schedule* as “a loss or abnormality of a psychological, physiological or anatomical structure or function”) and that his impairment was sustained as a result of the January 1, 1997 motor vehicle accident.

In dispute is whether the expenses claimed are reasonable and necessary. Further, there are questions as to what, if any, limits exist on the amount and duration of the benefit (and the effect, if any, of the transitional provisions of section 70 of the *Schedule*) and whether L.F. has “incurred” attendant care expenses.

**(b) What are the implications of the transitional provisions of subsection 70(3) of the Schedule?**

The pertinent portion of section 70 states:

(1) Despite anything else in this Regulation, if a motor vehicle liability policy is in effect on the day this Regulation comes into force, subsections (2) and (3) apply until the earlier of the following:

1. The first expiry date under the motor vehicle liability policy.
2. The date on which the motor vehicle liability policy is terminated by the insurer or the insured.

...

(3) The sum of the medical, rehabilitation and attendant care benefits paid under the motor vehicle liability policy for any one accident in respect of an insured person who does not sustain a catastrophic impairment as a result of the accident shall not exceed \$1,000,000, and the limits set out in clauses 19(1) (a) and (2) (a) do not apply.

The parties agree that L.F. falls within section 70. The parties disagree as to the effect of this provision.

The Insurer submits that because this transitional provision speaks specifically to monetary limits and is silent regarding duration, the subsection 18(2) 104-week limit on attendant care benefits under this *Schedule* stands.

The Applicant submits that section 70 can only be given a rational meaning by interpreting it as also setting aside the 104-week time period limit under subsection 18(2).

Subsection 19(2) of the present *Schedule* states that the maximum attendant care benefit payable in respect of an insured is \$72,000 (except where the insured sustained a catastrophic impairment as a result of the accident, which is not argued in this case).

I find that \$72,000 is not a randomly selected number. Rather, it is the mathematical result of the maximum period normally available for attendant care (twenty-four months under subsection 18(2), i.e. 104 weeks or two years) multiplied by the maximum monthly amount for attendant care (\$3,000 under paragraph 16(5)(a) for non-catastrophic impairment).

\$3,000 was also the maximum monthly amount available for attendant care under the preceding *1994 Schedule*<sup>8</sup> (excepting for more significant injuries as specified). There was, however, no time limit on attendant care benefits available in the *1994 Schedule*. There is no indication in the present *Schedule* of any intent to liberalize the available monthly amount for attendant care.

If effect were to be given to both subsection 18(2) (the durational limits) and paragraph 16(5)(a) (the monetary maximums) of the present *Schedule*, then the maximum amount available for attendant care would remain at \$72,000, despite the transitional provision of section 70.

---

<sup>8</sup>The *Statutory Accident Benefits Schedule — Accidents after December 31, 1993 and before November 1, 1996*, Ontario Regulation 776/93, as amended by Ontario Regulations 635/94, 781/94, 463/96 and 304/98.

I do not find this to be “a reasonable and just outcome.”<sup>9</sup> Nor is this result consistent with the “general presumption that changes to the wording of legislation are purposeful.”<sup>10</sup>

Rather, I find that a “just and reasonable outcome” is obtained only by interpreting subsection 70(3) of the *Schedule* regarding paragraph 19(2)(a) as continuing a \$3,000 monthly maximum (now enshrined in paragraph 16(5)(a) of the *Schedule*) and thus consequentially setting aside the subsection 18(2) durational limit and continuing the indefinite availability of attendant care benefits.

Succinctly, I find that there is no limit on the duration of available attendant care in cases where section 70 applies. I find that section 70 does not disturb the monthly limit of \$3,000 available for attendant care.

**(c) “Incurred”**

The parties agreed that the Ontario Court of Appeal decision in *Monachino and Liberty Mutual Fire Insurance Company et al.* [2000] 47 O.R. (3d) 483 (involving a claim for caregiver benefits under the *1990 Schedule*<sup>11</sup>) was decided under earlier and different legislation and does not apply.

---

<sup>9</sup>Director’s Delegate Draper in *Tustin v. C.G.* citing the Court of Appeal in *Bapoo v. Co-Operators General Insurance Co.* (1997), 36 O.R. (3d) 616:

The interpretation of a statutory provision should not only comply with the legislative text and promote the legislative purpose, it should produce a reasonable and just outcome. . . . Avoiding unjust or unacceptable results is an essential part of the court’s task in interpreting statutory language. (p.624)

<sup>10</sup>Director’s Delegate Naylor in *State Farm Mutual Automobile Insurance Company and Kristensen* (FSCO P99-00051, July 6, 2000) citing *Dreidger*, p. 451.

<sup>11</sup>The *Statutory Accident Benefits Schedule — Accidents On or Between June 22, 1990 and December 31, 1993*, Regulation 672 of R.R.O. 1990, as amended by Ontario Regulations 660/93 and 779/93.

Finlayson J.A. (speaking for the majority) had held that “[c]aregiving services by members of a loving family are not an expense or cost in the contemplation of this statutory framework.” The Insurer very fairly referred to subsection 2(7) of the *Schedule* which states that “an aide or attendant . . . includes a family member or friend who acts as the person’s aide or attendant, even if the family member or friend does not possess any special qualifications.”

State Farm, however, submitted that “[t]here are several decisions which stand for the proposition that for an expense to be ‘incurred’ it must have been paid for or there must be a promise to pay for it or there must otherwise be some legal obligation to pay the expense.”<sup>12</sup> State Farm submits that the evidence in this case is that no attendant care expenses have actually been incurred. Care was provided by L.F.’s parents and his fiancée. However, both the Applicant’s mother and his fiancée testified that they were never told by L.F. that they would be paid any monies for the care services they performed. L.F. has, in fact, received \$4,495.10 from State Farm for attendant care (Exhibit 11, Document “kkkkkkkk”).

In *Lombardi*, (supra) which dealt, in part, with attendant care benefits under this *Schedule*, Arbitrator Sampliner held that:

The insured or another person acting for them must either have paid money or incurred a debt to reimburse the services.<sup>13</sup> I agree with the case law that these sections are clearly intended as indemnity coverage for actual expenses incurred.<sup>14</sup>

---

<sup>12</sup>*Lombardi and State Farm Mutual Automobile Insurance Company* (FSCO A99-000957, April 11, 2001), *Horne and CIBC Insurance* (FSCO A00-000291, December 20, 1991), *Jelisc and Guarantee Company of North America* (FSCO A98-000029, April 8, 1999), *Morelli and Zurich Insurance Company* (FSCO A97-001997, January 14, 2000).

<sup>13</sup>*The Concise Oxford Dictionary* (Oxford University Press, 8<sup>th</sup> ed. 1992) p. 411, 599 [footnote in original]

<sup>14</sup>*Jelisc and Guarantee Company of North America* (FSCO A98-000029, April 8, 1999) [footnote in original]

The Insurer noted that the Applicant's mother testified that neither she nor her husband had received one penny for the services which they provided their son. The Applicant's fiancée testified that she provided her services voluntarily, that L.F. never promised her any payment, nor was she ever told that she would be paid anything.

Director's Delegate Draper, in *Moons and Co-operators General Insurance Company* (FSCO P00-00033, May 28, 2001), considered, without explicitly adopting, the following definition of "expense" from *Black's Law Dictionary* (6<sup>th</sup> Edition):

That which is expended, laid out or consumed. An outlay: charge: cost: price.  
The expenditure of money, time, labor, resources, and thought. That which is expended in order to secure benefit or bring about a result.

The Applicant submits that it is a "reasonable and a rational construction" of section 16 that the requirement that the insurer pay for "all reasonable and necessary expenses incurred" for services provided by an aide or an attendant includes "where there has been an expenditure of 'time, labour, resources and thought' by the Applicant's family for his attendant care needs resulting from this accident.

The Ontario Court (General Division) dealt with the interpretation of the word "incurred" in *Smith (Committee of) v. Wawanesa Mutual Insurance Company*, 42 O.R. (3d) 441. Mr. Justice Campbell concluded that:

. . . an insured, to incur an expenditure within four years within the meaning of the standard policy, need not actually receive the items or services or spend the money or become legally obliged to do so. It is sufficient if the reasonable necessity of the service or item and the amount of the expenditure are determined with certainty before the end of four years. It is a question of fact in each case, whether the requisite degree of certainty has been established.

This decision was followed by Arbitrator Wilson in *Stargratt and Zurich Insurance Company* (FSCO A99-000521, October 4, 2001). I note that the Ontario Court of Appeal, in *Hope v. Canadian General Insurance* [2002] O.J. No. 1643 subsequently disagreed with the result in *Smith* as to the duration of the benefit period, without “commenting on the merits of the analysis.”

I find that section 16 recognizes that, although attendant care benefits are payable to the insured person, the latter is or will be merely a conduit to the person ultimately entitled to this benefit, namely, the aide or attendant. In this case, I am persuaded that L.F.’s parents and his fiancée are entitled to whatever attendant care benefits are owing regarding their services.

As arbitrators, we, in part, under section 279 of the *Insurance Act* R.S.O. 1990, c.I.8, are charged to determine “entitlement” to statutory accident benefits.

Entitlement can arise in different forms. Entitlement can arise by reason of one’s status. A paragraph 25(2)(1) death benefit is payable to a spouse without monetary prerequisites.

Entitlement can arise by reason of one’s condition. Non-earner benefits are payable to those who sustain a requisite level of disability without the prerequisite of having sustained a monetary loss.

Entitlement can arise by reason of one’s need for goods and services. Such services include attendant care services under section 16. Payable are “expenses incurred by or on behalf of the insured person,” as long as they are “reasonable and necessary.” I am persuaded that L.F. sustained a need for attendant care benefits following this January 1, 1997 accident as a result thereof, having sustained a cervical dislocation of his cervical spine in addition to other injuries.

I accept the Applicant's evidence that when he was released from hospital on January 12, 1997, rather than return to live with his sister, he moved in with his mother (who had been a nurse) and father who could, and who did, take care of him, and that he subsequently received care from his fiancée. I accept, as set out below, that there were reasonable expenditures of time and labour for attendant care, and that these are incurred expenses which the care providers earned and to which they are ultimately entitled.

I further rely on section 39 of the *Schedule* which states, in part, that if an insurer determines that an insured is not entitled to an attendant care benefit, it shall require a DAC assessment within 14 days after receiving the application, and pending receipt of the DAC report, **shall** pay the attendant care benefit. The DAC determination is binding, subject to an adjudicator's order. Section 39 (and section 43, as set out below at page 56) create entitlement rights to insured persons regarding continuing attendant care benefits. They provide at the disposal of an insured an immediate interim monetary benefit where a neutral examiner has determined the need for attendant care, so that insureds, while in pain and disability following an accident, do not have to scramble for assistance, relying essentially on the voluntary kindness of family and friends.

State Farm did not comply with these provisions. It denied the Applicant an opportunity to have his entitlement appropriately assessed by a DAC. Nor did it pay, in full or in a timely manner, the attendant care assessed as required in November 1998 by Ms. R. Lai, its own expert retained for an insurer's medical examination for that very purpose. Its eventual payment of limited attendant benefits in February 2000 implicitly, however, supports my conclusion of L.F.'s entitlement to reasonable and necessary attendant care benefits.

L.F.'s mother and his fiancée both testified as to the extensive assistance that they provided the Applicant after this accident. The question is, what expenses are reasonable and necessary.

**(d) “Reasonable and Necessary”**

By letter dated December 29, 1998, L.F. wrote to State Farm detailing his attendant care claim. L.F. divided his claim between three periods, namely, January 12, 1997 (his hospital discharge) to March 30, 1997 (his move to Thunder Bay); April 1 to August 30, 1997 (his Thunder Bay residency); and from August 31, 1997 (his Toronto residency).

**(i) *January 12 to March 30, 1997***

In his December 1998 letter, L.F. claimed 84 hours per week of attendant care provided by his father for this initial two-and-a-half month period. However, in his oral testimony, L.F. stated that the assistance was provided by both of his parents.

In respect of this initial period, L.F. filed a report of Ms. E. Poon, an occupational therapist with Rehabilitation Network, based on her November 27, 1998 assessment. Ms. Poon opined that L.F. required 168 hours (24 hours per day or 722.4 hours per month, for a monthly total of \$5,506.01) of strictly attendant care per week (double that which L.F. himself was seeking at roughly the same time). Three quarters of the attendant care supported by Ms. Poon addressed L.F.’s mobility needs. Ms. Poon felt that L.F. required 24-hour attendant care as it was unsafe for him to ambulate or transfer independently, including on and off his bed. The Applicant’s mother testified that she did not feel it was safe for her son to get up on his own. She further stated that either she or her husband would be with their son almost all of the time he was on his feet.

The Insurer relies on the January 19, 2000 report of Ms. Lai, an occupational therapist with Choice Rehabilitation Services, regarding this same January to April 1997 period. Ms. Lai considered that 66.93 hours per month of attendant care was warranted for this period. The main difference between the reports is that Ms. Poon felt that 129.3 hours per week was required to assist L.F.’s mobility, whereas Ms. Lai was of the view that about half an hour per week was sufficient.

Hence, the question for this first period is largely whether or not it was reasonable and necessary for the Insurer to pay for a full-time aide or attendant to be essentially on stand by whenever L.F. needed to leave his bed.

I am not persuaded that this was reasonable or necessary. Ms. Poon did her assessment more than a year and a half after the period claimed. She appears to have relied entirely on the recollection of the Applicant and his fiancée. Ms. Poon provides no independent medical support for her assertion that “[s]ince [L.F.] was unsafe to ambulate/transfer independently, [L.F.] required 24 hour attendant care.”

Conversely, there is a March 20, 1997 contemporaneous consultation note from L.F.’s treating neurosurgeon, Dr. E.G. Duncan, which states that “[t]here are no restrictions on activities at this time.” In his prior discharge note, dictated January 11, 1997, Dr. Duncan does state that L.F. should wear an Aspen Collar when out of bed; he does not note any assistance that the Applicant might require while out of bed.

In a subsequent letter to State Farm, dated March 11, 1999, Dr. Duncan states that while certainly in the first one to two months following discharge from hospital it may have been appropriate for L.F. to have received assistance, given that L.F. had a mild neurologic deficit and that his recovery was uncomplicated, the 84 hours per week claimed for attendant care was excessive. Dr. Duncan does, however, qualify his opinion by noting that while he provided acute surgical treatment for the Applicant, his training and expertise did not qualify him to comment on the specifics of L.F.’s attendant care claim and in particular the associated costs.

L.F. attended fifteen physiotherapy sessions at the Memorial Hospital in Bowmanville, Ontario, between January 28 and February 27, 1997 (that is, during the period in question). Ms. L. Faulkner, RPT, notes in a May 5, 1997 note to the Insurer that initially L.F. had a walking tolerance of 15-20 minutes which progressed, by discharge, to up to 45 minutes. There is no notation of the need

for someone to be by L.F.'s side at all times. I do not find this consistent with a reasonable and necessary need for round-the-clock attendant care.

L.F. failed to point to anything in the boxes of documentation filed that contemporaneously confirms the reasonable and necessary need for 24-hour care. A later family doctor, Dr. Chaudri, states at page eleven of his December 5, 2000 report that \$5,500 per month of home care assistance was reasonable and necessary for the first three months, given the nature of his injuries including surgical fusion of his C-4 fractures. Dr. Chaudri, however, gives no explanation as to what particular services were reasonable and necessary, nor does he comment on the need for 24-hour attendant care.

Accordingly, I accept the evidence of Ms. Lai that 66.93 hours (or \$744.18) per month of attendant care was warranted for the period January 12 to March 30, 1997.

*(ii) April 1 to August 30, 1997*

In his December 29, 1998 letter, L.F. claimed 49 hours per week (seven hours per day) for attendant care for this period. Ms. Poon was of the view, based on her retrospective November 27, 1998 assessment, that L.F. required 18.53 hours of attendant care per week (79.69 hours or \$806.86 per month).

Ms. Lai estimated L.F.'s attendant care needs for the period April to October 1997 at 3.15 hours per week (or 13.54 hours per month, amounting to \$147.92 per month). The main difference between the opinions of Ms. Lai and Ms. Poon is that the latter assigns some 45 hours per month for meals, laundry and housekeeping, while the latter assigns less than two hours.

During this period, L.F. was under the care of Dr. L.E. Gillett in Thunder Bay (where he was residing with his fiancée). In a disability certificate date stamped June 26, 1997, Dr. Gillett did indicate that L.F.

suffered from an impairment that substantially prevented him from performing his pre-accident housekeeping and/or home maintenance activities, but failed to detail same or provide the basis for this opinion. No other contemporaneous expert opinion was provided. No contemporaneous records of assistance were provided.

I am persuaded as to the reasonableness of Ms. Lai's \$147.92 monthly assessment. I am not persuaded that the additional hours sought by the Applicant were reasonable or necessary.

*(iii) ongoing from August 31, 1997*

In his letter to State Farm of December 29, 1998, L.F. claimed 28 hours per week (four hours per day) of what he termed attendant care being provided by his fiancée, detailed as assistance being provided for cooking, doing dishes, laundry, dusting, grocery shopping, banking and assisting with medications when in pain.

The Applicant's expert, Ms. Poon, however, stated in her February 26, 1999 home assessment regarding the post August 31, 1997 period, that L.F. was living in a one-bedroom basement apartment with his fiancée, that he had resumed sweeping, dusting within reach and dishwashing, but that his performance was limited to short durations. She stated that L.F. was currently independent in all personal care activities, but that he required seventeen hours a week assistance in meal preparation and cleaning.

In her November 23, 1998 Assessment of Attendant Care Needs, Ms. Lai opined that L.F. required only \$134.68 (approximately eleven hours) of attendant care per month, largely in the area of the Applicant's fiancée providing ten minutes of massage per day and intermittent assistance.

Dr. W.O. Geisler is a Professor Emeritus of Physical Medicine and Rehabilitation at the University of Toronto. He was retained as an expert by the Applicant. His January 11, 2000 report indicates that he had read “all this documentation” and interviewed L.F. for almost four hours. On page 22 of his 24-page report he states: “I do not believe any attendant care is presently necessary.” Based on the opinions of the Applicant’s own expert, I am not persuaded that L.F. is entitled to attendant care benefits after January 11, 2000.

I further note the contemporaneous comments of Dr. R. McLachlan, neurologist, and Dr. Wilson in October 1997, that L.F. could cook and do housework, but could not lift (specifically heavy items) without marked discomfort. I also note the comments of Dr. Casses in March 1998 that L.F. was able to do dishes and vacuum, but with increasing pain, and Ms. J. Gilbert that L.F. was spending three to four hours a week doing household chores such as dishes, cleaning the bathroom, dusting, making the bed and general tidying. I also note the Applicant’s evidence that as a result of the treatment provided by Rosedale, he was able, in 1999, to do the dishes more, make the bed, sweep the floor, dust and basically try to keep his place clean.

Further, given L.F.’s more modest living arrangements and that the tasks encompassed under Form 1 (as set out in subsection 16(4) of the *Schedule*) differ from those of competitive employment in that they allow far greater flexibility in terms of timing, pacing and effort extended, I am not persuaded that the hours of attendant care advanced by Ms. Poon are reasonable or necessary.

I am persuaded that L.F. is entitled to Ms. Lai’s recommendations, namely \$134.68, for the period August 31, 1997 to January 11, 2000 (the date of Dr. Geisler’s report).

### 3. Medical Benefits

Section 14 of the *Schedule* entitles an insured to payment of “all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident,” falling within specified medical categories. L.F. claims payment of the following expenses:

**(a) \$9,737.65 for treatment provided by Rosedale Chiropractic & Physiotherapy Centre**

The parties agree the account of Rosedale is:

Active rehabilitation/physiotherapy	\$5,678.00
chiropractic care	1,319.65
massage therapy	2,660.00
behavioural therapy	<u>80.00</u>
	\$9,737.65 <sup>15</sup>

L.F. first attended at Rosedale on November 30, 1998. Dr. A. Kachooie, a treating specialist in Physical Medicine and Rehabilitation, had recommended in a September 9, 1998 consultation note to Dr. Chaudri, amongst other things, that L.F.’s rehabilitation program now include active physiotherapy, massage therapy, myofascial release, physical restoration and conditioning exercises, followed by a work-hardening program.

---

<sup>15</sup>Exhibit 24, Tab 2, is an August 1, 2001 letter from Rosedale listing the outstanding accounts as:

rehabilitation	\$ 9,673.53
chiropractic care	2,247.66
massage	4,531.53
behavioural therapy	<u>136.35</u>
	\$16,589.07

The difference in the accounts appears to be interest charged under section 46 of the *Schedule*. I do not see the basis of a clinic’s right to such interest, subject to the possible exception of a direct billing arrangement under subsection 44(2). The *Schedule* constitutes a contractual agreement between the insurer and the insured. Benefits under the *Schedule* are payable under subsection 44(1) to the person entitled to the benefit. Medical benefits under section 14 are payable to the insured person. I see no reason why interest on such benefits would be otherwise payable. Any interest owed by an insured to a clinic must, one would think, be pursuant to a separate agreement between the clinic and the insured. The rationale for this is that the significant interest component under the *Schedule* exists to encourage the swift provision of payable benefits, and hence insurable treatment, to insureds.

Dr. B. Sher is a chiropractor and the manager of Rosedale. He testified that the goal of the Rosedale treatment program was to return L.F. as much as possible to his pre-accident normal function. He stated that treatment begins initially with passive treatment (e.g. ultrasound and massage) together with active rehabilitation. The focus is to move away from passive to active care. The active program usually lasts twelve weeks, after which one moves to work hardening, if indicated, and then, if necessary, to supportive care.

Rosedale's first treatment plan is dated December 11, 1998. Dr. Sher is noted in the plan as the "regulated health professional." Six weeks of treatment is proposed, consisting of eighteen sessions for each of spinal manipulation therapy, massage therapy and progressive active rehabilitation as well as six sessions of behavioural therapy. The total cost is estimated at \$4,370. The plan states that at the end of the treatment, a return to activities of normal life is anticipated. The treatment plan is marked received by State Farm December 30, 1998.

This treatment plan was refused by State Farm by letter dated January 6, 1999. The reason for the refusal is simply given as being based on the reports of Drs. Ford and Hershberg, without any further explanation. Dr. Ford, an orthopaedic surgeon, had seen L.F. on November 18, 1998, (i.e. before the date of Rosedale's first treatment plan). Not surprisingly then, there is no mention of Rosedale's treatment plan in Dr. Ford's November 30, 1998 report. Dr. Ford, however, did opine that there was no requirement for any further formal treatment. Dr. Hershberg is a psychiatrist. His December 8, 1998 does not mention the Rosedale treatment plan.

The refusal letter states that the *Schedule* requires L.F. to be assessed by a DAC. It further states that if L.F. wishes to be assessed, he is to sign a consent to disclosure form. The refusal is evidently sent by State Farm to Rosedale by fax on January 13, 1999.

The State Farm letter of January 6, 1999 does not comply with sections 38 and 43 of the *Schedule*. The former required State Farm to conduct a DAC, the latter required the insurer to notify the DAC within 15 days. The DAC is not required *only* if within seven days of receiving notice of the DAC assessment, the insured gives written notice that the claim is not being pursued.

In the interim, Rosedale's second treatment plan, dated January 13, 1999, was received by the Insurer on January 21, 1999. This plan proposed an additional six weeks of spinal manipulation therapy, massage therapy and progressive active rehabilitation, at a cost of a further \$3,690. Again, an anticipated return to normal life is indicated for L.F. at the end of the treatment plan. There is no indication in this second plan as to why the first plan did not meet its goal or why this plan would succeed where the preceding plan evidently did not.

By letter dated January 25, 1999, L.F. indicated that he wished to attend a DAC within fifteen days of his letter. By letter to L.F.'s counsel dated January 29, 1999, State Farm stated that it would arrange for a medical/rehabilitation DAC. State Farm's internal notes, however, indicate that it was only on February 9, 1999 that an employee was requested to locate the medical/rehabilitation DAC nearest to L.F. By letter dated February 3, 1999, L.F.'s counsel forwarded the executed consent to disclosure form to State Farm.

Rosedale subsequently prepared a third treatment plan, dated March 1, 1999, which recommended a further four weeks of spinal manipulation therapy, massage therapy and progressive active rehabilitation. The cost is not specified. Again, an anticipated return to normal life is indicated for L.F. at the end of the treatment plan. Again, there is no indication in this plan why the prior plans did not meet their goals or why this plan would succeed. A very brief accompanying letter, however, from Rosedale indicates merely that L.F. "has improved, however still needs care."

The third treatment plan was received by State Farm on March 5, 1999. State Farm refused the plan by letter dated March 11, 1999. In separate correspondence, State Farm indicated that it was having difficulties setting up a DAC assessment as the centre previously requested had a conflict of interest.

Rosedale submitted a fourth treatment plan, dated April 5, 1999. It recommended \$860 in further spinal manipulation therapy, massage therapy and progressive active rehabilitation (four sessions of each). A return to normal life is again anticipated for L.F. at the end of the treatment plan. Yet, again, there is no indication why the prior plans did not meet their goals or why this plan would succeed where its predecessors did not.

By letter dated May 26, 1999, State Farm wrote Rosedale indicating that the DAC assessors had found its treatment plan neither reasonable or necessary. It appears that at most, only part of the DAC reports were sent to Rosedale. Subsection 43(4) of the *Schedule* requires that the person or persons who conducted the assessments shall provide a copy of the report (not just parts) to the insurer, the insured person and the insured person's health practitioner.

The medical/rehabilitation DAC was performed by five medical practitioners associated with the West Park Hospital, over a three-day period in April 1999. The covering letter to State Farm is dated May 3, 1999.

Chris Stadnik, a registered massage therapist, states in his DAC report dated April 1, 1999 that based on the findings of the clinical assessment, *further* massage therapy was not believed to be reasonable or necessary. There is no comment on past treatment at Rosedale other than the remark of L.F. (whom she found to be very cooperative) that "the massage therapy treatments helped a great deal and he feels most benefit from the chiropractic and massage therapy." There is no indication in the report as to which specific findings the practitioner is relying on or how those findings lead to the opinion expressed.

Dr. P. Salituro, D.C. was of the view, in his April 1, 1999 DAC report, that all “formal passive forms of treatment, including chiropractic, physiotherapy and massage treatment, should be discontinued. Formal active rehabilitation should also be discontinued.” This appears to be based on Dr. Salituro’s opinion that L.F. “has achieved maximum therapeutic benefit with the various interventions.” Dr. Salituro does not indicate how he came to this conclusion, nor does he provide an opinion on whether the prior treatment provided by Rosedale was reasonable or necessary.

I. Oliver, physiotherapist, provided a DAC report dated April 7, 1999, which states that based on the “present physical examination, the treatment outlined in the Treatment Plans is not reasonable as a result of the injuries sustained in the accident.” The findings include 80% flexion and rotation of the cervical spine and flexion and rotation “less than normal but functional.” There is no indication of what functional means or why the author feels that 80% cervical flexion and rotation (or the various other findings) translate to the treatment plans being not reasonable. It is also uncertain as to why the practitioner only refers to the March 1, 1999 treatment plan and not to the prior two plans.

Dr. Oshidari is a physiatrist. He provided a sixteen-page DAC report dated April 7, 1999. Ten pages of the report lists 206 documents he says he reviewed before seeing L.F. Three pages deal with L.F.’s post-accident history (which curiously contains no mention of Rosedale). There is a page of L.F.’s current complaints and a page for physical examination (noting that L.F. was “a very cooperative gentleman,” not in acute distress, no pain behaviours, cervical range of motion was reduced between 10 and 40%).

Dr. Oshidari’s opinion, however, is given in one paragraph. He opined that he did not believe that “any further physical intervention [of massage, chiropractic, acupuncture, physiotherapy, as well as kinesiology] is going to change the chronic discomfort and pain that he experiences in the neck, upper and low back area.” This appears to be based on L.F. having had a prolonged course of treatment, without any long-term benefit. This is contrary to what L.F. noted to Mr. Stadnik above and

Dr. Salituro's comment that L.F. reported an overall improvement of approximately 60 percent.

In a May 1999 summary, Dr. Oshidari's opinion is expanded upon:

[L.F.'s] prolonged course of treatment has yielded no long term benefit and, at this state, any further physical intervention is not going to change his chronic discomfort and pain. Therefore the Treatment Plan recommending spinal manipulative therapy, massage therapy and progressive active rehabilitation *are no longer* reasonable and necessary. [emphasis added]

The final DAC assessment dealt with vocational options.

I found the DAC assessments of little assistance in trying to determine the reasonableness and necessity of the Rosedale treatment. Nor were the insurer medical examinations of Drs. Ford and Hershberg of assistance.

Dr. Sher was of little assistance in establishing the reasonableness and necessity of the treatment provided by his clinic. While he stated in chief that the overall goal of the program is to return L.F. as much as possible to where he was prior to the accident, Dr. Sher was able to provide little documentation from the 235 pages of notes and records from his file to indicate what the weekly goals of treatment were or whether those goals were being met. Nor, other than one lifting measurement, was Dr. Sher able to point to any objective measurement of improvement.

The last date of treatment at Rosedale appears to have been June 2, 1999.

L.F. testified that the treatment that he received at Rosedale lessened his pain and stiffness, helped him relax and increased the number of hours he slept. He was able to sit, stand and do tasks (such as dishes, sweeping, dusting, cleaning) with less pain. He testified that he was taking less medication (which was causing, in part, drowsiness, nausea, constipation and diarrhea). He felt better emotionally and less stressed. He testified that when the therapy stopped, he felt more depressed, his sleep was worse and he was in more pain which led to greater frustration.

Dr. Chaudri, L.F.'s family doctor, indicates, however, in his January 26, 2000 report, that as of February 5, 1999, it was clear that L.F. was not getting better, complaining of amongst other things, neck pain, depression and increased fatigue. There is no note of any change on March 24 and April 8, 1999. On April 12, 1999, Dr. Chaudri states that L.F. was worse. The next visit is August 26, 1999, well after the Rosedale treatment had ended. Depression is less but headaches are noted to be increasing and his neck is somewhat worse.

Dr. Davila noted, however, in March 1999 a significant improvement in his symptoms of depression from October 1998 based on the self-reporting Beck Depression Inventory.

Gonthier J., speaking for the majority in the Supreme Court of Canada decision in *Smith v. Co-operators General Insurance Co.* [2002] S.C.J. No. 34, regarding limitation periods under the preceding schedule, stated that:

There is no dispute that one of the main objectives of insurance law is consumer protection, particularly in the field of automobile and home insurance.

Gonthier J. applied this general principle in coming to the conclusion that a refusal of a benefit must:

in straightforward and clear language [be] directed towards an unsophisticated person.

Arbitrator Muir has indicated in the recent decision of *Do and Allstate Insurance Company of Canada* (FSCO A01-000200, February 18, 2002):

It is not a reason for a refusal of a benefit to merely recite the language of the *Schedule*. The Insurer is also required to elaborate on the reason for its view that the treatment is not reasonable or necessary.

A fundamental purpose of the DAC system is to allow a quick independent opinion as to the merits of a proposed treatment plan so that an insured can make an educated choice whether to proceed with recommended treatment. It does an insured little good to read, after the fact, why the treatment was not reasonable or necessary. In this case, there was a considerable delay in L.F.'s DAC assessment. The longest delays were in arranging the DAC (January 29<sup>th</sup> to March 11<sup>th</sup>) and sending the DAC reports (April 19<sup>th</sup> to, at the earliest, May 26<sup>th</sup>). Treatment ended shortly thereafter.

This is a first-party claim. It can seldom be reasonable to give a blanket refusal to any and all future medical treatment. Nor is it reasonable to tell an applicant, who has been attending treatment for more than half a year (and when the insurer has also been in receipt of the initial treatment plan for more than half a year), only at the end of the treatment that it was unreasonable. The rights of examinations given to insurers contemplate equally, certain responsibilities. The very existence of DACs restricts the discretion of an insurer.

Therefore, the threshold of requisite reasonableness and necessity should reflect, if applicable, that an applicant has, in effect, been denied the benefit of what is intended to be a timely independent medical opinion. While an objective standard remains in such cases, a significant factor must be whether the treatment was reasonable from the perspective of what the applicant knew or ought to have known during the course of the treatment.

L.F. went to Rosedale seeking assistance to relieve his accident-related symptoms. His treating specialist, Dr. Kachooie, recommended such treatment in correspondence with L.F.'s family doctor, Dr. Chaudri. The treatment provider, Rosedale, recommended continuing treatment. I find that it was reasonable for L.F. to commence and pursue treatment at Rosedale. I do not find that it was reasonable for L.F. to postpone treatment for months until the DAC assessment was arranged, this system being predicated on quick independent assessments, specifically so as not to delay an insured's access to treatment.

I also find that it was necessary for L.F. to pursue such treatment. Section 55 of the *Schedule* requires an insured person who is entitled to weekly benefits to obtain such treatment and participate in such rehabilitation as is reasonable, available and necessary to permit the insured to engage in the applicable tasks and shorten the period during which the benefit is payable. This, as I understand it, was the whole intent of the treatment provided by Rosedale.

Upon receipt of the DAC reports, L.F. had some information indicating that the treatment was no longer reasonable or necessary, neither Dr. Ford nor Dr. Hershberg having addressed the Rosedale treatment plan. The DAC reports pointed out concerns that it was reasonable for L.F. and Rosedale to address, i.e. what were the specific incremental goals and were those goals being met.

I cannot, however, discern when L.F. received the DAC reports. The DAC summary report is dated May 3, 1999. State Farm, however, sent portions to Rosedale on May 26, 1999, leaving the impression in the letter that they only recently received the report. Dr. Oshidari's 16-page typed single spaced report is dated the same date as the assessment date. Curiously, so are those of Dr. Salituro, C. Stadnik and I. Oliver. I am persuaded that one or more of the authors back dated their report. Therefore, it seems more likely that the DAC reports came to the attention of L.F. and/or Rosedale more or less the same time as they appear to have come to the attention of State Farm, that is on or about May 26, 1999 which is close to the end of the treatment.

The contemporaneous medical notes are mixed as to whether the Rosedale treatment was assisting, overall, the Applicant's condition. I think, however, that the Applicant is to be credited for pursuing treatment, on the basis of the medical advice he was receiving, even though, perhaps on at least a periodic short-term basis, his symptoms may not have improved and may, in fact, on occasion have worsened. I think, however, based on the DAC reports, that it was reasonable, after May 26, 1999, to wind down the treatment. Treatment at Rosedale ended June 2, 1999. Accordingly, the account of \$9,737.65 is allowed.

**(b) a beach ball**

In his consultation note to Dr. Chaudri, dated February 18, 1999, Dr. Kachooie advised L.F. to “perform daily Beach Ball exercises.” There is no explanation as to what these exercises were or why they required a \$35 beach ball. Rosedale’s contemporaneous notes refer to exercises being performed involving a large “theraball.” I received no evidence as to why the purchase of a Beach Ball was also reasonable and necessary. The claim is not allowed.

**(c) assistive devices recommended by Ms. E. Poon**

In her February 1999 Home Assessment, Ms. Poon, the occupational therapist, recommended the following assistive devices to “facilitate [L.F.’s] involvement in his activities of daily living:”

A queen size mattress	\$490
a book holder	35
a light weight vacuum cleaner	120
a laundry cart	40
a step stool	10
a telescopic duster	12
a long handled bathtub scrub	12
a long handled dustpan	12
a pail with a wringer	15
a high back support cushion	85
	<hr/>
	\$781

Ms. Poon stated that L.F. required a new mattress because he did not have an appropriate one of his own and was borrowing a friend’s. Ms. Poon does not indicate why the existing mattress was inappropriate. I am not persuaded that a new mattress is reasonable, necessary or required as a result of this accident.

I am not persuaded that the remaining items (other than the a high back support cushion) are goods or services of a medical nature, as required by paragraph 14(2)(h). Ms. Poon stated that L.F. expressed difficulties with sustained neck flexion when reading due to pain. He was using a neck roll and hot water bottle for his neck. I find the high back support cushion to be a reasonable and necessary good of a medical nature, required as a result of this accident and allow \$85 for same.

#### **4. Rehabilitation Expenses**

##### **(a) a TENS unit**

L.F. claims, pursuant to section 15 of the *Schedule*, \$500 for the cost of a TENS machine.

Section 15 allows for payment to insureds for reasonable and necessary measures taken by an insured person to eliminate the effects of any disability resulting from the impairment or to facilitate the insured's reintegration into his or her family, the rest of society and the labour market.

Dr. Chaudri, in his December 5, 2000 report, supported a TENS unit as being reasonable, as were the leads and electrodes. For reasons set out above, I would not accept Dr. Chaudri's opinion on its own. Early in his testimony, L.F. testified that the TENS machine helped relax the muscles on his shoulders and back, and helped him to concentrate better. Later, however, his testimony was more equivocal.

Ms. C. Bierbrier, an occupational therapist, in her July 15, 2000 report, costs a TENS unit purchased in the year 2000 at \$488.85. She states its purpose as reducing pain and muscle tension. Dr. Geisler, in his December 1, 2000 report, states that the TENS unit combined with massage was somewhat good in reducing discomfort, although not as effective as massage and an analgesic, called Endocote, together. Given, in part, the difficulties in getting funding for ongoing modalities, I am persuaded that the TENS unit is warranted as a reasonable and necessary endeavour to reduce pain, and allow same.

**(b) *psychological treatment provided by Dr. R. Davila & Associates***

In his treatment plan dated April 30, 1999, Dr. Davila recommended four to six individual counselling sessions at \$180 an hour for L.F., to assist him to cope with his pain. The estimated cost, therefore, was \$740 to \$1,080. This followed a course of treatment which had commenced on October 1, 1998. In writing to State Farm on April 30, 1999, Dr. Davila indicated that L.F. had participated actively and had responded well to treatment, that his anxiety and depression had been reduced and he appeared to have developed more adaptive coping strategies with his pain condition. Dr. Davila indicated that he had started termination strategies, but considered it necessary to extend treatment for four to six more sessions to consolidate gains, and then re-evaluate the need for further psychological treatment.

In his report a year later, Dr. Davila indicated that State Farm advised that L.F. was to be scheduled for a DAC assessment. Dr. Davila indicated that he had never received a copy of the assessment and it was his understanding that such an assessment was never held. I am persuaded that Dr. Davila's limited follow-up endeavours to wind up treatment and consolidate gains that had been made were reasonable and necessary, and I allow this account.

**5. Cost of Examinations**

L.F. claims a number of medical reports as section 24 expenses. Section 24 requires an insurer to pay for expenses which:

- S** are incurred by or on behalf of the insured person;
- S** are incurred for the purpose of the *Schedule* in obtaining and attending an examination or assessment or in obtaining a certificate, report or treatment plan; and,
- S** are reasonable.

The following specific items are in dispute:

**(a) report of Dr. Butler dated December 8, 1998**

L.F.'s family doctor, Dr. Chaudri referred him to Dr. Butler. Dr. Butler's brief December 8, 1998 report muses about possible community college studies as a rehabilitation option for L.F. The report does not mention, amongst other things, that L.F. did not complete grade eleven. Nor does the report consider findings similar to those of Rehabilitation Network's vocational assessment of the same month which assessed L.F.'s academic abilities at approximately grade nine reading, grade six spelling and grade five arithmetic, which would not (in their view) meet the entry requirements of most post-secondary training programs.

I find that Dr. Butler's \$100 report barely meets the section 24 criteria noted above. Considering that limited reflection would seem to have gone into this report, I allow \$25 for its preparation.

**(b) reports of Dr. Lau in the amount of \$1,489**

As noted, Dr. Lau is a psychologist. L.F. was referred to Dr. Lau (apparently by his counsel) for the express purpose of identifying his aptitudes, abilities and transferable skills and determining suitable employment opportunities. In his December 1998 report, Dr. Lau opined on suitable employment alternatives as well as treatment recommendations. This report is included, as far as I am aware, in the accounts of Rehabilitation Network set out below.

Dr. Lau prepared a second report dated November 22, 2000 in which he provided an updated treatment assessment. Unfortunately, I was not advised of the specific amount of this account.

The reports address L.F.'s ability to return to work, one of the issues under the *Schedule*. I find that the reports meet the requirements of section 24. I allow the accounts, subject to proof of the amount of the second report and any dispute as to the reasonableness of the account itself.

**(c) reports of Dr. Chaudri in the amount of \$1,250**

L.F. claims \$600 for Dr. Chaudri's report of January 26, 2000. The report is essentially a history of the treatment provided. It does not directly address the issues in dispute under the *Schedule*. I disallow this account.

L.F. further claims \$650 for Dr. Chaudri's December 5, 2000 report. The first nine pages of this report appear to be identical to the January 26, 2000 report. Dr. Chaudri does then opine on the question of entitlement to ongoing income replacement benefits, as well as address a variety of other issues under the *Schedule*.

As the first report is essentially encompassed in the second report, and the second report, in addition to setting out background information, does address issues under the *Schedule*, I find the \$650 cost of the second report to be reasonably incurred for the purposes of section 24.

**(d) reports of Dr. Kachooie in the amount of \$628**

The Applicant claims \$200 for a November 26, 1998 report and \$428 for a December 12, 2000 report of Dr. Kachooie.

The November 26, 1998 report consists of three (to me, partially illegible) printed lines, stating that L.F. is unable to attend an assessment, the hours for which should be modified in length. The letter evidently refers to a proposed insurer's medical assessment. The letter was sent to the Insurer under cover of letter dated November 27, 1998.

I find that section 24 encompasses a doctor's comments on the reasonableness of insurer medical examinations. I do not imagine that this report took more than a few minutes to prepare. I allow \$25.

Dr. Kachooie's December 12, 2000 report is essentially a critique of the post-104 week disability Designated Assessment report dated January 18, 2000. A major purpose of this report appears to be in preparation for this arbitration proceeding. Section 24, however, specifically includes reimbursing the cost of a report for the purpose of the *Schedule*. The *Schedule* includes specific reference to the resolution of disputes through arbitration. I find that reports which pertain to the resolution of disputes under the *Schedule* may be encompassed under section 24. I find that Dr. Kachooie's December 12, 2000 report, which specifically addresses the precise post 104-week disability issue under the *Schedule*, was incurred for the purpose of the *Schedule*, and as such, the account of \$428 is payable as a section 24 expense.

**(e) reports of Dr. Davila totalling \$725**

The Applicant claims \$725 for two reports of Dr. Davila, a psychologist. The first, I am advised, is a one-page report dated October 13, 1998 and an accompanying treatment plan for which \$575 is claimed. The second is a six-page report dated April 7, 2000, for which \$150 is invoiced.

The first report, directed to the Insurer, opines on a course of "effective coping strategies" for L.F. to deal with anxiety, depression and pain symptoms. The treatment plan is essentially a filling in of the blanks, with a series of generalities such as noting goals of "resumption of an adaptive level of functioning" and "attainment of an acceptable quality of life with limitations." I am not persuaded that more than \$50 is warranted.

The April 7, 2000 report, directed to the Applicant's counsel, is basically a medico-legal report, but in part allows Dr. Davila to relate his frustrations in dealing with the Insurer. The report addresses only in a very general manner issues under the *Schedule*, and even then more in the sense of speculating as to L.F.'s future condition and needs. I am not persuaded that this report should be dealt with other than as a possible legal expense of the arbitration proceeding.

**(f) reports of Rehabilitation Network Canada Inc. totalling \$2,632.52**

By letter dated June 27, 1999, the Applicant submitted to the Insurer three reports prepared by Rehabilitation Network, namely a Home Assessment dated February 26, 1999 prepared by Ms. Poon, an occupational therapist, a Psychological Consultation Report dated December 28, 1999 prepared by Dr. Lau (noted above) and a Vocational Evaluation Report dated December 15, 1998 prepared by Mr. M. Jean, a vocational evaluation expert.

I find these reports were incurred by or on behalf of L.F., that they were incurred for assessments relating to the *Schedule* (namely, attendant care and psychological/pain treatment) and that they were reasonable. The Applicant is allowed \$2,632.52 for these reports, less any portion attributable for Dr. Lau, which is dealt with above.

**6. Is L.F. entitled to direct billing of the cost of his prescription medication, pursuant to subsection 44(2) of the *Schedule*?**

I did not receive any evidence or submissions regarding this issue. Therefore, the claim is denied.

**7. Is L.F. entitled to a special award pursuant to subsection 282(10) of the *Insurance Act*?**

An applicant is entitled to a special award, pursuant to subsection 282(10) of the *Insurance Act*, if an arbitrator finds that an insurer has unreasonably withheld or delayed payments. L.F. maintains that he is entitled to a special award for the following reasons:

**(a) *Superior Rehab Centre - alleged delay in treatment***

L.F. submits that as a result of alleged delays in proceeding with DAC examinations, his rehabilitation treatment at Superior Rehab Centre (“Superior”) was delayed “between November 1, 1997 and April 28, 1998 when State Farm indicates they will fund treatment.”

The evidence does not support this submission. Rather, Superior’s records (Exhibit 25, Tab 1, invoices #11126 and #11127) indicate that L.F. received eighty “rehabilitation program” sessions and sixteen massage sessions between November 2, 1997 (his initial assessment) and April 28, 1998. Superior’s total account was \$5,870 for its rehabilitation program and \$609.90 for massage. There is no dispute in this proceeding regarding any refusal of payment of these accounts following receipt of the DAC reports dated March 11 and 16, 1998.

Nor am I persuaded that there was any unreasonable delay or refusal of benefits. I note the Applicant’s own nearly three-month delay in returning to State Farm a simple OCF 14 Permission to Disclose Health Information to the Assessment Centre (sent to the Applicant by letter dated November 19, 1997, returned by letter dated February 11, 1998 and marked received by State Farm on February 16, 1998).

**(b) Superior Rehab Centre - alleged limit on treatment**

L.F. alleges that State Farm “arbitrarily” put a cap on the payment of physiotherapy treatment at Superior “both in frequency and in duration without obtaining updating medical information or reassessment.” L.F. refers to the DAC summary of the St. Joseph’s Care Group dated March 16, 1998 that recommends that L.F. “requires more physiotherapy treatment for at least the next two months, at least three times per week . . .”

I am not persuaded by the Applicant’s submissions. State Farm, by letter dated April 28, 1998 (Exhibit 10, document III), stated that they would pay all outstanding invoices from Superior and would accept invoices for physiotherapy three times a week until mid-May 1998 (being two months after the date of the DAC summary). Superior’s records confirm that L.F. received 26 more treatments after the DAC summary date, until May 14, 1998. The one-page letter from State Farm dated April 28, 1998 provided to me does not indicate a refusal to pay for any further treatment which might be found to be reasonable and necessary. However, the Applicant failed to refer me to any evidence supporting the reasonable and necessary need for Superior continuing physiotherapy treatment subsequent to May 14, 1998.

**(c) alleged failure to comply with Ms. Lai’s recommendations**

As noted, Ms. Lai is an occupational therapist retained by State Farm to conduct an in-home and attendant care assessment. In her report dated November 23, 1998 she recommended the purchase of several assistive devices to help L.F. participate in housekeeping and activities of daily living. She also recommended two occupational therapy follow-up visits to assist L.F. to use these devices and to teach him “energy conservation, work simplification, proper biomechanics with activities such as mopping, bathtub cleaning.” L.F. submits that this assistance was unreasonably delayed (in the case of the

assistive devices, according to Exhibit 9, Tab 6B, page 4, until January 14, 2000, that is, more than a year after the recommendation was made) or unreasonably denied (in the case of the educational sessions).

State Farm submits that the expenses were never in fact “incurred,” or that they were ever formally requested, or that they cannot be the subject of a special award because these items are not specific issues in this arbitration proceeding.

I am persuaded that the recommendations of the Insurer’s own expert were unreasonably withheld or denied. A long line of cases supports the proposition that expenses need not be actually incurred before being payable.<sup>16</sup> It is not reasonable for an insurer to use its rights under section 42 to obtain an insurer medical examination for the purpose of determining whether an insured is entitled to a benefit, and then fail to honour in a timely fashion its own expert’s recommendations. Further, it does not stand in the mouth of this insurer to claim that a further reminder request for payment of the specific recommendations of its own expert should have been made by the Applicant, especially when it took nearly seven months for State Farm to forward Ms. Lai’s report to the Applicant (when subsection 42(7) requires that an insurer forward a copy of the report within seven days). Regarding the defence that the assistive devices and education were not in issue in this proceeding, subsection 282(11) of the *Insurance Act* specifically contemplates a special award where a payment has been unreasonably delayed, and hence, is applicable in cases where presumably the actual benefit itself is no longer in issue.

---

<sup>16</sup>For example see *Caruso and General Accident Assurance Co. of Canada* (OIC A96-000644, March 27, 1997), where Arbitrator Makepeace states that “I do not accept the Insurer’s submission that a medical benefit expense is not payable unless it has already been incurred.”

**(d) *alleged failure to provide a labour market survey***

L.F. alleges that State Farm commissioned a labour market survey, but did not produce same until after the commencement of the dispute resolution process.

As noted above, an applicant is entitled to a special award if an arbitrator finds that an insurer has unreasonably withheld or delayed payments. An arbitrator does not have authority to consider a special award solely for the alleged unreasonable delay of producing a document.

**(e) *alleged delay in paying attendant care benefits***

L.F. submits that, contrary to subsection 39(6) of the *Schedule*, State Farm failed, until February 3, 2000 (at which time attendant care benefits were paid to October 1998), to pay a monthly attendant care benefit calculated by the Insurer's own expert, Ms. Lai. L.F. further submits that State Farm failed to provide a copy of Ms. Lai's Form 1 until arbitration briefs were served.

The Insurer submits that no attendant care expense was in fact "incurred." It further argues that if either L.F. or his counsel had reminded the Insurer of Ms. Lai's outstanding report, it would have been produced earlier. Lastly, the Insurer submits that subsection 39(6) does not apply as it is predicated on an application being made, and that in this case, no application was made "within 30 days after the circumstances arose that gave rise to the entitlement to the benefit, or as soon as practicable thereafter," pursuant to subsection 32(1) of the *Schedule*.

I accept that L.F. completed an Application for Accident Benefits on January 24, 1997 (Exhibit 9, Tab 2) within thirty days of this accident. The document has no section for attendant care benefits, although subsection 32(2) requires an insurer to provide a written explanation of the benefits available and information to assist the person applying for benefits. Filed as an exhibit was a brief booklet

regarding accident benefits which Ms. Rawsthorne, testifying as a State Farm representative, stated had been given to L.F. by letter dated January 17, 1997. A very brief entry merely states that attendant benefits will pay for reasonable and necessary expenses for a caregiver or attendant required as a result of the accident, without any further particulars.

I do not find that to be meaningful compliance with section 32. Having failed in its obligations to assist its own insured to apply for benefits to which he might be entitled, I fail to see how this insurer can then argue that L.F. failed his obligations under subsection 32(1). In any event, in October 1998, L.F.'s new counsel wrote State Farm stating that "[i]t is apparent that [L.F.] requires attendant care at this time," and sought confirmation of the total paid to date and asked that an attendant care DAC be performed. I do not see that either request was answered by State Farm.

Rather, State Farm advised the Applicant by letter dated November 12, 1998, that it had retained an occupational therapist to complete an assessment to determine the necessity of attendant care benefits. An insurer has no inherent power for such intrusion into the privacy of an applicant. Such authority is only provided by the insurer examination provisions of section 42. Again, such examinations are for "the purpose of determining whether an insured is entitled to a benefit." Having taken advantage of its rights under section 42, and its own expert having indicated that certain benefits were payable, it hardly stands in the mouth of this insurer to then state that section 39 is inapplicable, either regarding the interim payment of benefits or arranging an attendant care DAC. I further note that subsection 39(7) states that the DAC's "determination" is binding on the parties. Subsection 43(7), which deals with DAC attendant care assessments, states that the DAC "determination" is of "the *future* provision of attendant care benefits" (emphasis added), not past, already incurred expenses. State Farm's remedy if it did not accept its insured's attendant care claim (nor, apparently, initially, its own expert's opinion) was to refer L.F. to an attendant care DAC and abide by the latter's decision pending any adjudication, not to simply maintain its refusal.

In any event, I have determined above that the attendant care expenses were “incurred.” In reviewing the correspondence from State Farm in the months following Ms. Lai’s assessment, as set out in Exhibit 11, there appears to be silence regarding attendant care. I find that a reasonable excuse for its failure to respond cannot be that the insured side failed to remind the insurer.

An insurer shall give the insured person, within 14 days of receiving the application for an attendant care benefit, notice that it requires a certificate to be furnished. By letter dated November 13, 1998, State Farm requested such a certificate. By letter dated December 29, 1998, L.F. provided State Farm with particulars of his claim and, subsequently, by report dated February 26, 1999, the opinion of Ms. Poon was provided in support.

I am persuaded that State Farm unreasonably delayed payment of the attendant care benefits as calculated by Ms. Lai, at the very latest, upon receipt of Ms. Poon’s report.

**(f) failure to pay Dr. Davila’s April 30, 1999 treatment plan**

The Applicant submits that State Farm unreasonably delayed payment of Dr. Davila’s treatment plan dated April 30, 1999 (which recommended four to six individual counselling sessions at \$180 an hour). Included as an exhibit is a letter (Exhibit 11, Document dddddd) dated April 30, 1999 from Dr. Davila to State Farm enclosing this report. There is, however, confusion, as to when this treatment plan was actually received by State Farm. A letter from the latter dated June 21, 1999 (Exhibit 1, Document jjjjjj) states that it was not received until June 16, 1999. The latter letter further advises that if L.F. wishes to be assessed for the unapproved items, he was to sign the OCF-14 for the assessment to be arranged.

A follow up letter dated August 6, 1999 from State Farm to Dr. Davila (Exhibit 1, Document rrrrrr) indicates that the Insurer was still waiting for the OCF-14 to proceed with the DAC.

Given the evidence that the treatment plan was not received by State Farm until June 16, 1999 as well as the comments of Arbitrator Palmer regarding what she considered in *Avdalimov and CGU Insurance Company of Canada* (FSCO A00-000433, May 25,2001) as “a reasonable procedure established by the Minister’s Committee on the Designated Assessment Centre System,” and the apparent failure of the Applicant to provide a completed OCF-14 Form, I am not persuaded that State Farm unreasonably withheld payment of Dr. Davila’s treatment plan.

**(g) State Farm’s correspondence with Dr. E.G. Duncan**

L.F. submits that State Farm improperly wrote Dr. Duncan on January 14, 1999 (Exhibit 11, Document “www”) seeking completion of a Certificate for Attendant Care, when he had not seen the Applicant for nearly two years and was not familiar with his attendant care needs. L.F. further submits that State Farm failed to provide Dr. Duncan with necessary documentation.

I do not find the mere fact that State Farm wrote Dr. Duncan seeking information constitutes an unreasonable withholding or delay of benefits.

**(h) failure to advise L.F. of his right to attendant care benefits**

The Applicant submits that the Insurer, upon receipt of the Applicant’s completed Activities of Normal Life in January 21, 1997 (which noted that L.F. required assistance with a variety of activities), failed to alert the Applicant to his entitlement to a weekly attendant care benefit.

I have found above that State Farm unreasonably withheld payment of attendant care benefits, upon receipt of Ms. Lai’s Form 1 in 1998, and certainly no later than receipt of Ms. Poon’s report early the next year. As noted above, I find that the Insurer’s failure to properly assist L.F. in applying for benefits to which he was entitled, mitigates against technical defences raised by State Farm noted above, but does not provide a separate basis for a special award.

**(i) State Farm's stated reason for refusing the December 1999  
Rosedale Treatment Plan**

L.F. submits that it was unreasonable for the Insurer to deny the initial Rosedale treatment plan on the basis of the reports of Dr. Ford and Dr. Hershberg. I agree.

Neither doctor commented on this treatment, for the simple reason that their reports preceded State Farm's receipt of the Rosedale plan. In any event, I am not persuaded as to the expertise of Dr. Hershberg, a psychiatrist, to comment on the reasonable necessity of active rehabilitation, physiotherapy, chiropractic care, massage therapy and behavioural therapy.

Dr. Ford is an orthopaedic surgeon. In his November 30, 1998 report (based on a November 18<sup>th</sup> examination), Dr. Ford states that L.F. does not require "any further formal medical rehabilitation." He fails to give a reason for this opinion. One can glean, however, that this finding appears to be based on his view that there are no objective determinants for L.F. subjective report of pain. This, as set out in *Quattrocchi and State Farm Mutual Automobile Insurance Company* (OIC A-006854, September 29, 1997), cannot be the end of one's analysis.

However, more fundamentally, State Farm failed to provide copies of these insurer medical reports in its denial letter, despite the subsection 42(7) requirement that an insurer "shall" provide the insured person with a copy of the insurer medical report within seven days. I query whether an insurer should even be allowed to rely on an insurer medical report when it fails, without a reasonable excuse, to comply with its obligations in this regard under the *Schedule*.

Nor did State Farm indicate in its January 6, 1999 letter what exactly in these reports it was relying on in denying the benefits claimed. Under paragraph 32(2)(c) of the *Schedule*, an insurer has the obligation "to assist the [insured] person in applying for benefits." Under section 38, an insurer must give notice to

an insured if it will not pay for any goods and services contemplated by the treatment plan. I find, in light specifically of paragraph 32(2)(c), that this must be a meaningful notice, which allows an insured to make an educated decision whether or not to pursue certain treatment.

Merely providing the names of two doctors and saying that you are relying on them, without more, is providing not an explanation but an excuse. Only on January 29, 1999 (Exhibit 11, Document “bbbb”) did State Farm give L.F. some inkling as what in the medical reports formed the basis of its decision. Yet, even at that time, it failed to provide L.F. with copies of its reports, despite his specific request for same by letter date stamped received by State Farm on January 25, 1999 (Exhibit 11, Document “yyyy”). Rather, State Farm indicated that it had forwarded copies to his general practitioner “for comment.”

I find that this constitutes an unreasonable denial of benefits.

**(j) *Alleged failure to comply with sections 38 and 43 re Rosedale’s treatment plans***

L.F. submits that State Farm failed to comply with its obligations under sections 38 (notice of refusal) and 43 (setting up a medical/rehabilitation DAC) regarding these plans, as a result of which his ability to access treatment was delayed and his impairment worsened.

The first Rosedale treatment plan is dated December 11, 1998. Exhibit 20 shows treatment continuing at Rosedale, unabated, until the spring of 1999. It was the Applicant’s own submission in favour of the reasonableness of the Rosedale account that this treatment, which continued despite the Insurer’s lack of funding, helped his condition. However, I am not persuaded that treatment after June 2, 1999 was reasonable or necessary. For these reasons, I am not persuaded either that treatment was delayed or that his impairment was worsened as a result of State Farm’s refusal to pay this account.

**(k) State Farm's stated reason for refusing the March 1999  
Rosedale Treatment Plan**

L.F. submits that it was unreasonable for the Insurer to deny the further March 1999 Rosedale treatment plan solely on the basis of the reports of Dr. Ford and Dr. Hershberg, as set out in State Farm's letter of March 11, 1999 (Exhibit 11, document "mmmmm"). I agree, for the reasons set out above under item #(i) above.

**(l) Alleged failure of State Farm to follow recommendations of the  
West Park DAC**

L.F. submits that it was unreasonable for State Farm to fail to follow or fund the recommendations of Ms. C. Newburgh, vocational rehabilitation counsellor at the Assessment Centre of West Park Hospital, in her April 19, 1999 report, wherein she recommended vocational counselling (emphasising use of transferable skills) and rehabilitation (consisting of a labour market survey, job interview preparation, résumé writing, placement and ergonomic assessment).

Ms. Newburgh's opinions, however, were based on the prerequisite that L.F.'s physical capabilities be objectively measured to determine his employment capability.

L.F., however, testified that he is not capable of doing any job. He has not looked for any employment since this accident, full time or part time. His experts are of the view that he is not capable of returning to competitive employment. Dr. Geisler states in his December 2000 report that "[i]t is inconceivable to my mind that he could return to any gainful employment, as long as the pain phenomena persists." Dr. Scher in his March 2000 report states that "[i]n my opinion [L.F.] is substantially disabled from returning to competitive employment." Dr. Scherer, in his October 2000 vocational assessment, states that "[i]t is highly doubtful that an individual having this level of discomfort and restriction would be capable of performing any job on a steady full time basis, including sedentary, physical demand work."

Given the Applicant's evidence of his inability since this accident to endeavour to return to any competitive employment, I fail to discern how it lies in his mouth to say it was unreasonable for State Farm not to provide him with job interview preparation, résumé writing, labour market surveys, etc.

**(m) *The alleged failure of State Farm to reconsider IRB entitlement, based on further medical reports provided by L.F.***

L.F. submits that State Farm failed to provide the reports of Drs. Geisler, Scher and Scherer noted above to any medical or rehabilitation specialist for their consideration in order to determine whether it was appropriate to continue its denial of weekly benefits.

I find that the real question is whether it was unreasonable for State Farm to continue to deny weekly income replacement benefits in light of these reports.

The reports advanced by the Applicant do not rely on any alleged change in his condition, but rather on a different analysis and assessment of disability.

Although I have found L.F. is entitled to ongoing IRBs, I do not find that the Insurer's refusal unreasonable, based as it was on the opinion of the post-104 week disability DAC assessment (albeit with difficulties noted above). State Farm further commissioned a report of Dr. Ameis, dated August 7, 2001, to comment on continued disability and which supported its position (albeit, with the difficulties noted above).

**(n) *Failure to pay attendant care benefits past 104 weeks***

The Applicant submits that State Farm unreasonably withheld attendant care benefits past 104 weeks by its incorrect interpretation of section 70 of the *Schedule*.

Given that the import of the section 70 transitional provisions had not been previously explored, I am not persuaded that the Insurer's position was unreasonable.

### ***Conclusion***

I find that the Insurer, after taking advantage of its rights of examination under section 42, unreasonably withheld medical and attendant care benefits recommended by its own expert. I also find that State Farm failed to provide a reasonable basis for refusing to pay the Rosedale treatment plan. I find that a special award of \$2,500 is warranted.

### **EXPENSES:**

Having now determined all issues in dispute except expenses, should the parties not agree on the entitlement to or amount of the legal expenses of this arbitration proceeding, either party may request that the question of expenses be spoken to in accordance with Rule 77 of the *Dispute Resolution Practice Code* (Third Edition, April 15, 1997).

---

Lawrence Blackman  
Arbitrator

---

August 21, 2002

Date

**BETWEEN:**

**L.F.**

**Applicant**

**and**

**STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY**

**Insurer**

### **ARBITRATION ORDER**

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. State Farm Mutual Automobile Insurance Company pay L.F.:
  - (a) weekly income replacement benefits of \$185 ongoing from January 24, 2000;
  - (b) monthly attendant care benefits of \$744.18 from January 12 to March 30, 1997, \$147.92 from April 1 to August 30, 1997, and \$134.68 from August 31, 1997 to January 11, 2000, less payments made to date;
  - (c) \$9,737.65 for treatment received at Rosedale Chiropractic & Physiotherapy Centre;
  - (d) \$85 for a high back support cushion recommended by Ms. Poon;
  - (e) a TENS machine in the amount of \$488.85;
  - (f) \$425 for psychological treatment provided by Dr. R. Davila & Associates;
  - (g) \$25 for Dr. Butler's December 8, 1998 report;
  - (h) Dr. Lau's accounts for his December 28, 1998 and November 22, 2000 reports, subject to proof of the amount and any dispute as to the reasonableness of the latter account;

- (i) \$650 for Dr. Chaudri's December 5, 2000 report;
  - (j) \$453 for Dr. Kachooie's reports of November 26, 1998 and December 12, 2000;
  - (k) \$50 for Dr. Davila's October 13, 1998 report;
  - (l) \$2,632.52 for the reports of Rehabilitation Network Canada Inc., less any portion attributable for Dr. Lau's report;
  - (m) a special award in the amount of \$2,500; and,
  - (n) interest pursuant to subsection 46(2) of the *Schedule*.
2. The parties may now speak to the question of entitlement to payment of the legal expenses of this arbitration proceeding.

---

Lawrence Blackman  
Arbitrator

August 21, 2002

---

Date