Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A11-002436

BETWEEN:

CHANNOCH SHMUEL

Applicant

and

PERTH INSURANCE COMPANY

Insurer

REASONS FOR DECISION

Before: Edward Lee

Heard: December 3, 4, 5, and 6, 2012 at the offices of the Financial Services Commission of Ontario in Toronto. Written submissions received on February 1, 2013

Appearances: Harley Kruger for Mr. Shmuel
Nicholaus de Koning for Perth Insurance Company

Issues:

The Applicant, Channoch Shmuel, was injured in a motor vehicle accident on November 12, 2009. He applied for statutory accident benefits from Perth Insurance Company ("Perth"), payable under the *Schedule*.[1] Perth denied some of the benefits claimed. The parties were unable to resolve their disputes through mediation, and Mr. Shmuel applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

[1] *The Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996*, Ontario Regulation 403/96, as amended.

The issues in this hearing are:

1. Is Mr. Shmuel entitled to receive a medical benefit for twenty-nine treatment plans, totalling $29,299.27?

2. Is Mr. Shmuel entitled to attendant care benefits of $814.63 per month from November 12, 2009 to December 12, 2010?

3. Is Mr. Shmuel entitled to payments for housekeeping and home maintenance services of $100.00 per week from November 12, 2009 to December 12, 2010?

4. Is Mr. Shmuel entitled to payments for the cost of four examinations in the following amounts: $779.07, $450.00, $910.22 and $2,134.90?

5. Is Perth liable to pay a special award because it unreasonably withheld or delayed payments to Mr. Shmuel?

6. Is Perth liable to pay Mr. Shmuel's expenses in respect of the arbitration?

7. Is Mr. Shmuel liable to pay Perth's expenses in respect of the arbitration?

8. Is Mr. Shmuel entitled to interest for the overdue payment of benefits?

Result:

1. Mr. Shmuel is entitled to receive a medical benefit for six treatment plans, deemed approved, totalling $6,398.23.

2. Mr. Shmuel is not entitled to attendant care benefits of $814.63 per month from November 12, 2009 to December 12, 2010.

3. Mr. Shmuel is not entitled to payments for housekeeping and home maintenance services of $100.00 per week from November 12, 2009 to December 12, 2010.

4. Mr. Shmuel is not entitled to payments for the cost of four examinations in the following amounts: $779.07, $450.00, $910.22 and $2,134.90.

5. Mr. Shmuel is entitled to interest on the overdue payment of the cost of the six treatment plans that were deemed approved.

EVIDENCE AND ANALYSIS:

Mr. Shmuel's Credibility:

This was a "pain" case. Mr. Shmuel testified he was in severe pain because of the car accident of November 2009. The pain had an impact on his sleep and posture, and kept him from performing his housekeeping duties, and caused him to require attendant care and much medical and rehabilitative treatment. Even three years post-accident, he remained in constant pain.

There was little or no objective, measurable, medical or scientific evidence to substantiate Mr. Shmuel's pain complaints. Even Mr. Shmuel's sole medical witness, Dr. John Super, chiropractor, concluded that Mr. Shmuel had suffered soft tissue injuries from the car accident. As such, Mr. Shmuel's own testimony, relating to his subjective account of his pain, was central to his case.

Overall, I found Mr. Shmuel was not credible as a witness. He tended to minimize and sometimes omitted details of his many pre-accident health problems and difficulties. He had already qualified for ODSP in the summer before his car accident. In the year before his accident, he had experienced sleeping problems, and had suffered a head injury resulting in headaches and dizziness, requiring him to consult a neurologist. Finally, he also qualified for CPP in 2010 and these benefits were backdated to 2009 before his accident.

Mr. Shmuel was also dishonest with his own assessors, including Dr. Super, to whom he neglected to reveal many of these pre-accident symptoms and medical problems. Dr. Super agreed that Mr. Shmuel's pain reporting scale seemed excessive.

There were serious contradictions and inconsistencies about his housekeeping and attendant care claims. Finally, even minor discrepancies in details about his claim, such as his reports of where he lived at the time of his accident, contributed to the overall lack of credibility of his case.

Medical Witnesses:

Each party produced one medical witness.

(a) Dr. Adam Goldfarb, chiropractor:

Perth's witness, Dr. Goldfarb, testified Mr. Shmuel had demonstrated a greater range of motion in his in-office movements and through informal observation than in the actual testing, which was one of the factors which led him to conclude Mr. Shmuel had exaggerated his symptoms.

Dr. Goldfarb concluded that Mr. Shmuel had suffered uncomplicated soft tissue injuries, and there was an absence of objective evidence of neuromuscular pathology. He diagnosed Mr. Shmuel with uncomplicated muscle injury to the cervical/lumbar region. In his opinion, Mr. Shmuel had been receiving very little active treatment from Universal Rehab and these passive treatments were neither reasonable nor necessary, and did not lead to a return to function. They could even be detrimental to overall improvement.

(b) Dr. John Super, chiropractor

Dr. John Super was called by Mr. Shmuel. He had conducted a "Chiropractic Functional Med-legal Examination." Dr. Super's report did not suggest any physiological or biomechanical basis for Mr. Shmuel's complaints or pain experience. In testimony, Dr. Super agreed that Mr. Shmuel's injuries had been of the soft tissues and he was "perplexed' as to why Mr. Shmuel was

still experiencing his current pain levels, three years post-accident. He admitted that it was "difficult" to determine any causal relationship between the motor vehicle accident and Mr. Shmuel's injuries.

Despite the lack of objective findings, Dr. Super testified that all the treatment received by Mr. Shmuel at Universal Rehab had been reasonable and necessary, given the nature of the injury and his presentation.

I found the report and testimony of Dr. Super unconvincing and unreliable for several reasons. First, Dr. Super stated that Mr. Shmuel's problems had been caused by the motor vehicle accident due to lack of evidence of other contributing factors. On cross-examination, it was clear that Dr. Super had not been provided with crucial information about Mr. Shmuel's pre-accident health and medical problems, including his ODSP and CPP status, previous head injury, headaches, dizziness and pre-accident neurology consult. When presented with this information, Dr. Super admitted that his conclusions might have been different.

Further, I had concerns about Dr. Super's objectivity as a witness. Although he denied any linkage with Assessment Direct (whose assessments are part of this application), and no previous knowledge or involvement with Mr. Shmuel, he acknowledged an OCF-22[2] (prepared for Mr. Shmuel and dated July 6, 2010), with his signature on it. He admitted that he had previously given Assessment Direct permission to use his electronic signature.

Finally, the methodology applied by Dr. Super in the preparation of his report was inconsistent. He made fewer measurements than required when recording some of the ROM tests performed on Mr. Shmuel.[3]

I therefore found the report and testimony of Dr. Goldfarb more convincing than that of Dr. Super.

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[2]Exhibit I-1

[3]A-3, page 29

Medical and Rehabilitation benefits:

Mr. Shmuel claimed approximately twenty-nine treatment plans[4], totalling $29,922.27, were both reasonable and necessary or had been deemed approved and payable through operation of the *Schedule*.

(a) Were the twenty-nine treatment plans for rehabilitation reasonable and necessary?

All the disputed treatment plans, dated from November 13, 2009 to September 24, 2010, had been created and allegedly submitted by Universal Rehab Clinic. All treatment received by the applicant took place between November 13, 2009 and October 7, 2010 at the Universal Rehab Clinic.[5] The treatment plans included the following modalities: physical rehabilitation, education, acupuncture, massage therapy, documentation and education, instruction, brokerage, exercise, orthotics, electrophysiological measurements, training, TENS, and multiple therapies.[6]

All treatment plans were signed by various medical professionals on staff at Universal Rehab Clinic, including five or six massage therapists, and two or three chiropractors. None of the medical professionals attended before me to testify about these plans. The only representative of the Universal Rehab Clinic to appear was Irina Dargatcheda, office administrator.

Ms. Dargatcheda testified that her duties as an office administrator were to oversee the clinic work and to provide client service. She admitted having no personal knowledge of Mr. Shmuel's case, and having no medical training apart from past employment as a "somnographic technician". She stated that Universal Rehab Clinic was authorized to use the electronic signatures of its medical professionals in the preparation of its treatment plans, although none of these authorizations were adduced in evidence. She also stated there was a part-time medical doctor on staff, but later retracted this comment.

[4]A-46, List of treatment plans in Applicant's closing submissions

[5]Vol. 1, Tab 3A patient sign-in sheets

[6]A-46, Applicant's Closing Submissions

Ms. Dargatcheda described the intake procedure at Universal Rehab as follows: one of their "doctors" performed the initial consultation with the patient. A treatment plan was then produced by an office assistant and this plan was signed by the patient. It was then submitted to the insurance company. Subsequent treatment plans were periodically created by other office assistants (a staff of "three girls") who generated them with the computer. Electronic signatures of medical professionals were affixed to the plans before submission to the insurance company. At Universal Rehab, all patients "*got the same treatment plans*", and different plans were only produced if a patient had "a broken bone or psychological problems." In this manner, the twenty-nine treatment plans were generated and submitted for Mr. Shmuel over a period of approximately ten months.

As the torrent of treatment plans was unleashed, Mr. Shmuel attended at Universal Rehab Clinic at his discretion. The clinic was open five days a week from 10:00 a.m. to 8:00 p.m. No appointment was required. Mr. Shmuel could come at any time he wished and obtain the treatment he wanted. Sessions were largely self-directed, and patients chose their own treatment. Although Mr. Shmuel attended on over a hundred occasions, an examination of the clinical notes and records[7] of Universal Rehab Clinic reveals little more than sheets of illegible and indecipherable entries with some records of Mr. Shmuel's massage. No medical professional who had provided any of these services attended to decipher the notes, or to explain or clarify the course of treatment, why or when it had been recommended, its intended goals, trajectory or efficacy and how the treatment might have impacted Mr. Shmuel's health and recovery. It was also noteworthy that the sign-in sheets did not indicate how long Mr. Shmuel remained at the clinic for treatment on each occasion.

The applicant bears the burden of proving that the treatment he claims was reasonable and necessary. Arbitral case law has held that the reasonableness and necessity of a treatment must be established on a proper standard.

[7]Volume 1, Tab 3A

In *General Accident Insurance Company and Violi*, the following criteria were cited with approval:

1. the treatment goals, as identified, are reasonable;
2. these goals are being met to a reasonable degree; and
3. the overall costs [not just financial, but also investment of time, etc.] of achieving these goals is reasonable taking into consideration both the degree of success and the availability of other treatment alternatives.[8]

I find there was no medical evidence to show the treatment goals were identified or reasonable or being met. There was no evidence the overall costs were reasonable.

Nothing in the evidence demonstrated any medical professional was supervising or overseeing Mr. Shmuel's rehabilitative or medical care at Universal Rehab in any cohesive or guiding manner. Nothing suggested the treatment was timely, medically appropriate or medically suited to Mr. Shmuel. It was not even possible to determine what "treatment" had been administered to Mr. Shmuel in the course of his over one hundred visits to Universal Rehab during the ten-month period in question.

Finally, I am also unconvinced that mere pain relief, as discussed by Mr. Shmuel, was sufficient to render these treatments reasonable and necessary. Although pain relief is a legitimate treatment goal, in most cases it should not be the only goal. Pain relief should be part of a broader rehabilitation strategy, to be considered with return to and maintenance of function.[9] In the present case, Mr. Shmuel stated he got pain relief that lasted for the "first five or six hours" after his sessions at Universal Rehab, but the pain would recommence afterward. Three years post-accident and over dozens of sessions later, he testified he was still suffering the same pain.

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[8] *The General Accident Insurance Company of Canada and Violi* (FSCO P99-00047, September 27, 2000), Appeal

[9] See footnote 8, *supra*

Even if I accepted Mr. Shmuel's testimony about the severity of his pain, I do not find that the treatment he received was part of the broader rehabilitation strategy required of reasonable and necessary treatment. There was no evidence of return to or maintenance of function.
The effectiveness of his long term treatment was also highly doubtful, as pain relief treatment should not encourage an inappropriate or indefinite dependency, or interfere with other suspects of rehabilitation.[10] In fact, I accept Dr. Goldfarb's testimony that such therapy, in these conditions, might be detrimental to a patient's overall health.

I find that none of these treatment plans were reasonable or necessary.

(b) Were six of the twenty-nine treatment plans deemed approved?

Of the twenty-nine plans previously discussed, Mr. Shmuel claimed that six treatment plans,[11] totalling $6,398.23, had been deemed approved through operation of the *Schedule*. Counsel for the applicant failed to specify the provision of the *Schedule* on which this claim was based, but presumably, it was founded on section 38(8.2)(2) of the *Schedule*, which describes the consequences when an insurer fails to respond to a treatment plan.[12]

This part of the claim was based on testimony provided by Ms. Dargatcheda, who referred to a spreadsheet entitled "Outstanding Invoices Per MVA Patient", prepared by Universal Rehab.[13]

In cross-examination, Ms. Dargatcheda was shown a similar and almost identical spreadsheet that had been previously entered as part of the joint brief.[14] That earlier spreadsheet bore an identical title, date and time stamp to the spreadsheet referenced by Ms. Dargatcheda, yet the total claimed differed by approximately $3,000.00. Ms. Dargatcheda was unable to account for

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[10] *Ibid.*, at page 7

[11] Vol. 1, Tab 3A: Pages 55, 103, 117, 124, 135 and 171

[12] See Appendix 1

[13] Ex. A-1

[14] Vol. II, Tab 4B, page 95

the discrepancy or why two documents bearing the same name and time signature had different balances.

Regardless, Ms. Dargatcheda claimed the spreadsheet was an accurate record of invoices and treatment plans submitted on behalf of Mr. Shmuel. It purported to show when the plans had been prepared and sent to the insurance company, and whether the plans had been approved, denied or whether any response had been received. According to Ms. Dargatcheda, if Universal Rehab received no response or a late response to a submitted treatment plan, it was "deemed approved" and payable.

There was confirmation from Perth that at least two of these plans had been deemed approved.[15]

In regard to the four remaining plans, there were problems in the spreadsheet forming the basis of Ms. Dargatcheda's testimony. She herself had no personal knowledge of the data collected and reported therein. Instead, she admitted the spreadsheet had been prepared by "Olga" in the accounts department of Universal Rehab. This person did not attend before me.

There was no evidence the spreadsheet had been created in the ordinary course of business. Nor had it been created contemporaneously or within a reasonable time of the facts it sought to prove. Most importantly, no evidence was tendered in regard to the process or practices that created this record to ensure its accuracy or trustworthiness. There was no evidence as to whom had delivered the treatment plans to the insurance company and whether those details had been inputted into the computer contemporaneously or within a reasonable time. There was no evidence as to whom had attended at the fax machine or in the mail room to receive the denial, approval or to note the lack of response from the insurance company. These deficiencies reduced and detracted from the reliability, trustworthiness and probative value of this document.

[15]Joint Brief 1, Tab 17 [treatment plans at pages 103 and 124 deemed approved].

Nonetheless, Perth did not address or make a specific reply to the four remaining plans.[16] The insurer did not deny those plans had been submitted and received, and did not rebut the assertion that the insurance company had failed to respond to them within the timeframes set out in the *Schedule*, even though a representative of Perth Insurance Company with personal knowledge of this file testified before me.

Instead, counsel for the insurer contended that the treatment outlined in these disputed plans had not been incurred. Despite this argument, no jurisprudence was tendered to support the contention that a treatment plan, deemed approved, had to be incurred before it became payable. Counsel also failed to direct me to any provision in the *Schedule* detailing such a requirement.

The spreadsheet was unreliable, but it was not countered, and there was confirmation that at least two of the six plans were approved. I therefore find, more likely than not, that the other four plans had been submitted, received and in the absence of denial or response, had been deemed approved by the operation of the law.

Therefore, the six disputed treatment plans had been deemed approved by the law and thus are payable.

SECTION 24 ASSESSMENTS:

Four items were at issue.

No evidence for a psychological pre-screening by Dr. Vitelli ($450.00) and a psychological assessment ($2,134.90) was adduced at the hearing. Counsel for Mr. Shmuel stated Assessment Direct claimed these items had been deemed approved. No representatives of Assessment Direct attended at the hearing. These claims were not proven and are disallowed.

[16] Vol. 1, Tab 3A: Pages 55, 117, 135 and 171

The applicant also claimed $779.97 for an attendant care assessment.[17] No witnesses were called to testify in regard to this document. I accepted the evidence of Perth that this assessment, although dated November 17, 2009, was not delivered to Perth until February 19, 2010.[18] Further, the assessment was based entirely on Mr. Shmuel's statements about his pain and limitations. Given my findings on Mr. Shmuel's credibility, I find that this assessment was not reasonable or necessary.

No evidence, apart from testimony from Dr. Super, was called in regard to the $910.23 claimed for assistive devices. Given my findings concerning the quality of Dr. Super's evidence, I do not find Mr. Shmuel is entitled to payment for this item.

ATTENDANT CARE AND HOUSEKEEPING AND HOME MAINTENANCE SERVICES:

Mr. Shmuel testified he received housekeeping services and attendant care from his son-in-law, Nir Kronenblatt. Mr. Kronenblatt came to Mr. Shmuel's house and did cleaning, cooking, laundry and shopping, two to three times a week. He was there five hours a day. He also took Mr. Shmuel to the shower and helped him "wear his clothes".

Nevertheless, despite being both housekeeping and attendant care provider, Nir Kronenblatt did not attend before me. Mr. Shmuel attributed Mr. Kronenblatt's absence to his being upset because he had not been paid for the work he had done. I did not find this a credible explanation. Had he attended, Mr. Kronenblatt's testimony would have been instrumental in substantiating the claims for housekeeping and attendant care, and would only have increased the possibility of his getting paid for his services. I draw a negative inference based on the absence of corroboration of this claim by the housekeeping and attendant care provider.

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[17]Ex A-38, tab 3B, page 344.

[18]Joint Brief-1, tab 13.

I also noted that as of June 2009, as part of Mr. Shmuel's successful application for CPP benefits, his family doctor had recorded that Mr. Shmuel had "medium to moderate limitations for housekeeping (cleaning, laundry, meal preparation, shopping for essentials), ability to stand, and ability to sit for a sustained period as well as ability to participate physically in sustained activity."[19] This cast further doubt on Mr. Shmuel's own testimony, wherein he stated that pre-accident, he had been performing all his own housekeeping tasks, three to four times a week.

Finally, Mr. Shmuel submitted invoices for housekeeping and attendant care (all signed by Mr. Kronenblatt) up until late May 2011. The weekly and monthly amounts claimed were undiminished throughout the submission period, even though in testimony, Mr. Shmuel admitted Mr. Kronenblatt had stopped providing these services, at the latest, by November 2010. Clearly, at least six months of invoices were incorrect or false.

Based on these numerous problems with credibility, I do not find that Mr. Shmuel is entitled to housekeeping or attendant care services for the periods he claimed.

SPECIAL AWARD AND EXPENSES:

The parties did not make submissions on special award or expenses, and if necessary, they may make written submissions in regard to these two items in accordance with the *Dispute Resolution Practice Code.*

___________________________	August 12, 2013
Edward Lee Arbitrator	Date

[19] I-14, Vol. 2, Tab 3C, 530-535

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A11-002436

BETWEEN:

CHANNOCH SHMUEL

Applicant

and

PERTH 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. Mr. Shmuel is entitled to receive a medical benefit for six treatment plans, deemed approved, totalling $6,398.23.

2. Mr. Shmuel is not entitled to attendant care benefits of $814.63 per month from November 12, 2009 to December 12, 2010.

3. Mr. Shmuel is not entitled to payments for housekeeping and home maintenance services of $100.00 per week from November 12, 2009 to December 12, 2010.

4. Mr. Shmuel is not entitled to payments for the cost of four examinations in the following amounts: $779.97, $450.00, $910.22 and $2,134.90.

5. Mr. Shmuel is entitled to interest on the overdue payment of the cost of the six treatment plans that were deemed approved.

____
Edward Lee
Arbitrator

August 12, 2013
Date

APPENDIX

38(8) If no notice is given under subsection (5), the insurer shall give the insured person one of the following notices:

1. A notice,

   i. that discloses any conflict of interest the insurer has relating to the treatment plan,

   ii. that describes the goods and services, if any, contemplated by the treatment plan that the insurer agrees to pay for, and

   iii. that advises the insured person, if the insurer has not agreed to pay for all goods and services contemplated by the treatment plan, that the insurer requires the insured person to be examined under section 42 relating to the goods and services the insurer has not agreed to pay for.

2. A notice advising the insured person that the insurer,

   i. believes that the insured person may have an impairment to which a Pre-approved Framework Guideline applies, and

   ii. requires the insured person to be examined under section 42 to assist the insurer in determining if the insured person has an impairment to which a Pre-approved Framework Guideline applies.

(8.1) A notice under subsection (8) must be given,

(a) within 10 business days after the insurer receives the application, in the case of a notice described in paragraph 1 of subsection (8); or

(b) within five business days after the insurer receives the application, in the case of a notice described in paragraph 2 of subsection (8).

(8.2) If the insurer fails to give a notice under subsection (8) in accordance with subsection (8.1), the following rules apply:

1. In the case of a notice under paragraph 2 of subsection (8),

   i. the insurer shall not take the position that the insured person has an impairment to which a Pre-approved Framework Guideline applies, and

   ii. the insurer shall give a notice described in paragraph 1 of subsection (8) in accordance with subsection (8.1).

2. In the case of a notice under paragraph 1 of subsection (8), the insurer shall pay for all goods and services provided under the treatment plan that relate to the period starting on the 11th business day after the day the insurer received the application and ending on the day the insurer gives the notice described in paragraph 1 of subsection (8).