Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Neutral Citation: 2017 ONFSCDRS 159

FSCO A13-002136

BETWEEN:

JOSEPH GAROFALO

Applicant

and

ECONOMICAL MUTUAL INSURANCE COMPANY

Insurer

REASONS FOR DECISION

Before: Arbitrator Charles Matheson

Heard: On September 20 & 21, 2016; February 2, 7 & 27, 2017 and March 17 & 31, 2017

Appearances: Mr. Ben Fortino, lawyer, participated for Mr. Joseph Garofalo
Mr. Neil Colville-Reeves, lawyer, participated for Economical Mutual Insurance Company

Issues:

The Applicant, Mr. Joseph Garofalo, was injured in a motor vehicle accident ("MVA") on August 18, 2008. He applied for and received statutory accident benefits from Economical Mutual Insurance Company ("Economical"), payable under the *Schedule*.[1] The parties were unable to resolve their disputes through mediation, and Mr. Garofalo applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c. I.8, as amended.

[1] *The Statutory Accident Benefits Schedule - Effective November 1, 1996*, Ontario Regulation 403/96, as amended.

The issues in this Hearing are:

1. Is Mr. Garofalo entitled to receive a weekly Income Replacement Benefit ("IRB") in the amount of $400.00 from July 4, 2011 to date and on-going?
2. Is Mr. Garofalo entitled to receive a Medical Benefit in the amount of $623.00 for chiropractic treatment and a total body assessment as per the OCF-18, dated June 9, 2014?
3. Did Mr. Garofalo sustain a "Catastrophic Impairment" as a result of the accident within the meaning of the *Schedule*?
4. Is Mr. Garofalo entitled to interest for the overdue payment of benefits?
5. Is Economical liable to pay Mr. Garofalo's expenses in respect of the Arbitration?
6. Is Mr. Garofalo liable to pay Economical's expenses in respect of the Arbitration?

Result:

1. The Applicant is not entitled to IRBs beyond July 4, 2011 as a result of this accident.
2. The Applicant is not entitled to receive a Medical Benefit as cited in the June 9, 2014 OCF-18.
3. The Applicant did not sustain a Catastrophic Impairment as a result of this accident.
4. The Applicant is not entitled to interest for any overdue payments of benefits
5. Economical is not liable to pay the Applicant's expenses in respect to this Arbitration.
6. The Applicant is liable to pay Economical's reasonable expenses in respect to this Arbitration.

EVIDENCE AND ANALYSIS:

Legislation Considered

Statutory Accident Benefits Schedule - Accidents on or after November 1, 1996, O. Reg. 403/96

Background

The Applicant was 42 years old at the time of the MVA. The Applicant finished high school at grade 11.

The Applicant has held a series of jobs, all of which require manual labour with some level of customer service.

The Applicant has had a long and unfortunate medical history beginning with a May 29, 1994 workplace accident. In 2002, the Applicant applied for and received disability benefits from the Ontario Disability Support Program.

The Applicant had two previous MVAs, both in February of 2007, prior to this MVA.

Despite these hurdles, the Applicant, much to his credit, began working full-time once again as a construction labourer on June 11, 2008 until November 4, 2008. Since November 4, 2008, the

Applicant has not been gainfully employed, and had received IRBs up to July 4, 2011 when the benefit was terminated by the Insurer.

The Applicant was involved in two more MVAs since August 2008, namely, December 10, 2010 and February 11, 2013.

Decision

The Applicant did not appear at the first day of the Hearing and his counsel stated that he had lost contact with the Applicant a few days prior while counsel was prepping him for the Arbitration. Counsel for the Applicant requested a one-day adjournment in order to find the Applicant.

Insurer's counsel argued that should the Applicant not be found, he would move that this Arbitration be dismissed. I adjourned the Arbitration until the following morning.
On day two of the Arbitration, Applicant's counsel presented two documents: one from St. Joseph's Hamilton Hospital and the second from Dr. Gozlan, the psychologist. These are marked Exhibits 1 and 2 respectfully.

Applicant's counsel argued that he required a second adjournment in order for his client to attend the Arbitration Hearing, as the Applicant was not able to attend at this time. Counsel argued that he was unable to proceed to Arbitration without direction from his client or without the Applicant's direct testimony.

Applicant's counsel argued that the two documents showed that the Applicant was clearly having some sort of episode and was now under the care of his treating psychologist, and was unable to attend the Arbitration in the short term.

I noted that Dr. Gozlan and the hospital notes showed that the Applicant was suffering from panic attacks and also had suicidal ideations. The Applicant was observed by the hospital on September 18, 2016 and held overnight until September 19, 2016. Dr. Gozlan's office and staff had taken oversight of the Applicant on September 20, 2016.

The Insurer's counsel argued that if a short adjournment was granted, the Insurer would move to dismiss the Application for Arbitration with prejudice should the Applicant not attend or participate again causing further delays. Insurer's counsel requested that should an adjournment be granted, it must have the condition which necessitates the case must move forward on its merits once reconvened.

I granted an adjournment to the first date available in the parties' calendars, with the condition that I would hear the Insurer's Motion to dismiss should the Applicant not be available again.

The Arbitration reconvened as scheduled on February 2, 2017. The parties had scheduling conflicts with their respective expert witnesses and as such, agreed that the only witnesses to testify would be Dr. Greenspoon, the Applicant's treating physician, and Dr. Gozlan, the Applicant's treating psychologist. They also agreed that their respective expert reports and Catastrophic Impairment reports would be submitted without any testimony from the authors of said reports.

Issues

1. ***Is Mr. Garofalo entitled to receive a weekly Income Replacement Benefit in the amount of $400.00 from July 4, 2011 to date and on-going?***

The applicable section of the *Schedule* for the IRB is Part II, s. 5(2)(b), which reads as follows:

> **PERIOD OF BENEFIT**
>
> 5. (1) Subject to subsection (2), an income replacement benefit is payable during the period that the insured person suffers a substantial inability to perform the essential tasks of the employment in respect of which he or she qualifies for the benefit under section 4. O. Reg. 403/96, s. 5 (1).
> (2) The insurer is not required to pay an income replacement benefit,

> (a) for the first week of the disability;
>
> (b) for any period longer than 104 weeks of disability, unless, as a result of the accident, the insured person is suffering a complete inability to engage in any employment for which he or she is reasonably suited by education, training or experience;
>
> …

The parties have agreed that it is the burden of the Applicant to show that because of the August 18, 2008 MVA, he suffered a complete inability to engage in any employment for which he is reasonably suited by education, training or experience.

The undisputed facts and testimony in this case that pertain to the IRB are as follows:

- The Applicant did not advance an IRB claim until February 22, 2011;
- The Insurer paid a lump sum payment from the date of loss up to March 31, 2011 in the amount of $49,600.00;
- Subsequently post-104 week Insurer's Examinations were conducted to determine further entitlement while a weekly IRB was being paid:
    - A Functional Abilities Evaluation report, dated June 6, 2011, was written by Julian Dal Cin;
    - A psychological assessment report, dated June 2, 2011,was written by Dr. Michael Schwartz;
    - A physiatry assessment report, dated June 9, 2011, was written by Dr. Saplys; and
    - A vocational assessment report, dated June 21, 2011, was written by Don Bruin,
- The IRB was terminated on July 4, 2011; and
- All the reports found or supported the concept that the Applicant did not suffer a complete inability to engage in any employment for which he was reasonably suited by education, training and experience.

The inescapable testimony of the Applicant under cross-examination when he was questioned about the vocational assessment report and the four different occupational options presented to him by the vocational assessor, was his admission that he could do all of the listed occupations.

The evidence was clear that all the assessors and the Applicant himself believed that he was capable of working at some sort of occupation during the timeframe that he was assessed in mid-2011. I note that the next MVA in sequence of events happened in December 2010, a full six months prior to the assessments.

In my view, the Applicant did not satisfy his burden and show he was entitled to the IRB in that he was suffering a complete inability to engage in any employment for which he is reasonably suited by education, training or experience as a result of the August 18, 2008 MVA. Therefore, for these reasons, the Applicant is not entitled to IRBs beyond July 4, 2011 as a result of this MVA.

2. Is Mr. Garofalo entitled to receive a Medical Benefit in the amount of $623.00 for chiropractic treatment and a total body assessment as per the OCF-18, dated June 9, 2014?

The applicable section of the *Schedule* is Part V, s. 14(2), which reads as follows:

MEDICAL BENEFIT

14. (1) The insurer shall pay an insured person who sustains an impairment as a result of an accident a medical benefit. O. Reg. 403/96, s. 14 (1).
(2) The medical benefit shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for,
(a) medical, surgical, dental, optometric, hospital, nursing, ambulance, audiometric and speech-language pathology services;
(b) chiropractic, psychological, occupational therapy and physiotherapy services;

(c) medication;
(d) prescription eyewear;
(e) dentures and other dental devices;
(f) hearing aids, wheelchairs or other mobility devices, prostheses, orthotics and other assistive devices;
(g) transportation for the insured person to and from treatment sessions, including transportation for an aide or attendant;
(h) other goods and services of a medical nature that the insured person requires. O. Reg. 403/96, s. 14 (2).

The parties agreed that it is the burden of the Applicant to show that the Medical Benefit he is seeking is a reasonable and necessary expense and that it is linked directly to the August 18, 2008 MVA.

There was no evidence presented on this topic from the Applicant or the facility that submitted the OCF-18. Closing submissions for the Applicant did not address this issue.

The subject OCF-18 was submitted on June 9, 2014, after both the December 2010 and the March 2013 MVAs. I note that this facility also submitted the identical treatment plan in March 2013 for that MVA. In my view, this treatment plan has not been properly linked to the MVA of August 18, 2008. Therefore, the Applicant is not entitled to receive a Medical Benefit as cited in the June 9, 2014 OCF-18.

3. Did Mr. Garofalo sustain a "Catastrophic Impairment" as a result of the accident within the meaning of the Schedule?

The Applicant is seeking a catastrophic determination as a result of the August 18, 2008 MVA.

The applicable section of the *Schedule* reads as follows:

(1.2) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs after September 30, 2003 is,

(f) subject to subsections (1.4), (2.1) and (3), an impairment or combination of impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 per cent or more impairment of the whole person; or

(g) subject to subsections (1.4), (2.1) and (3), an impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder. O. Reg. 281/03, s. 1 (5).

The Applicant asserts that he is 57 percent Whole Person Impaired ("WPI"), which exceeds the 55 percent WPI requirement for a person to be determined to be catastrophically impaired within the meaning of the *Schedule*, as per section (f), above.

The Applicant also argues that he can be found to have a marked impairment, and by virtue of a marked impairment, could be found catastrophically impaired within the meaning of the *Schedule*, as per section (g) above.

Both the Applicant and the Insurer produced assessments of the Applicant for the catastrophic determination with findings of their WPI percentage being summarized - AssessNet for the Applicant and Simac for the Insurer. The reports can be summarized by a chart which reads as follows:

	Assessnet	Simac
Spine	5%	0%
Neck	15%	0%
Shoulder	8%	0%
Headaches	10%	0%
Sleep Disturbance	9%	
Chronic Pain	3%	
Mental/Behavioral	29%	12%
WPI	57%	12%

The AssessNet report was generated August 7, 2015, and the Simac report was generated on January 21, 2016.

The Insurer argues that AssessNet's assessments should be rejected because the results are flawed. The Insurer argues that the differences between the two summaries of the Catastrophic Impairment reports is that the Applicant's assessors did not account for the pre-existing issues in each category, as required by the American Medical Association's *Guides to the Evaluation of Permanent Impairment* ("AMA *Guides*"), for the reduction of a WPI percentage when factoring a pre-existing impairment. The Insurer is relying upon a section of the AMA *Guides* which reads as follows:

> If "apportionment" is needed, the analysis must consider the nature of the impairment and its possible relationship to each alleged factor, and it must provide an explanation of the medical basis for conclusions and opinions. Apportionment and causation are considered more fully in the Glossary (p. 315).
>
> For example, in apportioning a spine impairment, first the current spine problem would be estimated. The estimate for the pre-existing impairment would be subtracted from that for the present impairment to account for the effects of the former. Using this approach apportionment would require accurate information and data on both impairments.

The Insurer argues that both AssessNet and Simac rate the spine at 5% but AssessNet failed to account for the pre-existing impairment as called for under the AMA *Guides*, as noted above.

For further clarification on this point, the Insurer argued that AssessNet indicated that the impairment rating for a Class 4 impairment is at 15%-29%. AssessNet used the extreme end of the spectrum without reduction for a pre-existing impairment. Simac estimated the rate at 12%. The Insurer implies that Simac came to the correct percentage number as they subtracted the pre-existing impairment percentage from the current impairment percentage.

The Insurer asserts that there are inaccuracies, inconsistencies or misstatements in the AssessNet report given that it appears they have been provided with incomplete or inaccurate information regarding the Applicant's pre-MVA condition and circumstances. On February 8, 2005, Dr. Greenspoon's clinical notes and records provided the following diagnosis for the Applicant:

> ASSESSMENT
> Lumbar myalgia
> Pain disorder associated with both psychological factors and a medical condition
> deconditioning

The Insurer argues that the conclusions of AssessNet's assessments entirely ignored any pre-existing physical and mental health issues. Further the Insurer pointed out that Dr. Ennis' report from December 2006 (in which a chronic pain diagnosis was made) was reviewed, but it was not considered by AssessNet's Dr. Armenia. However, Dr. Armenia provided an identical diagnosis made more than 10 years earlier. Thus the Insurer argues that Dr. Armenia's conclusions are contrary to the AMA *Guides* and are of little value.

In addition, the Insurer argues that the specific rating issues discussed at pages 58-66 of AssessNet's report fail to consider any of these pre-existing issues. The Insurer argues that clear and compelling evidence regarding the conclusions reached by AssessNet in relation to the Applicant's WPI percentage should be rejected. It is the Insurer's position that the conclusions of Dr. Jaroszynski and his (Simac) assessment team's WPI percentage should be accepted.

Further, the Insurer argues that AssessNet's assessment results and Dr. Greenspoon's clinical notes during the same time frame are at odds with each other. It is Dr. Greenspoon's finding that the Applicant had full range of motion during his visit to his office on November 3, 2015.

The Insurer argues that the evidence on this point is clear and unequivocal. When examined in a non-medical/legal environment at his family doctor's office, his range of motion was full and it is that evidence that should be accepted by the Tribunal.

In my view, credibility of the Applicant and the Applicant's assessments are an issue. I am unconvinced that the AssessNet assessments took into consideration the pre-existing conditions of the Applicant as per the AMA *Guides* and did not reduce the WPI percentage numbers accordingly.

In my view, under these circumstances, AssessNet's percentages are not accurate. As a result, the Applicant's WPI percentage falls well short of the WPI percentage required to qualify as catastrophically impaired under the *Schedule*.

In my view, the link was not strong enough between the 2008 MVA and the Applicant's recent expert reports and his current condition. The Applicant testified he worked for some 12 weeks beyond the MVA and that he continued to look for work, but didn't want to work for other personal reasons concerning his son. In December 2010, he suffered another MVA and then suffered a death of a critical family member. In June 2011, the Applicant testified he could have performed several different jobs, yet six months earlier, he was so distraught following the 2010 MVA and the death of his sibling which resulted in the Applicant spending time in the hospital. These issues are listed within Dr. Gozlan's 2016 report. In my view, these traumatic events are glossed over too easily, without a closer examination or explanation by Dr. Gozlan.

In regards to a marked impairment, the Applicant argues that the assessor came to the following conclusions about impairment levels in the four spheres:

(i) Activities of Daily Living – Moderate
(ii) Social Functioning – Moderate
(iii) Persistence and Pace – Moderate
(iv) Deterioration or Decompensation in a Work-Like (Complex) Settings – Marked

The Applicant argues that as a result, given that Mr. Garofalo had one of the four spheres of function rated as a class 4 (Marked level), he should be deemed to be catastrophic.

The Insurer argues that Dr. Armenia, the doctor who concluded that Mr. Garofalo had a Marked impairment in the sphere of Adaptation (which is referred to in the AMA *Guides* as

'Deterioration or Decompensation in a Work or Work-Like Setting'), provided an Axis 1 diagnosis in his 2015 report, identical to a diagnosis provided by the family doctor in 2005. Dr. Armenia failed to explain how this diagnosis was MVA related given the identical diagnosis 10 years prior.

Further, the Insurer argued that "it is noted at page 58 of the AssessNet report that Mr. Garofalo 'has been unable to return to his pre-MVA employment, not only because of his protracted physical problems but also due to chronic pain and moderately severe psychological emotional difficulties." The Insurer submits that this conclusion:

- Ignores pre-existing chronic pain;
- Ignores a pre-existing psychological diagnosis identical to the one made in 2005; and
- Is premised on the false assumption that Mr. Garofalo could not continue working after the August 2008 MVA due to MVA related impairments;

In addition, the Insurer argues that it is by Mr. Garofalo's own testimony that he was encouraged and told by his treating health professionals in 2010-2011 to return to work and was never told that he was unable to work.

In regards to a Marked impairment, I find myself in agreement with the Insurer's arguments and note that the assessments were conducted in 2015, years after two other subsequent MVAs. I remain unconvinced that the AssessNet assessors are completely accurate and the resulting Marked impairment is as a direct result of the 2008 MVA. In my view, on a balance of probability, I remain unconvinced that the Applicant sustained a Marked impairment making him catastrophic as a direct result of the 2008 MVA.

Therefore, for the reasons above, I find the Applicant did not sustain a Catastrophic Impairment as a result of the August 18, 2008 MVA.

As a result of the above decisions, the Applicant is not entitled to interest for any overdue payments of benefits; the Insurer is not liable to pay the Applicant's expenses in respect to this

Arbitration; and the Applicant is liable to pay the Insurer's reasonable expenses in respect to this Arbitration.

EXPENSES:

Neither party made submissions on expenses. Should the parties become unable to resolve this issue, they shall subsequently schedule an expense hearing before me in accordance with the provisions of Rules 75 to 79 of the *Dispute Resolution Practice Code*.

June 12, 2017

Charles Matheson
Arbitrator

Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

Neutral Citation: 2017 ONFSCDRS 159

FSCO A13-002136

BETWEEN:

JOSEPH GAROFALO

Applicant

and

ECONOMICAL MUTUAL INSURANCE COMPANY

Insurer

ARBITRATION ORDER

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

1. The Applicant is not entitled to Income Replacement Benefits beyond July 4, 2011 as a result of this accident.
2. The Applicant is not entitled to receive a Medical Benefit as cited in the June 9, 2014 OCF-18.
3. The Applicant did not sustain a Catastrophic Impairment as a result of this accident.
4. The Applicant is not entitled to interest for any overdue payments of benefits.
5. The Insurer is not liable to pay the Applicant's expenses in respect to this Arbitration.
6. The Applicant is liable to pay the Insurer's reasonable expenses in respect to this Arbitration.

June 12, 2017

Charles Matheson
Arbitrator

Date